IN THE MATTER OF:	*The Regulated Health Professions Act,* C.C.S.M., c. R117, Part 8
AND IN THE MATTER OF:	DR. LEONARD ELIA LOCKMAN, a member of the College of Physicians and Surgeons of Manitoba
AND IN THE MATTER OF:	A Notice of Inquiry dated November 25, 2020, as amended June 10, 2021 and April 6, 2022

INQUIRY PANEL:

Dr. Joel Kettner, Chairperson

Dr. Jim Price

David Bjornson, Public Representative

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

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REASONS FOR DECISION OF THE INQUIRY PANEL

INTRODUCTION

Commencing April 11, 2022 and continuing on April 18, 20, 22 and 27, 2022, the Inquiry Panel (the "Panel") of the College of Physicians and Surgeons of Manitoba (the "CPSM") was reconvened for the purpose of conducting an inquiry (the "Hearing") pursuant to Part 8 of *The Regulated Health Professions Act* C.C.S.M., c. R117 (the "Act") into charges against Dr. Leonard Elia Lockman ("Dr. Lockman"), a member of the CPSM, as set forth in an Amended Notice of Inquiry, as most recently amended April 6, 2022. The Inquiry Panel previously heard and made findings with respect to a preliminary matter, the details of which are set out in the Reasons for Decision dated July 27, 2021.

The Amended Notice of Inquiry charged Dr. Lockman with professional misconduct, with contravening the CPSM's By-laws, the Standards of Practice of Medicine and the Code of Ethics, with displaying a lack of skill, knowledge, and judgment in the practice of medicine, and with demonstrating an incapacity or unfitness to practice medicine.

The original Notice of Inquiry had 16 counts (charges). Counts 5, 6, 10, 12, and 13, were withdrawn.

The counts which the Panel was required to establish, on the balance of probabilities, are listed below:

1. Between in or about January 1, 2011 and November 30, 2019, Dr. Lockman contravened the CPSM's By-laws, Standards of Practice of Medicine and/or Code of Ethics (as in effect at the relevant time); displayed a lack of knowledge, skill and judgment in the practice of medicine and/or engaged in professional misconduct in that Dr. Lockman demonstrated widespread deficiencies through multiple and repeated failures to provide adequate or

appropriate care and management, including his medical record keeping, in respect to all or many of the patients whose care was reviewed by the CPSM.

2. Between in or about January 1, 2011 and November 30, 2019, Dr. Lockman engaged in professional misconduct; contravened the CPSM's By-laws, the Standards of Practice of Medicine and/or the Code of Ethics (as in effect at the relevant time); and/or displayed a lack of knowledge, skill and judgment in the practice of medicine in that Dr. Lockman created and maintained his patient records for the provision of care specific to each patient in a manner that resulted in multiple entries in those records that do not correlate to the care that he actually provided or to actual clinical circumstances of the specific patients, and/or that inaccurately or falsely represents significant aspects of their care, management or diagnoses.

3. In respect of a patient, identified as *Patient 3,* on or about May 1, 2017, Dr. Lockman falsely documented a clinical encounter that did not occur and then made an inappropriate claim for insured services under *The Health Services Insurance Act* (the "HISA") in respect to that fabricated clinical encounter and thereby engaged in professional misconduct and/or contravened the Code of Ethics.

4. In respect of a patient, identified as *Patient 2*, on or about August 1, 2017, Dr. Lockman falsely documented a clinical encounter that did not occur and then made an inappropriate claim for insured services under the HISA in respect to that fabricated clinical encounter and thereby engaged in professional misconduct and/or contravened the Code of Ethics.

7. Between in or about January 2012 and in or about September 2019, Dr. Lockman caused or permitted one or more of the claims for insured services under the HSIA using the Chronic Disease Management ("CDM") and/or Chronic Care Management ("CCM") tariffs, as listed at Appendix B of the Notice of Inquiry, to be submitted in circumstances where the claim was

inappropriate and/or unsupported and Dr. Lockman thereby engaged in professional misconduct and/or contravened the Code of Ethics.

8. Between in or about January 2012 and in or about September 2020, Dr. Lockman, both as a physician providing care at and in his role as the medical director and owner of the St. Vital Family Medical and Walk-In Clinic (the "Clinic"), Dr. Lockman was responsible for an unethical system for billing insured services under the HSIA using the CDM and/or CCM tariffs that included the submission of inappropriate and/or unsupported claims for insured services under the HSIA, including the claims using the CDM and/or CCM tariffs for services, as listed in Appendix B of the Notice of Inquiry, and thereby engaged in professional misconduct, and/or contravened the Code of Ethics.

9. Between in or about December 2015 and in or about March 2020, Dr. Lockman, in his capacity as the owner and medical director of the Clinic, contravened the Standards of Practice of Medicine in that Dr. Lockman failed to ensure that his EMR system had a comprehensive audit capability which entered all access onto a permanent file log, identified and recorded where the access originated and by whom, and identified if alterations are made to the record and by whom, what was altered, and when the alteration was made.

11. On or about April 18, 2018, Dr. Lockman engaged in professional misconduct and/or contravened the Code of Ethics in that Dr. Lockman behaved in an unprofessional manner both during a clinical encounter with a patient, identified as *Patient 5*, and one of his family members on April 18, 2018 when *Patient 5* attended at the Clinic to see Dr. Lockman as a patient, and respecting Dr. Lockman's subsequent communication with *Patient 5* related to that visit.

14. Between in or about September 18 and 21, 2020, Dr. Lockman contravened the Code of Ethics, displayed a lack of knowledge, skill, and judgment in the practice of medicine, and/or engaged in professional misconduct respecting

the manner in which Dr. Lockman conducted himself when a patient, identified as *Patient A*, presented in urgent need of care at the Clinic and in Dr. Lockman's subsequent documentation in *Patient A*'s medical record.

15. Between in or about September 18 and 29, 2020, Dr. Lockman contravened the Code of Ethics, and/or engaged in professional misconduct respecting his conduct and communication toward a doctor, identified as *Doctor X*, including representations regarding Dr. Lockman's reasons for not assisting *Dr. X* with *Patient A* on September 18, 2020.

16. By reason of one or more of the allegations, individually or cumulatively, Dr. Lockman has demonstrated an unfitness to practice medicine.

The Amended Notice of Inquiry also contained factual particulars with respect to the allegations at Counts 1, 2, 8, 14, and 15.

The Hearing proceeded in the absence of Dr. Lockman but in the presence of his counsel, and in the presence of counsel for the Complaints Investigation Committee of the CPSM (herein the "CPSM"). Through his counsel, Dr. Lockman admitted his membership in the CPSM and confirmed that the Panel had jurisdiction over the matters at issue. Through his counsel, Dr. Lockman also acknowledged service upon him of the Amended Notice of Inquiry and consented to the filing of the Amended Notice of Inquiry.

Through his counsel, Dr. Lockman waived the reading of the Amended Notice of Inquiry and entered a plea of guilty/admission to Counts 1, 2, 3, 4, 7, 8, 9, 11, 14 and 15. By doing so, Dr. Lockman admitted the truth of all of the allegations and of the factual particulars in support of the allegations in the Amended Notice of Inquiry for those Counts and also admitted that the facts and matters outlined therein constituted professional misconduct, a breach of the Code of Ethics, a breach of the CPSM By-laws, a breach of the Standards of Practice of Medicine, and a lack of knowledge, skill and judgment in the practice of medicine, as more particularly referred to in the Amended Notice of Inquiry.

Through his counsel, Dr. Lockman did not admit or enter a plea of guilty to Count 16 but advised that, in his view, this was a matter solely for the Panel's consideration. Dr. Lockman, through his counsel, advised that Dr. Lockman would not, however, be contesting Count 16.

As set out in the Amended Notice of Inquiry, the CPSM chose not to proceed with Counts 5, 6, 10, 12 and 13 and they were withdrawn accordingly.

The CPSM and Dr. Lockman proceeded by way of a Joint Recommendation as to the disposition of this matter as follows:

- An Order reprimanding Dr. Lockman pursuant to subsection 126(1)(a) of the Act;
- An Order cancelling Dr. Lockman's registration with the CPSM pursuant to subsection 126(1)(i) of the Act; and
- An Order that Dr. Lockman pay to the CPSM costs in the amount of $40,000 pursuant to subsection 127(1)(a) of the Act.

The Panel reviewed and considered several documents, all of which were filed as exhibits in the proceedings by consent. The complete list of exhibits are set out in Schedule A, attached hereto.

Decisions of the Panel

For the reasons set out herein, the Panel is satisfied that the Joint Recommendation as to disposition is sound and appropriate and has therefore been accepted by the Panel.

For the reasons set out herein, having regard to the evidence provided and Dr. Lockman's admissions of guilt regarding counts 1, 2, 3, 4, 7, 8, 9, 11, 14 and 15, the Panel is satisfied that these counts and their particulars have been established on a balance of probabilities.

For the reasons set out herein, the Panel, having regard to the evidence provided, is satisfied that Count 16 that Dr. Lockman demonstrated an unfitness to practice medicine, has been established on a balance of probabilities.

The Panel's specific reasons for its decisions are explained below.

BACKGROUND

Dr. Lockman practiced medicine for approximately 30 years. Dr. Lockman was the Medical Director and Owner of the St. Vital Family Medical and Walk-in clinic (the "Clinic") at all material times.

At all material times, Dr. Lockman and the Clinic used the MaxGold electronic medical record (EMR) system. The details of that system were set out in a memorandum filed in the hearing.

Dr. Lockman had been previously censured by the CPSM in May 2015 for failing to meet the standard of the profession when referring his patients to the Emergency Department for care in that he referred the patient without taking an adequate history and without performing an adequate physical examination or assessment of the patient to determine if the patient's acuity warranted emergent or urgent intervention. Dr. Lockman had also documented that one or more of his patients had declined a physical examination when one or more of the patients stated that they did not decline an examination.

Effective June 21, 2019, the Registrar of the CPSM imposed 12 interim conditions on Dr. Lockman's certificate to practice. (Exhibit 24).

1. You are required to only practice medicine at the St. Vital Medical Clinic, Winnipeg, Manitoba, and you are not permitted to change your practice location without prior written consent of the Chair. In your practice, you will see no more than 30 patients per day and will limit your practice to a maximum of 5 days per week.

2. You are required to create a complete and accurate record of each patient encounter, in accordance with the requirements of the College's *Standards of Practice of Medicine*, particularly at Parts 2 and 5. Without limiting the foregoing:

    a. For each patient encounter, you will document on the patient's chart:

        i. an adequate patient history;

        ii. particulars of any physical examinations;

        iii. an assessment of the problem, including a differential diagnosis or presumptive diagnosis;

        iv. any planned investigations, referrals or follow-up; and

        v. any treatment prescribed.

    b. You will maintain in each patient chart:

        i. a problem list;

        ii. a flow sheet of prescribed medications, including those prescribed by you and, where applicable, medications known to be prescribed by others;

        iii. a chronic disease flowsheet with any one or more of the following chronic diseases:

            1. diabetes,

            2. asthma,

            3. hypertension,

            4. congestive heart failure, and

5. ischemic heart disease.

3. You shall maintain a daily diary or appointment sheet which shall include the name of each patient seen or treated, or in respect to whom some professional service was rendered by you.

4. You are required to establish and maintain a tracking system to ensure that you convey to the patient all abnormal diagnostic results received respecting that patient, as well as any recommended follow up care.

5. At your own expense, you are required to participate in the University of Manitoba, Max Rady College of Medicine, Rady Faculty of Health Sciences, Division of Continuing Professional Development medical record-keeping course on the next occasion on which it is offered, and promptly thereafter provide to the Chair proof of participation in that course. An equivalent course satisfactory to the Chair may be substituted in the event that this course is not available within a reasonable time frame.

6. If you fail to take the record-keeping course required at paragraph 5 on or before December 31, 2019, you will be suspended indefinitely until you have completed same.

7. As of July 4, 2019, you will be prohibited from practicing medicine unless and until a Practice Supervisor satisfactory to the Chair agrees to supervise your practice in accordance with these conditions and has executed an undertaking in a form acceptable to the Chair for that purpose.

8. Once a Practice Supervisor is appointed, you will be required to cooperate with all aspects of the supervision of your practice by the Practice Supervisor in accordance with the conditions on your certificate of practice, including by providing the Practice Supervisor

with records reasonably required to discharge their duties, particularly including those described above at points 2 and 3.

9. You shall facilitate review by your Practice Supervisor, weekly, of not less than fifteen (15) patient charts from your office practice for patients seen over the previous week ("Review Period"). This will require providing the Practice Supervisor with any daily diary or appointment sheet requested. You shall not be involved in the selection of charts to be reviewed. The Practice Supervisor will be required to select at least two (2) charts from each day during which you practiced during the Review Period. The purpose of the review is to allow the Practice Supervisor to assess whether:

    a. patient charting is up-to-date and in compliance with these conditions and Parts 2 and 5 of the *Standards of Practice of Medicine*; and

    b. the care provided meets the applicable standard of care.

10. Notwithstanding paragraph 8, if you see fewer than fifteen patients over the Review Period, the Practice Supervisor will be required to review charts for all patients seen.

11. The Practice Supervisor will report to the Chair respecting your practice and your compliance with these conditions in accordance with their Practice Supervisor's undertaking.

12. You will pay all costs arising from the supervision of your practice by your Practice Supervisor.

EVIDENCE

The Panel received into evidence the Affidavit of Meredith McLeod (the "McLeod Affidavit"), the Affidavit of Curtis Peters (the "Peters Affidavit"), the Expert Report of Dr. Carol Scurfield and the Expert Report of Dr. Alexander Singer. In addition, the Panel heard oral evidence from CPSM investigator, Dr. Karen Bullock-Pries, and from Drs. Scurfield and Singer.

McLeod Affidavit

Meredith McLeod is the Coordinator for the Complaints and Investigation Department of the CPSM.

Three complaints, identified as IC3050, IC3056, and IC3083, were referred to the Investigation Committee in March of 2017 based on letters of complaint from *Dr. 1* and her spouse, *Patient 1*. In regard to IC3056, among other issues, *Dr. 1* raised concern in her complaint letter about the validity of certain diagnoses in her patient record, including ischemic heart disease, diabetes, and hypertension. *Dr. 1* and Patient 1 were referred to as "Group 4 Patients" in the materials filed before the Panel.

The complaint identified as IC3145 was referred to the Investigation Committee in August 2017 based on a letter of complaint from *Patient 2*.

The complaint identified as IC3159 was referred to the Investigation Committee in September 2017 based on a letter of complaint from *Patient 3*.

The complaint identified as IC3528 was initiated by the Registrar based on information obtained by the CPSM and referred to the Investigation Committee in April 2018. This complaint lists a group of 12 patients (collectively "Group 1") plus *Dr. 1* and *Patient 1*.

An interactive audit of Dr. Lockman's practice was conducted on January 25, 2019. Patient records for 16 patients were reviewed ("Group 2"). Care provided to Group 1 patients was audited on April 8, 2019.

Dr. Lockman's practice of medicine was monitored by a practice supervisor, *Dr. X*, as of July 2019. Concerns respecting Dr. Lockman's care of a third group of patients ("Group 3") were identified through monitoring reports provided by *Dr. X*.

The CPSM obtained information indicating that Dr. Lockman submitted billings for physicians practicing at the Clinic, including *Dr. 2*. Concerns related to Dr. Lockman's CDM billing practices for claims submitted in *Dr. 2*'s name were raised with Dr. Lockman by letter dated October 8, 2019.

The complaint identified as IC3290 was referred to the Investigation Committee in May 2018 based on a letter of complaint from *Patient 5*, relating to care and conduct.

The complaint identified as IC5326 was referred to the Investigation Committee in October 2020 as a result of an e-mail sent to the CPSM by Dr. Lockman on September 21, 2020 related to *Dr. X*. The complaint raised a concern that Dr. Lockman misrepresented an incident with *Dr. X* in an attempt to impugn *Dr. X*'s reputation and to possibly pre-empt a potential forthcoming complaint by *Dr. X*.

The McLeod Affidavit included responses by Dr. Lockman as well as transcripts of various interviews that took place with Dr. Lockman regarding the complaints identified.

<u>Peters Affidavit</u>

Curtis Peters was the former Acting Director and then Acting Executive Director of the Insured Benefits Branch with Manitoba Health Seniors and Active Living ("MHSAL" or "Manitoba Health"). As such, Mr. Peters was experienced regarding

organizational policies and procedures within the Insured Benefits Branch of Manitoba Health, including the administration of *The Health Services Insurance Act* ("HSIA").

His affidavit provided the Panel with the following information that is pertinent to the deliberations of the Panel.

> The HSIA and its regulations establish a legislative framework for the payment of claims for insured medical services submitted by medical practitioners in Manitoba. The Physician's Manual is a Schedule to The Payments for Insured Medical Services Regulation (the "Regulation"). Payments for insured medical services are made in accordance with the rules of application and subject to the terms and conditions set out in the Physician's Manual.
>
> Manitoba Health expects medical practitioners:
>
> (a) To be aware of and comply with the rules of application and terms and conditions set out in the Physician's Manual, which is published on the MHSAL website;
>
> (b) To conduct themselves honourably and in good faith when deciding whether criteria are met for the tariffs they claim; and
>
> (c) Are making appropriate clinical decisions relating to the medical services underlying each of the tariffs they claim.
>
> Tariffs have been established in the Physician's Manual for the annual management of chronic diseases in general practice by primary care providers. These fall under the heading "Chronic Disease Management" ("CDM") and the sub-heading "Comprehensive Care" ("CCM") in the Physician's Manual.
>
> CDM tariffs exist for:
>
> (a) Annual management of diabetes, including development of patient care plan (78431);

(b) Annual management of asthma, including development of patient care plan (78432);

(c) Annual management of congestive heart failure, including development of patient care plan (78433);

(d) Annual management of coronary artery disease, including development of patient care plan (78434); and

(e) Annual management of hypertension, including development of patient care plan (78435).

The CDM tariffs have specific clinical requirements in order to claim the tariff, which are set out in the Physician's Manual. Each of the CDM tariffs may only be claimed for patients with a confirmed diagnosis of the disease relevant to the tariff. Management of risk factors alone in the absence of a confirmed diagnosis would not qualify as chronic disease management.

For all CDM tariffs, a patient care plan for the management of the patient's chronic disease must be developed before the tariff can be claimed. Additionally, each CDM tariff has a list of services set out in the Physician's Manual that must be provided before the tariff may be claimed.

The CDM tariffs require that the claimant has provided "the majority of [the] patient's ongoing comprehensive care in relation to the active management" of the respective chronic disease "during the preceding twelve (12) months".

CCM tariffs exist for:

(a) Annual management of primary care for a patient between 50 – 74 years of age without a chronic disease (78454);

(b) Annual management of primary care for a patient 75 years of age and over without a chronic disease (78455);

(c) Annual management of primary care for a patient diagnosed with one chronic disease (78456);

(d) Annual management of primary care for a patient diagnosed with two chronic diseases (78457); and

(e) Annual management of primary care for a patient diagnosed with three or more chronic disease (78458).

The specific clinical requirements for claiming the CCM tariffs are set out in the Physician's Manual. Like the CDM tariffs, the specific CCM tariffs for annual management of primary care for patients' diagnosed chronic diseases may only be claimed in respect to patients with a confirmed diagnosis of the disease relevant to the tariff.

Evidence of Karen Bullock-Pries

Dr. Bullock-Pries is an investigator with the CPSM. Her role is to bring information to the Investigation Committee for their consideration.

Dr. Bullock-Pries described the evidence as set out in the McLeod Affidavit, including her interviews and correspondence with Dr. Lockman, and various patient records filed as evidence.

While not cross-examined, Dr. Bullock-Pries responded to questions asked of her by the Panel.

The details of much of this evidence is discussed elsewhere in these Reasons for Decision.

Evidence of Dr. Scurfield

Dr. Scurfield prepared a report and supporting materials that were filed as exhibits. In addition, Dr. Scurfield was called to give oral evidence before the Panel. At

the start of her testimony, counsel for the CPSM sought to qualify Dr. Scurfield as an expert, which qualifications were not objected to by Dr. Lockman's counsel.

Dr. Scurfield acted as an independent auditor in this matter. She is registered to practice medicine in Manitoba and currently does so through the Women's Health Clinic. Dr. Scurfield obtained her medical degree from the University of Manitoba in 1980 and most recently obtained a Masters of Science (Community Health) Title: Midwifery Legislation in Manitoba in 2002. She has acted as an auditor for the CPSM since 1989. Her work as an auditor involves audits of charts for physicians who are on Conditional Registration, those who have had complaints that require chart audits for investigation or standards reasons, and audits of elderly physicians. Dr. Scurfield has engaged in paper audits as well as in-person interactive audits.

The Panel, having heard and reviewed Dr. Scurfield's credentials, was satisfied that she was an expert in her field and could present the evidence in her reports and before the Panel.

Dr. Scurfield described her report generally and then specifically on certain patient records, which are included in her written report. While not cross-examined, Dr. Scurfield responded to questions asked of her by the Panel.

Dr. Scurfield testified that she approaches her audits in a manner that she deems to be fair and uses her best efforts to see if good care and good charting is being carried out by the physician. Good charting is necessary to provide good care. Charting is necessary to allow for an adequate audit to occur, for others to be able to step in to provide patient care, and to create a game plan and tool to address a patient's care.

Dr. Scurfield's report followed an audit that she conducted having regard to Dr. Lockman's care of patients with chronic illness. Dr. Scurfield's retainer letter, which set out the scope of her audit, is found at page 6 of Exhibit 10. In particular, Dr. Scurfield was asked to consider the following questions:

(a) For each chronic disease identified, is there evidence to confirm the diagnosis;

(b) If the diagnosis is not confirmed, is the care based on risk factors for the diagnosis?

(c) Are the patient assessments appropriate for the diagnosis?

(d) Is the treatment, as documented, appropriate for the diagnosis?

(e) Is there evidence that the documented treatments and/or plan was carried out?

(f) Does the documentation meet the expected standard of care?

Following Dr. Scurfield's audit and an interview with Dr. Lockman, she noted numerous concerns related to both charting and client care based on the sixteen charts she reviewed (Group 2). In particular, the following concerns were noted (pg. 8 of Exhibit 10) by Dr. Scurfied, key excerpts of which are quoted here: :

(a) The electronic chart has a very poor current medication list. There is no simple way of looking and seeing what the current medications are or what dose they are on;

(b) His encounter notes are poor. He records very little history even on those that he is seeing for a complete assessment or periodic exam. Standard questions that would be asked of patients being followed for a chronic health condition such as asthma or diabetes are not asked;

(c) The organization of his encounter notes is very poor despite a template that clearly delineates a history section, an objective section for physical exams and results of investigation, an assessment section and a plan section, which are all important aspects of a medical encounter. He puts his plan in the history and/or in the objective area. The plans

are vague and often are simply a recommendation about when to return.

(d) His management of diabetes suffers from the lack of organization in his records. It was not clear that adequate monitoring for complications takes place. There is no consistent record of a foot exam and only occasionally is there a mention of visual screening done by an optometrist. He uses macros that generally are placed in the history portion of the record for example “diabetic counselling, drugs, diet exercise, side effects drugs”. This should really be in the plan section of the encounter note. As well, it really doesn’t add anything to the record in that it is too vague. If the physician is using a macro to streamline the charting it must contain useful information;

(e) His management of asthmatic patients is also poor in that he is not asking them standard questions to try and ascertain how well controlled their disease process is;

(f) Many charts have abbreviation for ischemic heart disease (IHD) in areas where health and diagnoses are recorded. He states that IHD on his records has nothing to do with a diagnosis of ischemic heart disease. IHD often is used as the diagnosis for billing in these patients who may not even be at risk of IHD. When this abbreviation appears in a problem list it gives an erroneous impression that this person suffers from ischemic heart disease;

(g) The electronic record does not have flow sheets that can be used to monitor medications such as warfarin or for monitoring the management of chronic diseases such as diabetes; and

(h) The records where he appears to be performing a periodic health exam do not have any history with respect to use of alcohol or drugs. Their diet and exercise patterns are not recorded. A review of systems is not

recorded. In the physical exam recordings, he appears to do a Glasgow Coma Scale on everyone, which is not designed to be used with an ambulatory population.

Dr. Scurfield's second audit, of patients set out in Group 1, led to her following overall conclusions (Exhibit 11):

(a) The records display a lack of organization;

(b) There is a consistent lack of adequate history taking, appropriate examination, and appropriate plan;

(c) There is evidence of inappropriate prescribing of antibiotics;

(d) There is a concern with respect to other management, with respect to diabetes management in particular;

(e) There is poor use of the Framingham Risk assessment tool which has left patients with inappropriate diagnoses of ischemic heart disease;

(f) Test results do not appear to be consistently followed when abnormal results are found; and

(g) Lab tests such a pap and blood tests are not consistently done when indicated.

Dr. Scurfield, as a follow up to her January 25, 2019 audit, provided a second (supplementary) report for Group 2 patients where the following overriding issues were stated by Dr. Scurfield (Exhibit 12):

(a) The notes are disorganized without a structure that would be considered usual for medical records. This disorganization makes it very difficult to follow what is happening at the visit the record was created for;

(b) The histories are inadequate and suggest that the appropriate questions are not being asked of the patients;

(c) Physical exams as recorded are often not related to the complaint the patient has. A physical exam should include pertinent findings with respect to the patient's symptoms or chronic disease;

(d) The medication lists are not useful and in fact could be dangerous. The medication list which is titled "active" is in fact not active but lists medications which the patient may or may not be on at the present time;

(e) Diabetic follow up is poor. The recommended interval of follow up is not evidenced in any of the records. If a diabetic is being instructed to follow up at the appropriate interval but is not coming in it is useful to record that. With management of chronic diseases, it is important to provide opportunistic follow up. If a person comes because they have a viral complaint it is important to quickly follow up with their chronic disease(s) and to record that;

(f) The use of macros is inappropriate, and it is important to modify a macro if it does not completely and accurately reflect the history and physical and advice given to the patient;

(g) Problem lists should be developed instead of only listing the visit and what they were billed as. The problem list is critical in patients with many chronic illnesses or those that have conditions that are stable but need episodic follow up. This is not done.

(h) Risk factors for illnesses should be recorded under the risk factor portion of the record summary. Risk factors are not diagnoses and should not be used as such.

Evidence of Dr. Singer

Dr. Singer prepared a report and supporting materials that were filed as exhibits. In addition, Dr. Singer was called to give oral evidence before the Panel. At the start of his testimony, counsel for CPSM sought to qualify Dr. Singer as an expert, which qualifications were not objected to by Dr. Lockman's counsel.

Dr. Singer obtained his medical degree in 2007 from the University College Dublin. He did his post-graduate training in family medicine at the University of Manitoba, Department of Family Medicine, from 2007 to 2009. Dr. Singer has been registered with the CPSM to practice since 2010, since which time he has practiced as a family physician with a full scope of practice. Dr. Singer is currently an Associate Professor with the Department of Family Medicine, at the University of Manitoba and is the director of research and quality improvement. Dr. Singer 's research includes electronic medical record (EMR) data quality and the use of electronic medical records for research purposes.

The Panel, having heard and reviewed Dr. Singer's credentials, was satisfied that he was an expert in his field and could present the evidence in his reports and before the Panel.

Dr. Singer described the evidence in his report generally and then specifically drew the attention of the Panel to certain patient records, which are included in his written report. Dr. Singer was not cross-examined but did respond to questions asked by the Panel.

Dr. Singer's retainer letters for an initial and supplementary report, which set out the scope of his engagement, are found at pages 2 and 45 of Exhibit 13. Dr. Singer was asked to review the clinical records of 42 patients (Groups 1 – 4) for an assessment of Dr. Lockman's management of his patients who have chronic diseases, including respecting his diagnoses, management, and record keeping practices. In particular, Dr. Singer was asked to consider the following questions:

(a) Whether diagnostic criteria are met in cases where a chronic disease diagnosis is documented;

(b) For patients who have one or more chronic diseases (specifically diabetes, hypertension, congestive heart failure, asthma or coronary artery disease), whether the chronic disease is being actively managed to the expected standard of care;

(c) Whether Dr. Lockman's record keeping meets expected professional standards; and

(d) Are Dr. Lockman's billing practices accurate and consistent with the expected standard of practice? (Note: this fourth question was added in the supplementary report requested of Dr. Singer)

Dr. Singer's responses to these specific questions are found in the summary of the findings in his initial report and in the supplemental report at Exhibit 13, with additional information found at Exhibits 14 to 16.

Below are selected excerpts from Dr. Singer's *Summary of Review of Compiled Information Related to Patients Seen by Dr. Lockman*, August 30, 2021 (revised September 10, 2021), Exhibit 13 p. 232.

> 1) *Whether diagnostic criteria are met in cases where a chronic disease diagnosis is documented?*
>
> In several cases there are insufficient explanations for the inadequate documentation related to the care provided. Several cases detail inadequate documentation related to patient presentations, objective findings, assessments, and management plans. The documentation regarding how diagnoses were made rarely had details that would permit the reader to understand the rationale that led to the decision or alternatives considered. The plans did not provide sufficient detail to

allow for understanding if diagnoses were being reassessed based on investigations ordered or pending consultations.

The most troubling aspect of Dr. Lockman's approach to diagnosis of chronic disease relates to the manner in which he describes Coronary Artery Disease (CAD) also referred to as Ischaemic Heart Disease (IHD).

The logic applied by Dr. Lockman regarding his application of the diagnosis of CAD/IHD was that he was including "asymptomatic IHD/CAD" as part of the inclusion criteria. However, this is inconsistent with how CAD is defined, which is that in order to have the condition a patient must have observable ischaemic changes in the coronary arteries or an event preceding (i.e. heart attack) that demonstrates one or more arteries are blocked. Dr. Lockman's explanation of how he used the diagnosis of CAD/IHD is both inconsistent with the documentation provided and devoid of a clear appreciation of the difference between primary and secondary prevention. Additionally, the discussions with patients which occurred with Dr. Bullock-Pries do not support his assertion that he was "managing" patients' risk in a manner that would have justified this explanation.

The term "risk equivalency" has no basis that I am aware of in medical literature and cannot be considered a diagnosis or principle consistent with good medical care. As previously described, risk assessment prevention and management of chronic diseases are typical aspects in Family Practice. While screening for CAD is an insured service, it is not meant to be remunerated by specific CDM tariffs. The rationale applied by Dr. Lockman appears to be attempting to justify billing practices that do not represent appropriate use of diagnostic criteria common to the discipline nor is it a justified based on the intent or specifics of the rules related to the Manitoba Health CDM tariffs.

2) For patients who have one or more chronic diseases (specifically diabetes, hypertension, congestive heart failure, asthma, or coronary artery disease), whether the chronic disease is being actively managed to the expected standard of care?

There are several instances where Dr. Lockman does not appear to be paying appropriate attention to medications he prescribes. There are also several examples, where specific interactions between chronic disease do not appear to be recognized or taken into account holistically. In the interview there are several justifications of lack of active management as related to “patient non-compliance” or presence of multiple care givers providing care. Nevertheless, physicians are responsible for the medications they prescribe. Even in situations of shared care and/or episodic care, one must pay attention to the potential for interactions and follow-up needs of medications prescribed. There are several cases that display an approach to COPD assessments and care that are not consistent with what would be considered an adequate standard of care. It is uncertain if the confusion of Asthma with COPD in the notes relates to the attempt to be remunerated for any obstructive lung disease or an insufficient understanding of the differences between these two conditions. Additionally, in relation to the management of exacerbations of Asthma and acute presentations of Bronchitis, Dr. Lockman appears to routinely be prescribing antibiotics. This is not advisable for several reasons in particular the potential to cause harm related to ineffective treatment of symptoms not likely to be caused by a bacterial infection.

3) Whether Dr. Lockman’s record keeping meets expected professional standards?

The case review in this document contains several examples of sub-optimal documentation, much of which is described in my prior report.

It is common in busy family practices to have short subjective sections or limited focused exams in the objective part of a note. However, Dr. Lockman has notes which are disorganized, use frequently repetitive phrases which likely do not represent the care provided and are missing crucial aspects of adequate medical records such as management plans.

Dr. Lockman defends the inappropriate inclusion of parts of a “plan” in the subjective section of the notes by stating, “I doubt anyone would be misled by the location of these notes.” While likely true, this is only half the story. Where one can easily be misled, is that several phrases are repeated multiple times in multiple patient charts over and over again. It is hard to believe that a nuanced and patient centred approach is being offered regarding this counselling when it is being documented identically in various contexts. While it is possible the care provided was adequate and appropriate in many cases, the documentation does not provide enough evidence of such. The totality of notes reviewed demonstrate a pattern of misleading notes that lack the detail to support an adequate standard of care is being delivered. Regarding management plans, which are perhaps the most important part of a cumulative care summary, the documentation is consistently lacking, and the justifications provided are often weak or entirely absent.

4) Are Dr. Lockman’s billing practices accurate and consistent with the expected standard of practice?

There is an overall pattern of billing practices that are not consistent with the care provided and inadequate attention to billing submissions being completed in a professional manner. There are several examples of patient interviews that confirm that some what Dr. Lockman claimed was the justification for his billing practices was not only inconsistent with the documentation but also the care provided.

ANALYSIS

The Panel was made aware that it must be satisfied that each of the charges have been established on a balance of probabilities. The Panel has considered the guilty pleas and admissions of Dr. Lockman having regard to the evidence filed, the oral evidence of the witnesses who were called by the CPSM, and the submissions of counsel for the CPSM and counsel for Dr. Lockman. Based on this review, the Panel is satisfied that all of the charges set forth and proceeded with in the Amended Notice of Inquiry, and the particulars contained therein, have been established on a balance of probabilities.

The following is the Panel's assessment of each of the Counts.

Count 1

Count 1 states:

Between in or about January 1, 2011 and November 30, 2019, Dr. Lockman contravened the CPSM's By-laws, Standards of Practice of Medicine and/or Code of Ethics (as in effect at the relevant time); displayed a lack of knowledge, skill and judgment in the practice of medicine and/or engaged in professional misconduct in that Dr. Lockman demonstrated widespread deficiencies through multiple and repeated failures to provide adequate or appropriate care and management, including his medical record keeping, in respect to all or many of the patients whose care was reviewed by the CPSM.

Count 1 included several particulars.

Particulars at 1.1 of Count 1 *alleged that Dr. Lockman in respect to fifty (50) patients listed at Appendix A of the Amended Notice of Inquiry repeatedly failed to create and maintain appropriate or adequate patient records in that he failed to document required information for one or more of the following in respect of his clinical encounters with those patients: presenting complaints and relevant functional inquiries; significant prior history/active problem lists; instructions, precautions, and advice to the*

patient, including regarding follow-up, adequate findings on physical examination, including relevant abnormalities or their absence, appropriate diagnoses, including indication as to whether they are tentative, differential or established; investigations ordered and results obtained; instructions, precautions, and advice to the patient, including instructions for follow-up; adequate information about the care provided and the management plan such that it can be understood by another physician, including respecting actions taken based on examinations and investigations; and adequate information about referrals to and consultation and collaboration with other health care providers.

The Panel was presented with several examples where Dr. Lockman failed to create and maintain appropriate or adequate patient records by failing to document required or appropriate information. The numerous patient records filed as exhibits in the Hearing showed this to be a consistent pattern. The following is one of many examples which demonstrate the validity of count 1 and other charges against Dr. Lockman :

Date of Visit: Oct-19-2016
Date of Birth: Jul-8-1962

Complaint:

Subjective:
F/.U = FLUSHOT LONG DISCUSSION
DIETARY COUNSELING,ADVICE ,REFER DIETARY CLINIC TO DISCUSS
HYPERLIPIDEMIA

Objective:
CALM RELAXED APYREX ENTN CH CLCVSN ABD SOFTCNSN MSKN

Assessment:
IHD
HYPER;LIPIDEMIA

Blood Pressure:	130	over	80		**ICD9 :**	4149-UNSPECIFIED CHRONIC ISCHEMIC HEAR
Pulse:					**Tariff :**	-
Temperature:		'C	32.0	'F	**Tariff :**	-
Height:	149.86	cm	59.00	in	**Tariff :**	-
Weight:	124.55	kg	274.01	lbs	**Tariff :**	-
BMI:	55.46	kg/m2			**Waist Circumference:**	
Recommended Weight Loss:	68.63	kg	150.98	lbs	cm	in

Problem : IHD -

Plan :
F/U IN 3 WKS 8529 + 8791

In the opinion of the Panel, this record exemplifies recurring problems identified in several charts that were provided to the panel. In the subjective part of the S-O-A-P (subjective-objective-assessment-plan) record format, it is unclear what the follow-up (F/U) was for or what the content or significance of the “long discussion” was and whether it was in reference to the “flu shot” or dietary matters.

It is unclear whether the patient requested dietary counseling (subjective) or why Dr. Lockman would have recommended such counseling, in which case that should have been recorded and explained in the assessment and plan.

The record indicates that an extensive physical exam was undertaken including observations of “apyrexic” (without fever), and normal ENT (ear, nose, and throat), chest, cardiovascular, abdomen, central nervous system, and musculoskeletal systems. If Dr. Lockman did perform these examinations, there are no symptoms or other explanation provided for their purpose. If he did not perform them, an inaccurate recording of normal findings could mislead future care providers.

The physical exam described in the record is not consistent with other parts of the record. For example, the temperature of 32˚F – a default measurement in the template - indicates that the temperature was not taken, was not correctly recorded, or the patient had hypothermia which was not referred to in the record.

The record shows a weight of 125 kg and body mass index of 55, diagnostic of morbid obesity, to which there is no text reference in the record.

The assessment specifies hyperlipidemia and IHD (ischemic heart disease). The only problem listed is IHD. For neither of these conditions is there any reference to relevant subjective or objective findings. For neither of these conditions is there a description of Dr. Lockman’s thoughts or analysis of the problem or the plan going forward. The only recorded plan is to follow up in three weeks but there is no description of the reason for the follow up or what will occur at the follow up.

The billing number 8529 requires that the visit include “a complete written record and advice to the patient”. There is no information in the record about advice

given to the patient. The billing number 8791 indicates that influenza vaccine was given, but there is no text that describes this, including any details of the injection. If, in fact, the patient was there for a flu shot, as possibly indicated in the first words of the "subjective", there would not be an indication for an extensive physical examination or an 8529 billing.

The record raises doubts about the purpose of the encounter, the subjective and objective information obtained at the clinical encounter, Dr. Lockman's assessment and plan, and what was expected to occur in the subsequent follow up.

In the opinion of the Panel, for the reasons described above, this record and the others like it do not meet the minimum standard of record keeping expected of a physician.

Particulars at 1.2 of Count 1 *alleged that Dr. Lockman, with respect to certain patients identified, failed to conduct an adequate assessment or physical examination of these patients in relation to their presenting complaints.*

The Panel was presented with several examples, including the following illustrative case:

Patient 22 (Group 2) was seen on February 10, 2017 for "cough, SOB (shortness of breath) for one month, gasping, more light headed".

It was not clear to the Panel whether these symptoms were persistent or had resolved prior to the encounter. This is important because it was recorded that the patient was "calm, relaxed, in no distress" and that the chest was clear.

This was part of a documented extensive physical examination including the genito-urinary tract, which would be an inappropriate and intrusive examination – if actually performed – under the described circumstances.

There is no explanation of the assessment "asthma exacerbation", there is no description of advice given to the patient, it is unclear what medications were prescribed

or changed, and it is unclear what the plan was for further investigations, other than a follow up in three weeks.

The next visit record is October, 2017 at which time there was no documentation of symptoms or asthma medication usage other than “good asthma and BP control”. The recorded reason for that encounter was knee pain. There is no specific description of a knee examination other than recording a normal musculoskeletal examination as part of a complete physical examination, including the genito-urinary tract.

Particulars at 1.3 of Count 1 *alleged that Dr. Lockman, with respect to certain patients identified, failed to perform preventative health assessments.*

Patient 31 (Group 2) is illustrative of 1.3. In reviewing the records for *Patient 31*, Dr. Singer noted:

> This was a complete physical exam on a 72-year-old man. The history is very brief and does not meet the usual standard that would be expected for a periodic health exam history. Basically, no history other than that he doesn’t smoke or drink alcohol. He may have urinary frequency but the history of this is not documented other than to say that he should stop caffeine because of it.
>
> A periodic health exam should touch on any chronic conditions, in this case hyperlipidemia, pernicious anemia, prostate issues and erectile dysfunction. There is no review of symptoms to see if there are any troubling issues that might suggest investigation. There is no mention of any screening that he may or may not have had done.
>
> He is on 6 medications: amitriptyline 25 mg, Celebrex 200, Cialis 20, Flomax cf.4 proctosydal cream 30 grams and Salicylic Acid 40%. but it is not clear what is being treated by his history or his problem list which is incomplete.
>
> A periodic health exam is the time to review the medications and ensure that they are doing what they are supposed to do. For example, it appears that he has osteoarthritis, but it is not clear how symptomatic he is or whether the Celebrex is helpful.

> Also, it is not clear why he is on amitriptyline and whether it is helping whatever condition he is treating. He is prescribing meds for erectile dysfunction but is not recording a discussion about the issue or any mention of any questions about side effects of the medication.
>
> The patient is having yearly PFTs done by Dr. Lockman in his office although it is not clear why as it appears, he is a non-smoker and there is no indication that he has ever had chest issues from the problem list supplied.
>
> The assessment portion of the record says IHD. When Dr. Lockman was questioned about this he states that it is simply meaning that he did an assessment on his computer to look at his risk for IHD, not that he has it. This should not be in his list of problems as it is misleading. It would have been appropriate to question this man about symptoms of IHD considering his age and his hyperlipemia this is not reflected in the record.

Particulars at 1.4 of Count 1 *alleged that Dr. Lockman failed to provide adequate treatment, management, and/or follow up care for the medical conditions described.*

Particulars at 1.4.1 of Count 1 *alleged that Dr. Lockman, in respect of his care and management of diabetes between January 1, 2011 and December 31, 2018 for certain patients identified: had an inadequate or no management plan; failed to requisition and monitor appropriate laboratory investigations; made inappropriate use of laboratory investigations; failed to perform routine assessments, including regarding weight, vital signs, vision and signs of neuropathy, or alternatively, to refer the patient for these assessment; inappropriately managed medications; and failed to appropriately coordinate with other health care providers.*

Particulars at 1.4.2 of Count 1 *alleged that Dr. Lockman, in respect of his care and management of asthma for certain patients identified: failed to adequately assess their clinical status; failed to make proper use of and adequately interpret spirometry; failed to provide appropriate treatment; and failed to develop an appropriate asthma action plan.*

Particulars at 1.4.3 of Count 1 *alleged that Dr. Lockman, in respect of certain patients identified, failed to appropriately investigate or manage risk factors for potential diagnoses of diabetes, ischemic heart disease and hyperlipidemia.*

Particulars at 1.4.4 of Count 1 *alleged that Dr. Lockman, in respect to patients identified, failed to manage their anemia.*

Particulars at 1.4.5 of Count 1 *alleged that Dr. Lockman failed to adequately manage the cardiomyopathy of an identified patient.*

Particular at 1.4.6 of Count *1 alleged that Dr. Lockman, in respect of certain patients identified, failed to adequately manage their congestive heart failure.*

The expert reports of Dr. Scurfield and Dr. Singer used examples to demonstrate and explain Dr. Lockman's failures to provide adequate treatment, management and/or follow care for the chronic medical conditions referred to in the particulars at 1.4 of Count 1.

The Panel is satisfied, on the balance of probabilities, that sufficient evidence was provided that Dr. Lockman did not demonstrate in his records, interviews, or written explanations that his practice of medicine met minimum standards including the following which are expected for the appropriate management of chronic diseases:

- Appropriate management plans;
- Appropriate requisitioning and monitoring appropriate laboratory investigations;
- Appropriate use of laboratory investigations;
- Appropriate performance of routine assessments, including weight, vital signs, vision, and signs of neuropathy, or, alternatively, to refer patients for these assessments;
- Appropriate management of medications;

- Appropriate coordination of care with other health care providers;
- Appropriate assessment of clinical status;
- Appropriate use of or interpretation of spirometry;
- Appropriate treatment, and
- Appropriate asthma action plans.

Particulars at 1.5 of Count 1 *alleged that Dr. Lockman, in respect of certain patients identified, failed to review or appropriately follow up on abnormal lab results or imaging.* The Panel was presented with examples regarding 1.5. Among these were:

- *Patient 18* (Group 2). Dr. Scurfield reported that the patient "had a mass noted in 2014 on a CT scan which was to be followed up in 6 months. No second CT report was provided for this audit. As well it was noted that she had evidence of emphysema. This was not recorded on her problem list and does not appear to be followed up regularly with respect to her symptoms and effect on her ability to function";
- *Patient 26* (Group 2) was found to have cardiomyopathy and sleep apnea in 2016 which does not appear to have further follow up.

Particulars at 1.6 of Count 1 *alleged that Dr. Lockman, in respect of a Patient 31, failed to adequately follow up on the patient's urologic disease.*

Dr. Singer's findings with respect to the care and treatment related to *Patient 31* are set out above. Dr. Singer's report demonstrated inadequate follow up on the patient's urologic disease including erectile dysfunction and urinary frequency.

Particulars at 1.7 of Count 1 *alleged that Dr. Lockman, in respect of certain patients identified, failed to maintain the standard of care in respect to his use and reliance on pulmonary function testing and spirometry testing conducted at his clinic.*

An example of this failing was described by Dr. Scurfield in her review of records of *Patient 31* described in her Summative Report of Group 2 patients at exhibit 12. “The patient is having yearly PFTs (pulmonary function tests) done by Dr. Lockman in his office although it is not clear why as it appears, he is a non-smoker and there is no indication that he has ever had chest issues from the problem list supplied.”

Dr. Lockman’s response is documented as follows: “With respect to yearly PFT's, I accept that these may be unnecessary for this patient I plan to re-evaluate my use of PFT's going forward and will only do them for patients who are smokers, or who have chest issues or other possible lung pathology.”

Particulars at 1.8.1 of Count 1 *alleged that Dr. Lockman, in respect of certain patients identified, inappropriately prescribed antibiotic or antiviral agents.*

There were several examples in support of 1.8.1. Multiple patients received prescriptions for prolonged use of Zithromax, including Patients 21 and 22 (Group 20) for 22 days, significantly longer than the usual course of five days. Both *Patients 12* and *19* were prescribed long courses of antibiotics with no documentation of an explanation supporting their prescriptions for extensive use.

Particulars at 1.8.2 of Count 1 *alleged that Dr. Lockman, in respect of certain patients identified, inappropriately prescribed steroids.*

For *Patients 22* and *27* (Group 2), Dr. Lockman prescribed steroids when it was not appropriate to do so or for an extensive duration, without documentation of an explanation of why the prescriptions were considered appropriate.

Particulars at 1.8.3 of Count 1 *alleged that Dr. Lockman, in respect of certain patients identified, inappropriately prescribed medication without sufficient regard for interactions with other medications.*

One of the more serious examples of 1.8.3 involved *Patient 21* (Group 2). *Patient 21* was 71 years of age at the relevant time. She was prescribed cyclobenzaprine for a hip injury. There is no discussion within the chart as to why it was specifically selected nor was there any discussion about any potential side effects and interplay between this muscle relaxant – which can have sedating side effects - and other sedating medications she was already taking. After a series of falls, *Patient 21* was admitted to the Health Sciences Centre, where the attending physician wrote to Dr. Lockman, stating:

> Dr. Lockman,
>
> I have significant concerns regarding [*Patient 21*'s] list of medications and the massive amounts of psychotropic drugs she was on at her age. This borders on malpractice. I have weaned and stopped many drugs and urge you to continue weaning as she tolerates. Included is her new list of meds. Nursing will fax you her blood sugars. Of note, her mobility and cognition improved <u>drastically</u> with these changes.

Particulars at 1.8.4 of Count 1 *alleged that Dr. Lockman, in respect of certain patients identified, inappropriately prescribed medications without sufficient regard for the patient's renal function and/or electrolyte effects.*

An example in support of 1.8.4 is that of *Patient 19*. The patient was prescribed medication that, particularly having regard to its prescribed course, could have renal effects that were not documented and therefore, may not have been properly considered or monitored.

Particulars at 1.8.5 of Count 1 *alleged that Dr. Lockman, in respect of Patient 19, prescribed clonazepam without adequate rationale.*

In the absence of a documented explanation, the Panel is satisfied that Dr. Lockman prescribed clonazepam to *Patient 19* without adequate rationale.

Particulars at 1.8.6 of Count 1 *alleged that Dr. Lockman, in respect of Patient 16, inappropriately prescribed furosemide without adequate rationale.*

In the absence of a documented explanation, the Panel is satisfied that Dr. Lockman prescribed furosemide to *Patient 16* without adequate rationale.

Having regard to the foregoing and Dr. Lockman's admissions with respect to Count 1, the Panel is satisfied that count 1 and all of its particulars has been established on a balance of probabilities.

As set out in detail in the expert reports and as made clear in the particulars of Count 1, which have been established before the Panel, Dr. Lockman failed to provide adequate or appropriate care and management, including his medical record keeping, in respect to many of his patients. As such, he displayed a lack of skill, knowledge, and judgment in the practice of medicine.

Further, the Panel is satisfied that Dr. Lockman breached several provisions of the applicable Codes of Ethics and Standards of Practice. Based on the evidence filed with the Panel and the admissions of Dr. Lockman, the following are relevant code provisions and standards of practice that Dr. Lockman violated from January 1, 2011 and November 30, 2019 under Count 1.

<u>Code of Ethics as of December 2008 (2008 Code)</u>

1. Consider first the well-being of the patient.

4. Practice the art and science of medicine competently and without impairment.

<u>Code of Ethics as of December 2015 (2015 Code)</u>

1. Consider first the well-being of the patient.

5. Practice the art and science of medicine competently, with integrity and without impairment.

Code of Ethics as of June 2019 (2019 Code)

A – Virtues Exemplified by the Ethical Physician: Prudence

B – Fundamental Commitments of the Medical Profession:

- Commitment to the well-being of the patient
- Commitment to professional integrity and competence

C – Professional Responsibilities:

6. Recommend evidence-informed treatment options

11. Empower the patient to make informed decisions regarding their health by communicating with and helping the patient (or, where appropriate, their substitute decision-maker) navigate reasonable therapeutic options to determine the best course of action consistent with their goals of care; communicate with and help the patient assess material risks and benefits before consenting to any treatment or intervention.

By-Law 1 as of December 2008 (“By-Law 1”)

Article 24 of By-Law #1, enacted as of December 1, 2008, and in force until December 14, 2015, the relevant portions of which provided:

24.1 Clinical Records

Members in practice shall keep:

(a) Clinical records on every patient which shall include:

(i) patient demographic information, including:

(A) full name as it appears on the patient’s health insurance registration card;

(B) current address;

(C) personal health identification number or other unique identifier;

(D) date of birth;

(E) telephone number and any alternate telephone contract numbers; and

(F) next of kin.

(ii) all dates on which the patient was seen and for each visit:

(A) an adequate patient history;

(B) particulars of physical examinations, investigation orders and the results of same;

(C) the diagnosis made (if any);

(D) the treatment prescribed; and

(E) ancillary medical or psychological investigations.

(b) Daily diary or appointment sheets showing for each day the names of patients seen or treated or in respect of which some professional service is rendered.

Standards of Practice as of December 2015 (2015 SoP)

As of December 14, 2015, the Standards of Practice were found in By-Law 11, the relevant portions of which provided:

2(1) A member must provide good medical care to a patient and include in the medical care that he or she provides:

(a) an assessment of the patient that includes the recording of a pertinent history of symptoms and psychological and social factors for the purpose of making a conventional diagnosis, when required;

(b) the physical examination of the patient that is required to make or confirm a diagnosis;

(c) the taking into account of the patient's values, preferences and culture;

(d) sufficient communication with the patient or his or her legal representative about the patient's condition and the nature of the treatment and an explanation of the evidence-based and conventional treatment options, including the material risks, benefits and efficacy of the options in order to enable informed decision-making by the patient;

(e) timely communication with the patient about the care;

(f) a timely review of the course and efficacy of treatment;

(g) the referral of the patient to another member or health care professional, when appropriate; and

(h) the documentation of the patient record at the same time as the medical care is provided or as soon as possible after the care is provided.

5(1) A member who orders a diagnostic test or makes a referral to another health care professional must have a system in place to review the test results and the results of referrals to other health care professionals and have reasonable arrangements in place to follow-up with the patient when necessary.

5(2) A member who orders a diagnostic test and directs a copy of the results to another member remains responsible for any follow-up care required, unless the member to whom a copy of the results is directed has agreed to accept responsibility for the patient's follow-up care.

12(1) If a member or a patient suggests a referral to another health care professional, the member must discuss the purpose of the consultation with the patient;

22(3) In order to meet an acceptable standard of practice, the member must demonstrate that there has been:

(a) a documented patient evaluation by the Manitoba member signing the prescription, including history and physical examination, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indicators;

(b) sufficient direct dialogue between the Manitoba member and patient regarding treatment options and the risks and benefits of treatment(s);

(c) a review of the course and efficacy of treatment to assess therapeutic outcome, and

(d) maintenance of a contemporaneous medical record that is easily available to the Manitoba member, the patient, and the patient's other health care professionals.

27(1) A member must appropriately document the provision of patient care in a record specific to each patient. Whether in paper or electronic form, the record must be legible, accessible to ensure continuity of care, and in English.

27(2) A member must document on the patient record the medical care given to the patient containing enough information for another member to be sufficiently informed of the care provided.

27(3) A patient record must contain or provide the following information

(a) patient demographic information including:

(i) full name as it appears on the patient's health insurance registration card;

(ii) current address;

(iii) personal health identification number or other unique identifier;

(iv) date of birth;

(v) telephone number and any alternate telephone contract numbers; and

(vi) next of kin.

(b) all dates the patient was seen or communication with the member and the identity of the member attending the patient on those dates.

(c) Patient clinical information including:

A. documentation of presenting complaints and relevant functional inquiry;

B. significant prior history/active problem list;

C. current medications, allergies and drug sensitivity, where relevant;

D. relevant social history including alcohol or drug use or abuse;

E. relevant family history including alcohol and drug use or abuse;

F. findings on physical examination, including relevant abnormalities or their absence;

G. diagnoses (tentative, differential or established);

H. treatment advised and provided, including medication prescribed;

I. If a prescription is issued:

(A) the name of the medication;

(B) the dose of medication to be taken at each administration;

(C) the frequency that medication is to be taken or administered;

(D) the duration of the period for which the patient is to take the medication;

(E) whether or not refills have been issued or approved.

J. investigations ordered and results obtained;

K. instructions, precautions and advice to the patient, including instructions for follow-up;

L. responses of the patient to the advice given, if refused;

M. reports received or sent in regard to the patient's medical care;

N. particulars of any sample medication provided to the patient.

(d) the following reports and information:

(i) laboratory and imaging reports;

(ii) pathology reports;

(iii) letters of referral and consultation reports;

(iv) hospital summaries; and

(v) surgical notes.

(e) on referring member's record a summary of any telephone consultation between two members with respect to a specific patient, and on the consultant's record, enough information to validate the consult occurred.

27(4) A member who uses templates in a patient record must modify the content to reflect the actual circumstances of a patient encounter.

27(5) A member must not copy and paste the note of a prior visit by the patient unless the entry is modified to reflect the actual circumstances of the later visit.

Standards of Practice as of January 2019 (2019 SoP)

2. This Part sets out the requirements of good medical care in addition to those described in Section 3 of the Regulation which is as follows:

3(1) A member must provide good medical care to a patient and include in the medical care that he or she provides:

(a) an assessment of the patient that includes the recording of a pertinent history of symptoms and psychological and social factors for the purpose of making an appropriate diagnosis, when required;

(b) the physical examination of the patient that is required to make or confirm a diagnosis;

(c) the consideration of the patient's values, preferences and culture;

(d) sufficient communication with the patient or his or her representative about the patient's condition and the nature of the treatment and an explanation of the evidence-based conventional treatment options, including the material risks, benefits and efficacy of the options in order to enable informed decision-making by the patient;

(e) timely communication with the patient about the care;

(f) a timely review of the course and efficacy of treatment;

(g) the referral of the patient to another member or health care professional, when appropriate; and

(h) the documentation of the patient record at the same time as the medical care is provided or as soon as possible after the care is provided

3(2) For the purpose of clause (1)(d), "material risks" are to be determined by the member having consideration for the special circumstances of each patient and the potential seriousness of risk for a reasonable person in the same circumstances.

4. (equivalent to Section 5 of the 2015 SoP, above)

19. (equivalent to Section 12 of the 2015 SoP, above)

25. (equivalent to Section 27 of the 2015 SoP, above, with minor differences)

57(3) In order to meet an acceptable standard of practice, the member must demonstrate that there has been:

(a) a documented patient evaluation by the Manitoba member signing the prescription, including history and physical examination, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications;

(b) sufficient direct dialogue between the Manitoba member and patient regarding treatment options and the risks and benefits of treatment(s);

(c) a review of the course and efficacy of treatment to assess therapeutic outcome, and

(d) maintenance of a contemporaneous medical record that is easily available to the Manitoba member, the patient, and the patient's other health care professionals.

Count 2

Count 2 states:

Between in or about January 1, 2011 and November 30, 2019, Dr. Lockman engaged in professional misconduct; contravened the CPSM's By-laws, the Standards of Practice of Medicine and/or the Code of Ethics (as in effect at the relevant time); and/or displayed a lack of knowledge, skill and judgment in the practice of medicine in that Dr. Lockman created and maintained his patient records for the provision of care specific to each patient in a manner that resulted in multiple entries in those records that do not correlate to the care that he actually provided or to actual clinical circumstances of the specific patients, and/or that inaccurately or falsely represents significant aspects of their care, management or diagnoses.

Particulars at 2.1.1 *of Count 2 alleged that Dr. Lockman, in respect of certain patients identified, noted the patients to be fit and healthy on preoperative or MPI forms in circumstances where significant disease(s) were documented by Dr. Lockman in each respective patient's medical record.*

The Panel was presented with a number of examples satisfying 2.1.1. Among those examples were:

- *Patient 10* (Group 1) had asthma, polycystic ovarian syndrome, obesity, and elevated blood pressure. She also smoked cigarettes. She was noted by Dr. Lockman to be "Fit and Healthy" for a preoperative examination, despite her significant risk factors for anesthesia.

- *Patient 26* (Group 2) was noted to be “Fit and Healthy” for a knee scope but had a BMI of 55 (i.e. morbid obesity) and cardiomyopathy, which are significant risk factors for anesthesia.

- *Patient 32* (Group 2) was noted to be “Fit and Healthy” despite having asthma, sleep apnea and obesity, which are significant risk factors for anesthesia.

Improper completion of pre-operative reports puts the patient and other medical practitioners relying on the report at risk. The true condition of a patient allows for proper procedures and precautions to be taken. For example, an anesthesiologist is likely to take additional steps with a patient who has sleep apnea versus a patient who does not.

Particulars at 2.1.2 *of Count 2 alleged that Dr. Lockman made use generally, and in particular with respect to certain patients identified, of templated entries in the patient’s record to record one or more components of a complete physical examination as having been performed when in fact they were not.*

The Panel was presented with a number of examples satisfying 2.1.2. A significant example is *Patient 21* (Group 2), who was 70 years old at the relevant time:

- On October 30, 2017, *Patient 21* attended before Dr. Lockman on a “walk-in” basis according to the patient record. The subjective and objective record was as follows:

Subjective:
COUGH WITH GREEN PHLEGM X 2 WKS
ASTHMA COUNSELING, STEROIDS, SALBUTAMOL, ATROVENT,
SINGULAR, PULMICORT, pFT, ETC. ASTHMA ACTION PLAN DISCUSSED WITH PATIENT
PT HAS NO MORE INHALERS
DIABETIC COUNSELING, DRUGS, DIET EXERCISE, REFERRAL FOR DIABETIC
COUNSELING, SIDE EFFECTS DRUGS.
DIETARY COUNSELING, ADVICE ,REFER DIETARY CLINIC TO DISCUSS
HYPERLIPIDEMIA
CORTICOSTEROID S/E’S
CUSHING~S,HTN,THROMBO5I5,MOOD,MEMORy PANCREATITIS, PEPTIC
ULCER, IMMUNOSUPPRESSION, SKIN ATROPHY, DERMATITIS, BONE
NECROSIS, AVN, CATARACTS, GLAUCOMA, SALT RETENTION, DELAYED
PUBERTY, HYPOGONADISM, TENDON RUPTURE.
DISCUSSED WITH PATIENT.

Objective:
CALM RELAXED APYREX ENTN CH CLCVSN ABD SOFT CNNS MSKN GUTN IN NO DISTRESS CHEERFUL

- On November 23, 2017, *Patient 21* returned on a “walk-in” basis. The subjective and objective record was as follows:

Subjective:
STILL HAS COUGH , HEART PALPITATIONS AND CANNOT SLEEP NO FEVER
ASTHMA COUNSELING, STEROIDS, SALBUTAMOL, ATROVENT,
SINGULAIR, PULMICORT, PFT, ETC. ASTHMA ACTION PLAN DISCUSSED WITH PATIENT

Objective:
CALM RELAXED APYREX ENTN CH CLCVSN ABD SOFT CNNS MSKN GUTN IN NO DISTRESS CHEERFUL HYDRN

The Panel noted the frequent use by Dr. Lockman of various templates (computer pre-set text) of abbreviations and acronyms, most commonly for documentation of objective findings of physical examinations. For example, “GUTN” indicates that a genito-urinary examination was done and that the findings were “normal”. In males, this would be expected to include observation and palpation of the lower abdomen, genitals and a digital rectal examination. For a female, this would be expected to include an examination of the lower abdomen, a digital examination of the vagina, a speculum examination of the vagina and uterine cervix and may include a digital rectal exam. In the example above, a patient complaining of a cough would not be expected to undergo such examinations. As opined in other parts of this document, the frequent use of these templates, often with little specific information, and without explanation for their indications, leaves the reader of these chart entries to draw one or more of several conclusions. These include: 1) the examination was not actually done, 2) the examination was done inappropriately or 3) the findings of the examination were not specified.

- On December 7, 2017, *Patient 21* returned to Dr. Lockman. The subjective and objected record was as follows:

Subjective:
RESULTS CXR CLEAR BUT STILL HAS COUGH PT HAS BEEN COUGHING FOR 7 WKS
PT AND DAUGHTER ADVISED TO GO HSC FOR FURTHER TESTING AND INVESTIGATION
DIABETIC COUNSELING, DRUGS, DIET EXERCISE, REFERRAL FOR DIABETIC
COUNSELING, SIDE EFFECTS DRUGS.
LOSE WEIGHT, DASH DIET, STOP CAFFEINE, EXERCISE HTN COUNSELLING
DIETARY COUNSELING, ADVICE ,REFER DIETARY CLINIC TO DISCUSS
HYPERLIPIDEMIA

Objective:
CALM RELAXED APYREX ENTN CH CLCVSN ABD SOFT CNNS MSKN GUTN IN NO
DISTRESS CHEERFUL HYDRN

There is no documentation of an explanation why *Patient 21* would receive three complete examinations within several weeks, as well as diabetic and dietary advice when being directed to attend the Health Sciences Centre for testing and investigation for a cough that had persisted for 7 weeks.

Particulars at 2.1.3 *of Count 2 alleged that Dr. Lockman, in respect of certain patients identified, recorded information in patient records that was inconsistent and confusing.*

The Panel was provided with evidence, including *Patient 27* (Group 2) who was documented to have a normal musculoskeletal examination at an attendance on June 22, 2016, despite having undergone a below-knee amputation in March of that same year. In the same record, Dr. Lockman noted that the “stump was rotting away”.

Particulars at 2.1.4 *of Count 2 alleged that Dr. Lockman, in respect of certain patients identified, that he documented in patient records providing advice that he either did not provide or was not appropriate in the circumstances.*

Several examples can be found within the patient records of noted advice that would be inconsistent with the circumstances of the patient. Noted above, it is documented (presumably an automatic template entry) that *Patient 21* was cautioned about the side effects of medication that may delay puberty, despite the patient being 70 years old at the time of the clinical encounter.

Another example is with respect to *Patient 24* (Group 2) who, during a clinical encounter of August 26, 2015, was cautioned, according to what appears to be

an automatic templated entry, among other things, to “lose weight” and “diet and exercise”. This is so despite the patient, who was 67 years old at the time of the visit, being noted to weigh 38.64 kg or 85 lbs with a BMI (body of mass index) of 16.0, indicating being underweight.

As discussed in detail by Dr. Singer, so many clinical encounter notes used templates related to such things as advice, counselling, referrals, drug side effects, that it was not clear which, if any, of the template list were actually performed.

Particulars at 2.2 *of Count 2 alleged that Dr. Lockman, in respect of certain patients identified, did not keep the active medication list in the patient record current and therefore it was inaccurate.*

Evidence was provided that the EMR system utilized by the Clinic did not properly update the active medication list and that Dr. Lockman failed to manually adjust the list so as to only show and record the active medications at the time of any given clinical encounter.

For example, *Patient 31* (Group 2) is noted in the clinical encounter note of February 15, 2019 as having the following Active Medications:

Active Medications :

FLOMAX CR 0.4 MG PO 2TABS60
SIG
VIAGRA 100 MG PO 1/2TD4
SIG
PROCTOSYDAL CREAM 30 G SKIN
PRN 1
CELEBREX 200 MG PO OD 30
VIT B12 INJECTION 10 ML 1 ML
IJN MTHLY10M
SALICYLIC ACID 40% IN VASELINE 1:1 30
G SKIN HS 1
CIALIS 20 MG PO OD 10
AMITRIPTYLINE 25 MG PO HS
30

Rx from date of visit:

Prescription:
ZITHROMAX 500MG ON DAY 1 THEN 250 MG
X10D 0 MG PO OD 12
Refills: 0

Celebrex and Amytiptiline were listed under “active medications”. However, other records indicated that the patient had not been prescribed Celebrex since 2014 and that Amitriptyline had only been prescribed once in December 2015.

Particulars at 2.3 *of Count 2 alleged that Dr. Lockman, in respect of certain patients identified, recorded in the respective patient records a diagnosis of a medical condition as having been established for the patient when in fact the diagnosis was either wrong, not yet confirmed, or not supported by the clinical information contained in the patient's record.*

The particulars at 2.3 of Count 2 identify several different diagnoses for a number of different patients that were unsupported by the patient records as discussed by the expert witnesses.

A few of these are highlighted here:

- *Patient 1* (Group 4) had a number of unsupported entries of diagnoses, including hypertension and IHD and an associated CDM tariff claimed within a short period. Patient 1 had diabetes but saw Dr. Lockman for prescriptions and lab requisitions that were not for diabetes management. *Patient 1*'s primary care provider for diabetes had a CDM tariff claim rejected as it had been claimed by Dr. Lockman;

- *Patient 25* (Group 2) had an unsupported IHD entry in her patient record. This is so despite the fact that Patient 25 had been assessed by a cardiologist, who confirmed the patient did not have IHD;

- *Patient 65* (Group 2) had an unsupported IHD entry dating back to 2017. Dr. Lockman had justified the entry to the CPSM by indicating the diagnosis was based on a multitude of risk factors, including symptoms of diabetes, hyperlipidemia, and metabolic syndrome. On review, the patient record did not reveal the symptoms noted and consideration around metabolic syndrome did not arise until September 2019.

Having regard to the foregoing and Dr. Lockman's admissions with respect to Count 2, the Panel is satisfied that Count 2 has been established on a balance of probabilities.

As Count 2 spans a time period from January 2011 to November 2019, three separate Codes of Ethics Apply. As particularized below, the Panel is satisfied Dr. Lockman breached provisions of the various Codes of Ethics having regard to his patient records. In particular, the following obligations under the relevant Code of Ethics were breached:

2008 Code

In addition to sections 1 and 4 (set out above), section 36, which provides:

> 36. Use health care resources prudently.

2015 Code

In addition to sections 1 and 5 (set out above), section 47, which provides:

> 47. Use health care resources prudently.

2019 Code

- A – Virtues Exemplified by the Ethical Physician: Honesty, Integrity and Prudence
- B – Fundamental Commitments of the Medical Profession:
  - Commitment to the well-being of the patient
  - Commitment to professional integrity and competence
- C – Professional Responsibilities – Patient-Physician Relationship:

  > 40. Support the profession's responsibility to promote equitable access to health care resources and to promote resource stewardship.

The Panel is also satisfied that Dr. Lockman breached his obligations under the applicable standards of practice having regard to the conduct identified in Count 2, including Article 24 of By-law 1, sections 2(1) and 27 of 2015 SoP, and sections 2 and 25 of 2019 SoP, all of which are set out above.

Count 3

Count 3 states:

In respect of a patient, identified as Patient 3, on or about May 1, 2017, Dr. Lockman falsely documented a clinical encounter that did not occur and then made an inappropriate claim for insured services under The Health Services Insurance Act (the "HSIA") in respect to that fabricated clinical encounter and thereby engaged in professional misconduct and/or contravened the Code of Ethics.

The evidence related to Count 3 was contained solely within the McLeod Affidavit and was discussed by Dr. Bullock-Pries in her oral testimony, summarized as follows.

Patient 3 was a regular patient of Dr. 1, who had previously worked at the Clinic. On May 1, 2017, Patient 3 attended at the Clinic and advised that if Dr. 1 was no longer at the Clinic, she wished to retrieve her patient record.

Patient 3 met with Dr. Lockman briefly in the reception area to discuss the cost of retrieving her record. Dr. Lockman agreed to waive the $140 fee and advised his receptionist to note this in the record, which would be retrieved by *Patient 3* at a later date.

When *Patient 3* later retrieved and reviewed her record, she noted that Dr. Lockman recorded her attendance to the Clinic on May 1, 2017 as a clinical encounter. In particular, the record noted a discussion regarding "dietary counselling, advice, refer dietary clinic to discuss hyperlipidemia". Seeing this, Patient 3 filed a complaint with the CPSM.

In addition to inaccurately recording that a clinical encounter occurred, and that advice had been given and a referral to a dietary clinic was made, none of which occurred, Dr. Lockman billed Manitoba Health for the encounter. In particular, Dr. Lockman billed Manitoba Health for an office visit related to "Ischemic Heart Disease". This is so despite no evidence that *Patient*

> *3* had ischemic heart disease. Such a "diagnosis" on her patient record was, understandably, concerning to *Patient 3* as to the potential impact it may have on her, for example in obtaining health insurance.

Having regard to the foregoing and Dr. Lockman's admissions with respect to Count 3, the Panel is satisfied that Count 3 has been established on a balance of probabilities.

The 2015 Code was in force during the material time for which Count 3 is concerned. As a result of the conduct established under Count 3, Dr. Lockman was in breach of his obligations under the code. In addition to breaching sections 1 and 47 (set out above), the following section of the 2015 Code was breached by Dr. Lockman:

> 2. Practice the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.

Count 4

Count 4 states:

In respect of a patient, identified as Patient 2, on or about August 1, 2017, Dr. Lockman falsely documented a clinical encounter that did not occur and then made an inappropriate claim for insured services under the HISA in respect to that fabricated clinical encounter and thereby engaged in professional misconduct and/or contravened the Code of Ethics.

The following evidence related to Count 4 was contained solely within the McLeod Affidavit and was discussed by Dr. Bullock-Pries in her oral testimony.

> *Patient 2* had also been a regular patient of *Dr. 1* and upon *Dr. 1's* departure from the Clinic, *Patient 2* attended to the Clinic on August 1, 2017 to retrieve his patient record. *Patient 2* met with Dr. Lockman that day for the sole purpose of retrieving his record. This was the first and only time they had ever met.

> When he received his patient record, *Patient 2* saw a clinical encounter entry for August 1, 2017, which contained the following:
>
> Complaint: APPOINTMENT
>
> Subjective: PT TRI4D TO GET DISABILITY FROM CPP SAYS HE WAS DENIED. HE NOW WANTS HIS FILE SO HE CAN APPEAL TO CRA . PT HAS LIMITED FUNDS .WE WIL GET THE FILE AND THEN GIVE IT TO HIM TO APPEAL. LOSE WEIGHT,DA5H DIET,STOP CAFFEINE, EXERCISE HEN COUNSELLING DIETARY COUNSELING,ADVICE ,REFER DIETARY CLINIC TO DISCUSS HYPERLIPIDEMIA
>
> Objective: CALM RELAXED APYREX ENTN CH CLCVSN ABD SOFT CNSN MSKN GUTN IN NO DISTRESS CHEERFUL HYDRN
>
> Assessment: DM IHD HTN HYPERLIPIDEMIA CHRONIC BACK SPRAIN Blood Pressure: 140 over 80 ICD9 : 25000-TYPE II (NON-INSULIN DEPENDENT Pulse: Tariff Temperature: ‘C 32.0 ‘F Tariff Height:162.56 cm 64.00 in Tariff Weight: 69.55 kg 153.01 lbs Tariff : - BMI:26.32 kg/m2 Waist Circumference: Romme 3.75 kg 8.25 lbs cm in
>
> Problem : DM, NEEDS FILE FOR APPEAL FOR DISABILITY –
>
> Plan F/U IN 3 WKS 8529

> *Patient 2* was in the process of dealing with a disability claim and he was concerned about the impact this chart entry would have, particularly the documented ischemic heart disease noted as one of *Patient 2’s* diagnoses. This was “diagnosed” despite there being no evidence that *Patient 2* had ischemic heart disease.
>
> In addition to the inaccurate chart record, Dr. Lockman billed Manitoba Health under tariff 8529 for the fabricated August 1, 2017 encounter.

Having regard to the foregoing and Dr. Lockman’s admissions with respect to Count 4, the Panel is satisfied that count 4 has been established on a balance of probabilities.

As a result of the conduct established under Count 4, Dr. Lockman was in breach of sections 1, 2, and 47 of the 2015 Code (set out above).

Count 7

Count 7 states:

Between in or about January 2012 and in or about September 2019, Dr. Lockman caused or permitted one or more of the claims for insured services under the HSIA using the Chronic Disease Management ("CDM") and/or Chronic Care Management ("CCM") tariffs, as listed at Appendix B of the Notice of Inquiry, to be submitted in circumstances where the claim was inappropriate and/or unsupported and Dr. Lockman thereby engaged in professional misconduct and/or contravened the Code of Ethics.

In support of Count 7, the Panel was referred to the Peters Affidavit, with supporting evidence from the McLeod Affidavit, the written report and oral evidence of Dr. Scurfield, the written report and oral evidence of Dr. Singer, and the records of certain patients. This evidence is summarized below:

> As made clear in the materials before the Panel, the CPSM's jurisdiction over ethics and professionalism is distinct from the role of Manitoba Health, who are focused on the assessment of claims made to it for technical compliance with tariffs. It is the CPSM that governs a member's obligation to act professionally and ethically when billing for insured services.
>
> The fact that a payment is made with respect to a claimed tariff does not mean there has been verification that all requirements for the relevant tariff have been met. Manitoba Health trusts that the physician billing a CDM or CCM tariff is doing so incompliance with the Physician's Manual and Regulation.
>
> The evidence produced in support of Count 7, to which Dr. Lockman has admitted, goes beyond administrative errors. The randomly sampled patient records that comprise the records identified in Appendix B of the Amended Notice of Inquiry produced numerous examples of improper use of the CDM and CCM billing codes.
>
> In addition, Dr. Lockman entered inaccurate or misleading information into patient charts, details of which are reflected

in Count 2, seemingly to support the improperly claimed CDM or CCM tariff.

Having regard to the foregoing and Dr. Lockman's admissions with respect to Count 4, the Panel is satisfied that count 4 has been established on a balance of probabilities.

As a result of the conduct established under Count 7, Dr. Lockman was in breach of his obligations under the relevant Codes of Ethics as follows: sections 1, 2, and 35 of the 2008 Code, sections 1, 2, and 47 of the 2015 Code, and Part A (Integrity) and Part C (paragraph 40) of the 2019 Code, all of which have been set out above.

Count 8

Count 8 states;

Between in our about January 2012 and in or about September 2020, Dr. Lockman, both as a physician providing care at and in his role as the medical director and owner of the St. Vital Family Medical and Walk-In Clinic ("Clinic"), Dr. Lockman was responsible for an unethical system for billing insured services under the HSIA using the CDM and/or CCM tariffs that included the submission of inappropriate and/or unsupported claims for insured services under the HSIA, including the claims using the CDM and/or CCM tariffs for services, as listed in Appendix B of the Notice of Inquiry, and thereby engaged in professional misconduct, and/or contravened the Code of Ethics.

Count 8 builds on the evidence summarized and Dr. Lockman's admission for Count 7. Dr. Lockman has admitted, and the evidence supports, that as both the physician providing care and in his role as the medical director and owner of the Clinic, he improperly billed insured services under the HSIA using the CDM and CCM tariffs. This was done for not only Dr. Lockman's patients, but Dr. Lockman also made CDM and CCM tariff claims for Dr. 2.

The patient records identified as Group 5, being patients of *Dr. 2*, were filed as Exhibit 9. The billing records of Manitoba Health are included in the exhibit and

identify CDM and CCM tariffs billed to Dr. Lockman (identified as 0448). One of many examples is patient 37, who had been treated by *Dr. 2* until an appointment with Dr. Lockman on October 5 and November 10, 2016, for which he claimed tariff 78434 for Coronary Heart Disease (IHD). Dr. Lockman had not been providing primary care and had not been providing management care for 1 year. Further, the IHD diagnoses had never been previously diagnosed until seen by Dr. Lockman. There was no documented basis to claim the tariff.

At Exhibit 21, *Dr. 2* in writing to the CPSM confirmed that he did not prepare forms or make any billing for CDM tariffs during his time at the Clinic as he had not managed any of his patients for one year or more. He had worked at the Clinic for about 10 months and then left.

Having regard to the foregoing and Dr. Lockman's admissions with respect to Count 8, the Panel is satisfied that Count 8 has been established on a balance of probabilities.

As a result of the conduct established under Count 8, Dr. Lockman was in breach of his obligations under the relevant Codes of Ethics as follows: sections 1, 2, and 35 of the 2008 Code, sections 1, 2, and 47 of the 2015 Code, and Part A (Integrity) and Part C (paragraph 40) of the 2019 Code, all of which have been set out above.

As a further result of the conduct established under Count 8, Dr. Lockman was also in breach of his standards of practice. The relevant provisions of the 2015 SoP are as follows[1]:

> 45(2) If a member engages in medical care in a non-institutional setting, the member must maintain full direction and control of his or her medical practice, including:
>
> (a) the medical care provided to or for a patient;

[1] The corresponding sections for the 2019 SoP are 16(2), 17(2) and 51.

(b) the safety and quality of the premises in which the member practises and of the calibration of equipment used in the medical care he or she provides:

(c) documentation in, access to and security of patient records, including documenting medical care provided to a patient, patient appointment schedules, patient billing and payment records for the medical care of a patient;

(d) any advertising of or for the medical practice;

(e) billing for any medical care that is not an insured service under *The Health Services Insurance Act*; and

(f) the qualifications and performance of each staff member supervised by the member.

46(2) The Medical Director must:

(a) ensure that only qualified members provide medical care in the non-institutional setting;

(b) ensure that, regardless of the name of the non-institutional setting, the name(s) of all the physician(s) and medical corporations are clearly posted, either on the exterior of the non-institutional setting or in the reception area;

(c) ensure the non-institutional setting complies with the Code of Ethics;

(d) ensure that all communication about the patient is through or on behalf of the appropriate attending member;

(e) be responsible for and have authority over all aspects of non-institutional setting operation which can affect the quality of patient care.

72 A member must keep an accounting record showing the date every health service was rendered by the member to a patient, the type of service, and the charge made.

Count 9

Count 9 states:

Between in or about December 2015 and in or about March 2020, Dr. Lockman in his capacity as the owner and medical director of the clinic where he

practiced, contravened the Standards of Practice of Medicine in that you failed to ensure that your EMR system had a comprehensive audit capability which entered all access onto a permanent file log, identified and recorded where the access originated and by whom, and identified if alterations are made to the record and by whom, what was altered, and when the alteration was made.

In support of Count 9, the Panel heard evidence from Dr. Bullock-Pries, Dr. Scurfield and Dr. Singer regarding their observations of the EMR system used by Dr. Lockman.

In addition to the evidence the Panel specifically received on the EMR system, it was evident from reviewing the patient records that the EMR system did not produce an accurate summary of the patient's medical history at any given time. This was particularly true regarding the patient's list of active medications. As emphasized by the expert evidence provided, accurate, accessible, and current information are necessary for competent and safe practice.

Having regard to the foregoing and Dr. Lockman's admissions with respect to Count 9, the Panel is satisfied that Count 9 has been established on a balance of probabilities.

As a result of the conduct established under Count 9, Dr. Lockman was in breach of his standards of practice. In addition to breaching sections 45(2) and 46(2), referenced above, of the 2015 SoP, Dr. Lockman was also in breach of the following provisions[2]:

> 34 Electronic medical records must have comprehensive audit capability, including a system which enters all access onto a permanent file log, identifying and recording where the access originated and by whom, and if alterations are made to the record, identifying whom, what was altered and when the alteration was made.
>
> 36(1) The obligations in this by-law respecting patient records are in addition to any other requirements relating to patient records under *The Act*, *The Personal Health Information Act*, and any other enactment, by-

[2] The corresponding sections for the 2019 SoP are 16(2), 17(2), 32 and 34 (1)

law, standard of practice or code of ethics with which a member must comply.

Count 11

Count 11 states:

On or about April 18, 2018 Dr. Lockman engaged in professional misconduct and/or contravened the Code of Ethics in that Dr. Lockman behaved in an unprofessional manner both during a clinical encounter with a patient, identified as Patient 5, and one of his family members on April 18, 2018 when Patient 5 attended at the Clinic to see Dr. Lockman as a patient and respecting Dr. Lockman's subsequent communication with Patient 5 related to that visit.

The evidence related to Count 11 was contained solely in the McLeod Affidavit.

> *Patient 5*, who suffered from Parkinson's disease, was 70 years old when he attended before Dr. Lockman, his treating physician, on April 18, 2018. Requiring assistance, Patient 5 attended with his daughter-in-law (identified in the proceeding as "AB"). The reason for the attendance was to initiate the process of paneling Patient 5 for personal care home admission and involvement with the Geriatric Mental Assessment Team.
>
> Based on the evidence provided, at the attendance Dr. Lockman became frustrated with AB apparently because she was unable to provide information regarding a recent medication change for Patient 5 from another health care provider. In an attempt to find answers, AB went to use her phone to text. This caused Dr. Lockman to raise his voice, telling her she could not do that and he stood to leave the room. Patient 5 received no medical services from Dr. Lockman as a result and was asked to leave within 5 minutes of the appointment beginning. AB informed Dr. Lockman that she would be reporting him for his conduct toward her and her father-in-law.
>
> Based on the evidence provided, once at the reception desk, AB asked for the name of the clinic manager. This was

overheard by Dr. Lockman, who advised he owned the clinic and welcomed her to lodge a complaint.

Based on the evidence provided, after the attendance, Patient 5 received a letter from Dr. Lockman dated April 18, 2018. Dr. Lockman was terminating the physician-patient relationship. The letter, written in all capital letters, including the following excerpts:

> I DECIDED TODAY IN CONSULTATION WITH YOU TO TERMINATE OUR PHYSICIAN-PATIENT RELATIONSHIP DUE TO THE FOLLOWING REASONS:
>
> 1. MY WORKLOAD
>
> 2. THE FACT THAT YOU INFORMED ME THAT YOU HAD LOST FAITH IN ME AS YOUR FAMILY DOCTOR
>
> 3. MY PERSONAL SAFETY AND THE SAFETY OF MY STAFF. YOUR DAUGHTER IN LAW [AB] WAS NOT ONLY DISRESPECTFUL TO ME TODAY BUT ALSO THREATENED AND HARASSED BOTH ME AND MY FRONT DESK. SHE ALSO DISPLAYED PREJUDICE TOWARDS ME AS SHE KEPT ON YELLING THAT "I HAD HEARD ABOUT YOU". IF HER PREJUDICE IS BASED SOLELY ON THE COLOR OF MY SKIN, SHE HAS ALSO VIOLATED MY CHARTER RIGHTS….
>
> IT WAS CLEAR FROM THE CONSULTATION THAT SHE DID NOT KNOW WHAT MEDICATIONS YOU WERE ON AND WHEN YOU INDICATED TO BOTH OF US THAT YOU COULD NOT REMEMBER THE NAME OF THE MEDICATION CHANGED BY YOUR NEUROLOGIST, SHE SPOKE ON HER PHONE IN FRONT OF ME. OUR PROTOCOL IN OUR CLINIC IS THAT WE EXPECT PATIENTS OUT OF RESPECT TO TURN OFF THEIR PHONES WHEN WE ENTER THE CONSULTING ROOMS BUT CLEARLY THIS DID NOT APPLY TO HER…
>
> IT IS MY BELIEF THAT YOUR PARKINSON'S DISEASE IS NOW STABLE…

Patient 5 was hospitalized two weeks after his encounter with Dr. Lockman, due to symptoms of his advancing Parkinson's.

Having regard to the foregoing and Dr. Lockman's admissions with respect to Count 11, the Panel is satisfied that Count 11 has been established on a balance of probabilities.

As a result of the conduct established under Count 11, Dr. Lockman breached his obligations under the applicable code. In addition to breaching sections 1 and 2 (set out above), the following section of the 2015 Code was breached by Dr. Lockman:

> 36. When a patient expresses discontent with medical care received from you, attempt to resolve the issues. If the issues are not resolvable, provide the patient with information about the role of the College and its complaints process.

Count 14

Count 14 states:

Between in or about September 18 and 21, 2020, Dr. Lockman contravened the Code of Ethics, displayed a lack of knowledge, skill, and judgment in the practice of medicine, and/or engaged in professional misconduct respecting the manner in which Dr. Lockman conducted himself when a patient, identified as Patient A, presented in urgent need of care at the Clinic and in Dr. Lockman's subsequent documentation in Patient A's medical record.

Count 14 also contained various particulars. The evidence related to Count 14 was contained solely in the McLeod Affidavit.

> Based on the evidence provided, at the material time, Patient A was 73 years old when he attended at Dr. Lockman's Clinic along with a neighbour. Patient A had collapsed in front of a nearby retail store and was in respiratory distress.
>
> Staff of the Clinic advised the neighbour and Patient A that neither Dr. Lockman nor Dr. X were seeking walk-in patients. However, the neighbour was insistent that Patient A be seen. Dr. X attended to the reception area upon hearing commotion and recognized that Patient A needed immediate assistance. Dr. X went to Dr. Lockman for further information and for him to provide assistance as he was familiar with Patient A. At the same time, a staff member of the Clinic also consulted Dr. Lockman, who instructed the

> staff member to call 911 while refusing to attend personally to Patient A.
>
> Similarly, Dr. Lockman refused Dr. X's request for assistance. The patient Dr. Lockman was seeing at the time indicated that Dr. Lockman should attend to the urgent situation as they were essentially finished her visit. Again, Dr. Lockman refused to do so.
>
> Dr. X attended to Patient A, Dr. Lockman's patient, until the EMS arrived approximately 20 minutes later.
>
> In the days that followed, Dr. Lockman made inappropriate and unprofessional entries in Patient A's medical record, including details as to the dispute with Dr. X and difficulties with his EMR. In particular, and among other things, Dr. Lockman wrote in the patient's chart:
>
> THERE WAS NO UNFOLDING CRISIS, NOR DID I REFUSE TO SEE OR LAY EYES ON THIS PATIENT…
>
> Witness statements attached to the McLeod Affidavit along with Dr. Lockman's own admission contradict the note in the chart.

Having regard to the foregoing and Dr. Lockman's admissions with respect to Count 14, the Panel is satisfied that Count 14 has been established on a balance of probabilities.

The Panel is satisfied that Dr. Lockman breached the Code of Ethics having regard to his conduct with respect to Patient A. In particular, the following obligations under the 2019 Code were breached:

- A – Virtues Exemplified by the Ethical Physician: Compassion
- B – Fundamental Commitments of the Medical Profession:
    - Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient;

- Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred.

- C – Professional Responsibilities – Patient-Physician Relationship:

  8. Provide whatever appropriate assistance you can to any person who needs emergency medical care.

Count 15

Count 15 states:

Between in or about September 18 and 29, 2020, Dr. Lockman contravened the Code of Ethics, and/or engaged in professional misconduct respecting his conduct and communication toward a doctor, identified as Doctor X, including representations regarding Dr. Lockman's reasons for not assisting Dr. X with Patient A on September 18, 2020.

Count 15 follows from Count 14 and also contained various particulars. The evidence related to Count 15 was contained solely in the McLeod Affidavit.

> Following the incident described above involving Patient A, Dr. X re-attended to Dr. Lockman to discuss the incident. Dr. X advised Dr. Lockman that he should have at least stepped out to look at Patient A, provided Dr. X with assistance or given details about his medical history and medications. Dr. Lockman and Dr. X disagreed as to whether Dr. Lockman should have left the patient he was attending. Dr. X advised that it was inappropriate to simply direct staff to call 911 without having seen Patient A.
>
> Dr. X advised that he felt it was his duty as a professional to inform Dr. Lockman of what he believed to be an abandonment of his duty as a physician and his duty to assist. Dr. X also advised that he may have a duty to report the matter to the CPSM. During this conversation, Dr. X was standing in the doorway while Dr. Lockman was sitting at his desk.

> The following Sunday morning, Dr. X received text messages from Dr. Lockman asking him to call him on an urgent basis to discuss the incident that occurred on Friday. Dr. X responded later in the day indicating he would speak to Dr. Lockman on Monday.
>
> Before Dr. X responded by text, Dr. Lockman e-mailed Dr. X's wife, requesting that Dr. X call him before 3:00 p.m. Dr. Lockman specifically wrote:
>
> ….On Friday 18 September 2020, your husband violated my personal space on 2 occassions [sic], yelling and screaming in front of patients. On the second occasion between 4 10 pm and about 4:35 pm not only did he violate my personal space and displayed aggression towards me but he also uttered several threats. You should ask him what those threats were…If I do not hear from either of you by 3pm today, I am going to have to make a decision on whether we can continue working together as a toxic relationship will not only endanger patient safety but my safety and the safety of my staff as well. I need some reassurance that what happened on Friday cannot recur so I can counsel my staff on Monday. I hope to hear from you by 3 pm today.
>
> On Monday, Dr. X along with a staff member met with Dr. Lockman, where Dr. Lockman was described as being extremely agitated and aggressive. During the conversation, Dr. Lockman accused Dr. X of threatening him the Friday before, claiming Dr. X invaded his personal space and that Dr. X had a plastic pipe in his hand, waiving it around while threatening him.
>
> This allegation was then made to the CPSM by an e-mail sent on September 21, 2020, where Dr. Lockman indicated that Dr. X threatened him, including that he uttered threats and had an unidentified object in his hand. This allegation was later retracted by Dr. Lockman.

Having regard to the foregoing and Dr. Lockman's admissions with respect to Count 15, the Panel is satisfied that Count 15 has been established on a balance of probabilities.

The Panel is satisfied that Dr. Lockman breached the Code of Ethics having regard to his conduct with respect to *Dr. X*. In particular, the following obligations under the 2019 Code were breached:

- A – Virtues Exemplified by the Ethical Physician: Honesty and Integrity
- C – Professional Responsibilities –Physicians and Colleagues

31. Treat your colleagues with dignity and as persons worthy of respect. Colleagues include all learners, health care partners, and members of the health care team.

32. Engage in respectful communications in all media.

33. Take responsibility for promoting civility, and confronting incivility, within and beyond the profession. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.

34. Assume responsibility for your personal actions and behaviours and espouse behaviours that contribute to a positive training and practice culture.

Count 16

Count 16 states:

By reason of one or more of the foregoing allegations, individually and cumulatively, you have demonstrated an unfitness to practice medicine.

In contrast to all other counts, Dr. Lockman did not admit or enter a plea of guilty to Count 16 but advised that, in his view, this was a matter solely for the Panel's consideration. Count 16 was not contested.

For this reason and because this charge is the most serious charge reflecting a cumulative assessment of the other more specific counts, because Dr. Lockman neither pleaded guilty nor contested the charge, and because there is no specific definition of unfitness in the Standards of Practice or Codes of Ethics, the Panel deliberated especially carefully in its judgment regarding this charge.

The Panel considered that the term unfitness reflects the recent past or the present status of a physician. It is based on evidence regarding past behaviours and on the admissions of the specific counts and particulars, but the panel is not required to judge at what point in time the physician became unfit to practice medicine. Similarly, the panel's assessment of unfitness does not predict the future of the physician's fitness to practice medicine, nor does it determine any future decisions of the CPSM with respect to his licensure.

The Panel understood that the determination of fitness to practice medicine in this context should be based on objective evidence of objective and observable behaviours, actions and outcomes. The evidence in this hearing focused primarily on behaviours and actions, mostly evident from documentation in his charts in his records. The Panel's determination of fitness to practice medicine was not based on speculation or opinions about the intent, motives, values, insights, personal health or other remediable or irremediable factors within or beyond the control of Dr. Lockman. Nor was it influenced by issues such as the duration of his practice, the number of patients that continued to see him, or any personal or family consequences of our decisions. These issues were raised by Dr. Lockman's counsel at the beginning of the hearing.

For the Panel, the first and main consideration was the safety of patients and the protection of the public. The Panel viewed the question of fitness to practice medicine, operationally, with respect to whether a license to practice should be sustained or removed by the CPSM. It was from this perspective that the Panel made its decision.

Members of the CPSM are expected to practice medicine competently and safely, and with decency, integrity and in accordance with the law. A member may be found to have demonstrated an unfitness to practice medicine based on a single act or omission or series of acts or omissions that demonstrate an inability or unwillingness to adhere to these professional expectations.

The Panel agreed with the charge of the CPSM that Dr. Lockman is unfit to practice medicine. This decision is based on the extensive and serious other charges made against Dr. Lockman by the CPSM, which in the opinion of the panel were sufficiently supported by the evidence presented and further supported by the admissions of guilt by Dr. Lockman.

Dr. Lockman's conduct, to which he has pled guilty or admitted to, is significant, varied, and long standing as indicated by the 12 interim conditions for Dr. Lockman's certificate to practice imposed by the Registrar of the CPSM June 21, 2019. These conditions have been listed in the Background section of this document and are contained in Exhibit 24. As explained and concluded by the Panel, based on the evidence presented to it and Dr. Lockman's admissions, Dr. Lockman:

- Frequently created inaccurate, unclear, and/or inappropriate patient records;
- Repeatedly described in his records physical examinations which were either inappropriate or not performed;
- Failed frequently to provide relevant information in patient records that would support his decisions regarding diagnosis and treatment;
- Failed frequently to include in his records any particulars about advice or explanations to his patients;
- Failed to demonstrate that he provided appropriate care to patients, particularly those with chronic illnesses;
- On several occasions, provided information to physician colleagues that was inaccurate and potentially harmful to the patient;
- Permitted an EMR system to be employed that was deficient;
- Permitted an active medication list to exist in the patient record that was inaccurate, difficult to decipher, and potentially harmful;

- Made unsupported diagnoses or created the impression of a diagnosis by inclusion in the patient record;

- Failed to follow up on medications, lab results, use appropriate diagnostic tools, and consider information that ought to have led to an inquiry of a potential medical diagnosis;

- Repeatedly made false claims for CDM and CCM tariffs for him personally and for the Clinic generally;

The list above is not exhaustive, but, as described earlier, highlights, in the opinion of the Panel, significant and consistent failures of Dr. Lockman to practice medicine competently in a way that is consistent with the CPSM standards and ethics and with reasonable expectations of the public. Any one of these counts are serious charges in and of themselves but may not necessarily be grounds for a judgment of unfitness to practice medicine. Some of the particulars of the counts were considered by the Panel to be more serious and substantiated than others. Physicians are not expected to be perfect in their behaviour, decision-making, or documentation. Scrutiny of a physician's practice will always find fault, flaws, and room for improvement.

The Panel's decision regarding the charge of unfitness to practice medicine reflects our consideration of the evidence of the seriousness, frequency, patterns of his practice and his admissions of guilt for each of the counts and its particulars, separately, and collectively.

The Panel is satisfied that as a result of his conduct as described in Counts 1, 2, 3, 4, 7, 8, 9, 11, 13, 14 and 15, individually and cumulatively, and having regard to the evidence presented and Dr. Lockman's admissions, that Dr. Lockman has demonstrated an unfitness to practice, thus establishing Count 16.

THE JOINT RECOMMENDATION

The task of our Panel was to decide whether the Joint Recommendation as to Disposition should be accepted and which Order or Orders ought to be granted

pursuant to section 126 of the Act. In the opinion of the Panel, the following objectives were considered most relevant to our decision:

- The protection of the public. Orders under section 126 of the Regulated Health Professionals Act are not simply intended to protect the particular patients of the physician involved or those who are likely to come into contact with the physician, but are also intended to protect the public generally by maintaining high standards of competence and professional integrity among physicians;
- The punishment of the physician involved;
- Specific deterrence, in the sense of preventing the physician involved from committing similar acts of misconduct in the future;
- General deterrence, in the sense of informing and educating the profession generally as to the serious consequences which will result from breaches or recognized standards of competent and ethical practice;
- Protection of the public trust in the sense of preventing a loss of faith on the part of the public in the medical profession's ability to regulate itself;
- Proportionality between the conduct of the physician and the orders granted under section 126 of the Act. This is important because of the objective of fairness to the physician and to maintain the trust and confidence of the members in their College's policies and procedures.

The understanding of the Panel is that the fundamental and primary purpose of Orders made under section 126 of the Act is the protection of the public, including the protection of patients and others with whom the physician will come into contact, and the protection of the public more generally by the maintenance of high standards of competence and integrity among physicians.

The Panel understood that a joint submission on penalty must satisfy fundamental penalty principles. The Panel understood this to mean that the penalty

should express the Panel's denunciation of the misconduct and act as a deterrent, both to the member and to the profession. The penalty should be proportionate to the misconduct. See *College of Physicians and Surgeons of Ontario v. Khan*, 2021 ONCPSD 30.

The Panel is of the view that the objectives and purpose of an Order under section 126 is satisfied by the Joint Recommendation, in that:

(a) An order of reprimand pursuant to subsection 126(1)(a) of the Act is a formal denunciation of Dr. Lockman's misconduct;

(b) An order of cancellation of Dr. Lockman's registration with the CPSM pursuant to subsection 126(1)(i) is the most serious of penalties;

(c) The facts of this matter, as set out in detail above, support a serious penalty.

(d) The fundamental objective of the CPSM, as a self-regulated body, is the protection of the public. The public is protected with an order of cancellation of Dr. Lockman's registration.

(e) The Joint Recommendation acts not only as a specific deterrent to Dr. Lockman but also as a general deterrent in that it imposes serious punishment for serious misconduct, which serves as education to the public and other physicians as to the consequences of such misconduct.

(f) The Joint Recommendation also imposes a financial consequence against Dr. Lockman by being responsible for, at least a portion, of the costs associated with the investigation and inquiry of the matters before this Panel. Evidence was not provided during the hearing to explain or justify the cost assessment to Dr. Lockman. The Panel has had questions about the amount of the penalty but decided that it did not have sufficient reason to reject this part of the Joint Recommendation.

(g) The Joint Recommendation agreed to by Dr. Lockman reflects his acceptance of his guilt in these matters, which spared the CPSM and others a contested inquiry. The Panel had been informed at the time of their appointment , that the hearing could take as long as seven or more weeks. The Joint Recommendation avoided the necessity of calling patients to give evidence, and adding to the significant costs that had already been endured by the College because of the long period of time and extensive investigation and monitoring of Dr. Lockman's practice.

In assessing the appropriateness of the Joint Recommendation in relation to the nature and extent of Dr. Lockman's misconduct, and the objective of the protection of the public, the Panel reviewed the evidence and arguments submitted to it by the parties.

The Panel was advised by counsel that it should not depart from a Joint Recommendation unless the proposed recommendation would bring the administration into disrepute or is otherwise contrary to the public interest, citing the case of *R. v. Anthony-Cook*, 2016 SCC 43.

CONCLUSION

Based on all of the foregoing, the Panel has determined that the Joint Recommendation as to Disposition made by the CPSM and by Dr. Lockman should be accepted. The Panel hereby issues to the CPSM our Resolution and Order, a document that accompanies this documentation of the reasons for our decisions.

DATED this 29th day of September, 2022

Joel Kettner

DR. JOEL KETTNER
Chairperson of the Inquiry Panel

Jim Price

DR. JIM PRICE

David Bjornson

DAVID BJORNSON, Public Representative

Schedule A

Exhibit No.

1. An Amended Notice of Inquiry - as amended June 10, 2021
2. An Amended Notice of Inquiry - as amended April 6, 2022
3. Joint Recommendation – April 6, 2022
4. Affidavit of Meredith McLeod with Exhibits
5. Group 1 Patient Records (redacted)
6. Group 2 Patient Records
7. Group 3 Patient Records (redacted)
8. Group 4 Patient Records (redacted)
9. Group 5 Patient Records (redacted)
10. Documents re: Dr. C. S. (redacted)
11. Dr. C. S. Summative Report – Group 1 Patients
12. Dr. C. S. Summative Report – Group 2 Patients
13. Documents re: Dr. A.S. (redacted)
14. Dr. A. S. Summative Report – Overall Conclusions
15. Dr. A. S. Summative Report – Group 1 Patients
16. Dr. A. S. Summative Report – Group 2 Patients
17. Dr. A. S. Summative Report – Group 3 Patients
18. Patient Statements (selected from Groups 2 and 3 – redacted)
19. Affidavit of Curtis Peters
20. Memorandum re: meeting at Max Systems offices
21. Communications with Dr. 2
22. Emails between Dr. Lockman and Mr. Chepil

23. Email with Mr. Chepil

24. Interim Conditions served to Dr. Lockman (June 20, 2019)’

25. Letter from Dr. Lockman re: record keeping course (October 17, 2019)

26. CAPE results re: October 2020 assessment (February 23, 2021)

27. Decision of Appeal of Interim Conditions

28. Combined evidence for Group 1, Group 2, and Group 3

29. Censure (May 6, 2015)

30. College of Physicians and Surgeons of Ontario v. Khan, 2021 ONCPSD

IN THE MATTER OF:	*The Regulated Health Professions Act*, C.C.S.M. c. R117, Part 8 (the "Act")
AND IN THE MATTER OF:	DR. LEONARD ELIA LOCKMAN, a member of the College of Physicians and Surgeons of Manitoba
AND IN THE MATTER OF:	A NOTICE OF INQUIRY DATED NOVEMBER 25, 2020, AS AMENDED JUNE 10, 2021 AND APRIL 6, 2022

INQUIRY PANEL:

Dr. Joel Kettner, Chairperson

Dr. Jim Price

David Bjornson, Public Representative

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

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COUNSEL FOR THE INQUIRY PANEL

Lynda K. Troup

RESOLUTION AND ORDER OF THE INQUIRY PANEL

WHEREAS Dr. Leonard Elia Lockman ("Dr. Lockman"), a member of the College of Physicians and Surgeons of Manitoba (the "CPSM") was charged with contravening the CPSM's By-laws, the Standards of Practice of Medicine and the Code of Ethics, with displaying a lack of skill, knowledge, and judgment in the practice of medicine, and with demonstrating an incapacity or unfitness to practice medicine, as more particularly outlined in a Notice of Inquiry, dated November 25, 2020, as amended June 10, 2021 and April 6, 2022.

AND WHEREAS Dr. Lockman was summoned before an Inquiry Panel (the "Panel") of the CPSM on April 11, 2022 for the purpose of conducting an inquiry (the "Inquiry") pursuant to Part 8 of the Act into the allegations against Dr. Lockman as set out in the Notice of Inquiry

AND WHEREAS Dr. Lockman did not attend personally before the Panel but was represented by legal counsel;

AND WHEREAS an Amended Notice of Inquiry, dated April 6, 2022, outlining the charges and particularizing the allegations against Dr. Lockman was filed as an exhibit in the hearing before the Panel;

AND WHEREAS Dr. Lockman, through his counsel waived a reading of the charges as set out in the Amended Notice of Inquiry and entered a plea of guilty and/or admission to all of the counts relating to all of the charges outlined in the Amended Notice of Inquiry with the exception of count 16, to which Dr. Lockman pled no contest;

AND WHEREAS the Panel reviewed the exhibits filed, considered the evidence presented before it and heard submissions from counsel for the CPSM and submissions from counsel for Dr. Lockman, and received a Joint Recommendation as to Disposition of the charges and allegations outlined in the Amended Notice of Inquiry;

AND WHEREAS the Panel decided that the Joint Recommendation as to Disposition was appropriate in the circumstances;

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

1. Pursuant to subsection 124(2)(a),(b) and (d) of the Act, Dr. Lockman is guilty of committing acts of professional misconduct; having contravened the applicable Standards of Practice, Code of Ethics and By-laws of the CPSM; and having displayed a lack of knowledge, skill and judgment in the practice of medicine as particularized in Count 1.1 to 1.8 of the Amended Notice of Inquiry.

2. Pursuant to subsection 124(2)(a),(b) and (d) of the Act, Dr. Lockman is guilty of committing acts of professional misconduct; having contravened the applicable Standards of Practice, Code of Ethics and By-laws of the CPSM; and having displayed a lack of knowledge, skill and judgment in the practice of medicine as particularized in Count 2.1 to 2.3 of the Amended Notice of Inquiry.

3. Pursuant to subsection 124(2)(a) and (b) of the Act, Dr. Lockman is guilty of committing acts of professional misconduct and having contravened the Code of Ethics as particularized in Count 3 of the Amended Notice of Inquiry.

4. Pursuant to subsection 124(2)(a) and (b) of the Act, Dr. Lockman is guilty of committing acts of professional misconduct and having contravened the Code of Ethics as particularized in Count 4 of the Amended Notice of Inquiry.

5. Pursuant to subsection 124(2)(a) and (b) of the Act, Dr. Lockman is guilty of committing acts of professional misconduct and having contravened the Code of Ethics as particularized in Count 7 of the Amended Notice of Inquiry.

6. Pursuant to subsection 124(2)(a) and (b) of the Act, Dr. Lockman is guilty of committing acts of professional misconduct and having contravened the Code of Ethics as particularized in Count 8.1 to 8.4 of the Amended Notice of Inquiry.

7. Pursuant to subsection 124(2)(b) of the Act, Dr. Lockman is guilty of having contravened the Standards of Practice as particularized in Count 9 of the Amended Notice of Inquiry.

8. Pursuant to subsection 124(2)(a) and (b) of the Act, Dr. Lockman is guilty of committing acts of professional misconduct and having contravened the Code of Ethics as particularized in Count 11 of the Amended Notice of Inquiry.

9. Pursuant to subsection 124(2)(a),(b) and (d) of the Act, Dr. Lockman is guilty of committing acts of professional misconduct; having contravened the applicable Code of Ethics; and having displayed a lack of knowledge, skill and judgment in the practice of medicine as particularized in Count 14.1 to 14.4 of the Amended Notice of Inquiry.

10. Pursuant to subsection 124(2)(a) and (b) of the Act, Dr. Lockman is guilty of committing acts of professional misconduct and having contravened the Code of Ethics as particularized in Count 15 of the Amended Notice of Inquiry.

11. Pursuant to subsection 124(2)(e) of the Act, Dr. Lockman has demonstrated an unfitness to practise medicine.

12. Pursuant to subsection 126 of the Act:

    (a) Dr. Lockman is hereby reprimanded by the Panel [ss. 126(1)(a);] and

    (b) Dr. Lockman's registration with the CPSM is hereby cancelled [ss. 126 (1)(i)]

13. Pursuant to section 127(1)(a) of the Act, Dr. Lockman shall pay to the CPSM costs in the amount $40,000:

DATED this 23rd day of August, 2022.

Joel Kettner

DR. JOEL KETTNER
Chairperson of the Inquiry Panel

Jim Price

DR. JIM PRICE

David Bjornson

DAVID BJORNSON, Public Representative