NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Manitoba ("CPSM") and Dr. Daljit Singh Gill, this is notice that the Inquiry Committee ordered that, pursuant to subsection 122(2)(b) of *The Regulated Health Professions Act* ("RHPA"), there shall be no disclosure of the names or other identifying information of any patients referred to in the proceedings or who are named in any of the exhibits in the proceedings. This includes Patient 1, Patient 2, Patient 3, Patient 4, Patient 5, Patient 6, Patient 7, Patient 8, and Patient 9, all of whom were named by initials in the proceedings.

Subsection 122(5) of the RHPA reads:

> *No person, whether or not a member of the news media, shall publish anything else that identifies or may identify a person who, by virtue of an order made under subsection (2), can only be identified by initials.*

Subsection 171(1) of the RHPA reads:

> *A person who contravenes a provision of this Act, other than section 140 (confidentiality of information), or of the regulations is guilty of an offence and is liable on summary conviction to a fine*
>
> *(a) in the case of an individual,*
>
> *(i) for a first offence, to a fine of not more than $10,000, and*
> *(ii) for each subsequent offence, to a fine of not more than $50,000; and*
>
> *(b) in the case of a corporation,*
>
> *(i) for a first offence, to a fine of not more than $25,000, and*
> *(ii) for each subsequent offence, to a fine of not more than $100,000.*

CPSM has further edited this decision in accordance with subsection 129(2) of the RHPA to protect the privacy of complainants and witnesses. Subsection 129(2) provides:

> *129(2) For the purpose of protecting the privacy of the complainant or any witnesses, or both, the college may edit the decision or order — not including an edit that deletes the investigated member's name — before making it available to the public. Without limitation, edits may include using pseudonyms to describe the complainant or witnesses and deleting geographical references.*

IN THE MATTER OF:	*The Regulated Health Professions Act,* C.C.S.M., c. R117, Part 8
AND IN THE MATTER OF:	DR. DALJIT SINGH GILL, a member of the College of Physicians and Surgeons of Manitoba
AND IN THE MATTER OF:	Amended Notice of Inquiry, dated June 23, 2023, and Notice of Inquiry dated October 25, 2022

INQUIRY PANEL:

Dr. Clifford Yaffe, Chairperson

Dr. Eric Lane

Sandra Benavidez, 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 August 23, 2024 and continuing on October, 15, 2024, a hearing was convened before an Inquiry Panel (the "Panel") of the College of Physicians and Surgeons of Manitoba (the "CPSM") for the purpose of conducting an inquiry pursuant to Part 8 of *The Regulated Health Professions Act* C.C.S.M., c. R117 (the "Act") into charges against Dr. Daljit Singh Gill ("Dr. Gill"), a member of the CPSM, as set forth in an Amended Notice of Inquiry dated June 23, 2023 (the "June NOI") and a Notice of Inquiry dated October 25, 2023 (the "October NOI"), and collectively referred to as the "Notices of Inquiry".

The Notices of Inquiry charged Dr. Gill with professional misconduct, with contravening the CPSM's By-laws, the Standards of Practice of Medicine, practice directions 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.

Among other things, the June NOI states that:

1. Between in or about January 2018 and August 2022, Dr. Gill contravened CPSM Bylaws, the Standards of Practice of Medicine and/or the Code of Ethics, demonstrated a lack of knowledge, skill, and/or judgment in the practice of medicine, and/or committed professional misconduct, in that Dr. Gill:

a. failed to adequately document his involvement in patient care and failed to review diagnostic results in a timely way;

b. unethically and/or inappropriately submitted claims, or caused claims to be submitted on his behalf, under *The Health Services Insurance Act* C.C.S.M. c. H35 (“HSIA”) for insured services which he did not meet the applicable tariff requirements in that he submitted claims for visits in which he failed to create a patient record, for virtual visits that never took place and/or for family care conferences when no family member was present and/or he did not provide the necessary services; and

c. in respect to his management of requests for prescription (“Rx”) refills from pharmacists, provided unnecessarily short approvals for prescription refills, failed to respond to requests for refills in a timely way and unnecessarily sent approvals in piecemeal fashion causing delay and confusion for the purpose of facilitating inappropriate and/or unethical claims under the HSIA for prescription refills;

d. breached one or more of the undertakings he gave to the CPSM in September 2020 (and updated June 2021);

e. failed to adequately document his involvement in Patient 5’s care and failed to meet the standards for communication with Patient 5; and

f. failed to appropriately address pharmacy requests in respect to Patient 6.

2. Between in or about September 2017 and November 2017, Dr. Gill displayed a lack of skill, knowledge, and judgment in the practice of medicine, and/or contravened CPSM's By-laws, Standards of Practice of Medicine, practice directions, and/or the Code of Ethics in that he failed to maintain the standard of care in respect to his management of Patient 8's heart condition and failed to meet professional expectations in his communication with Patient 8.

3. Between in or about December 2017 and September 2020, Dr. Gill engaged in professional misconduct and/or displayed a lack of skill, knowledge, and judgement in the practice of medicine, and/or contravened CPSM's By-laws, Standards of Practice of Medicine, practice directions, and/or the Code of Ethics in that he provided false and misleading information to CPSM and failed to respond in a timely way and/or appropriately cooperate with CPSM's review and investigation of the concerns raised in Patient 8's complaint about his care and conduct and with another ongoing investigation.

4. By reason of one or more of the foregoing allegations, individually and cumulatively, Dr. Gill demonstrated an inability or unwillingness to comply with the requirements and standards of CPSM and otherwise.

Among other things, the October NOI states that:

1. On or about October 15, 2021, Dr. Gill engaged in professional misconduct, contravened CPSM's Code of Ethics and/or demonstrated an unfitness to practice medicine in respect to his conduct and communication with Patient 9 in that he inappropriately shared information with Patient 9 about his former practice location

and another regulated healthcare professional and involved the patient in a dispute with that other healthcare professional and encouraged them to make a complaint about that healthcare professional, after being advised against this by CPSM.

The June NOI also contains factual particulars with respect to Counts 1 to 3 set out above and the October NOI contains factual particulars with respect to Count 1 set out above.

The hearing proceeded virtually before the Panel on August 23, 2024, in the presence of Dr. Gill and his counsel, and in the presence of counsel for the Complaints Investigation Committee of the CPSM (herein the “CPSM”). Dr. Gill, through his counsel, admitted his membership in the CPSM, and confirmed that the Panel had jurisdiction over the matters at issue. The hearing was adjourned to be continued during the scheduled dates commencing October 15, 2024.

The hearing continued before the Panel on October 15, 2024, in the presence of Dr. Gill and his counsel, and in the presence of counsel for CPSM. Dr. Gill, through his counsel, acknowledged service upon him of the June NOI and October NOI.

Dr. Gill waived the requirement that the hearing must begin within 120 days after the complaints were referred to the Inquiry Panel pursuant to subsection 116(2) of the Act. In addition, he waived the reading of the June NOI and October NOI and admitted all Counts of the June NOI and all Counts of the October NOI, and all particulars relating to those Counts as outlined therein. By doing so, he admitted the truth of all of the allegations and of the factual particulars in support of the allegations in the June NOI and October NOI 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 practice directions, a lack of knowledge, skill and judgment in the practice of medicine, and an incapacity or unfitness to practice medicine, as more particularly referred to in the June NOI and October NOI.

The Panel reviewed and considered the following documents, all of which were filed as exhibits in the proceedings by consent:

1. The Notice of Inquiry dated June 19, 2023 (Exhibit 1);
2. The Notice of Inquiry dated October 25, 2023 (Exhibit 2);
3. The Amended Notice of Inquiry dated June 23, 2023 (Exhibit 3);
4. Statement of Agreed Facts (Exhibit 4);
5. Joint Recommendation (Exhibit 5); and
6. Agreed Book of Documents (Exhibit 6).

The Panel has considered the guilty plea of Dr. Gill having regard to the exhibits, evidence filed, and the submissions of counsel for the CPSM and the submissions of counsel for Dr. Gill.

On the basis of their review of the Statement of Agreed Facts and the guilty plea of Dr. Gill, the Panel is satisfied that all of the charges set forth in the June NOI and October NOI and the particulars contained therein have been proven on a balance of probabilities.

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

- An Order reprimanding Dr. Gill pursuant to subsection 126(1)(a) of the Act;
- An Order suspending Dr. Gill from the practice of medicine for a fixed period of six (6) months pursuant to subsection 126(1)(b) of the Act;
- An Order imposing conditions on Dr. Gill's right to practice pursuant to subsection 126(1)(f) of the Act, which include practice supervision, volume or practice restrictions, documentation requirements, requirements for managing prescriptions and diagnostic reports, and requirements for communicating with consulting health care providers (the "Agreement and Undertaking");
- An Order that Dr. Gill make restitution to Manitoba Health in an amount to be negotiated in good faith between Dr. Gill and Manitoba Health, pursuant to subsection 126(1)(h) of the Act;
- An Order that Dr. Gill complete a specific course of studies in ethics and professionalism;
- An Order that Dr. Gill pay the costs incurred by CPSM in monitoring compliance with the Agreement and Undertaking pursuant to subsection 126(5) of the Act; and
- An Order that Dr. Gill pay:

- to the CPSM costs in the amount of $36,126.20 pursuant to subsection 127(1)(a) of the Act, to be paid on or before October 15, 2024;

- a fine in the amount of $5,000.00 pursuant to subsection 127(1)(b) of the Act, to be paid on or before the date of the Inquiry; and

- the cost of the Inquiry within six (6) months of the Inquiry Panel's order, including fees for retaining a reporter, remuneration and reasonable expenses to members of the Inquiry Panel, and costs incurred by CPSM in providing counsel for the Inquiry Panel, pursuant to subsection 127(1)(a) of the Act.

The Panel is satisfied that the Joint Recommendation as to Disposition is sound and appropriate and ought to be accepted by the Panel. The Panel's specific reasons for its decision are outlined below.

BACKGROUND

Dr. Gill graduated from the University of Manitoba Faculty of Medicine in 2008 and completed post graduate training in Internal Medicine in 2012.

Dr. Gill has been registered as a specialist since 2012. In that time, Dr. Gill's non-institutional and non-personal care home practice settings have included Clinic A (2012 – 2019), Clinic B (2019 – 2020), Clinic C (2020 – 2021), and Clinic D (2021 to present). His professional practice has also included institutional and personal care home settings.

Investigation IC3192 and IC3882

The Investigation Committee's investigation underlying Counts 1(a)-(d), 2 and 3 of the June NOI was identified as IC3192 and IC3882 and related to Dr. Gill's conduct between September 2017 and August 2022.

Dr. Gill provided care for Patient 8 regarding his heart condition. When Patient 8 saw Dr. Gill on September 26, 2017, at Clinic A it was determined that he required an implantable defibrillator and Dr. Gill would be sending a referral to the St. Boniface Hospital Cardiac Lab (the "Cardiac Lab") for this purpose. In follow up to this plan, Patient 8 and his wife contacted Dr. Gill's office and the Cardiac Lab on multiple occasions in October 2017 to ensure that the referral was in progress. On October 18, 2017, Patient 8's wife was told by a staff member from Dr. Gill's office that the referral would be sent that day or the next, but upon follow up with the Cardiac Lab on October 23 and 27, she was advised that no referral had been received.

By October 27, 2017, there was still no referral and Patient 8's family physician took responsibility and made the necessary referral to another cardiologist. Patient 8 did not return to see Dr. Gill. Dr. Gill ultimately failed to send the referral.

On November 9, 2017, Patient 8 complained to CPSM about the delay he encountered when Dr. Gill failed to make the planned referral and with respect to a lack of communication from Dr. Gill's office. The Registrar referred the complaint to the Complaints Committee for review (CC3192).

Dr. Gill was provided with the complaint on December 1, 2017, and was to provide his response no later than January 5, 2018. Dr. Gill did not respond, and a reminder letter was sent on January 9, 2018.

On January 23, 2018, Dr. Garth Campbell (CPSM Medical Consultant) spoke with Dr. Gill. Dr. Gill advised that he did not receive the first letter of December 1, 2017, but had received the second letter of January 9, 2018, but there was no complaint letter attached. The complaint was emailed to Dr. Gill, and he was given 30 days to respond.

On February 27, 2018, an email was sent from Dr. Campbell to Dr. Gill reminding him that CPSM was awaiting his response. On March 1, 2018, an email was received from Dr. Gill saying that he would deliver a response the following day. On March 5, 2018, an email was received from Dr. Gill apologizing that he was not able to come in on March 2, 2018, and that he would bring the response the following day. An email sent March 7, 2018, advised that Dr. Gill mailed the response instead.

On March 20, 2018, Dr. Campbell sent an email to Dr. Gill advising that CPSM had not received his response and advised that if a response was not received that day, the case would be referred to the Investigation Committee. On March 20, 2018, Dr. Gill emailed him back and advised that he sent in the response quite some time ago, that he was currently in Anguilla and was rebooking a flight to return to Winnipeg. On March 21, 2018, an email was received from Dr. Gill advising that he was in Minneapolis and once in Winnipeg will immediately bring the response to CPSM.

The response from Dr. Gill was received on March 22, 2018 (it was inaccurately dated February 12). His response enclosed what was purported to be Patient 8’s patient

record. In his response, Dr. Gill stated that he created the referral letter for Patient 8 on October 9, 2017, and provided a copy with his response. He stated that he believed he faxed the referral letter himself but that there could have been a sender or recipient transmission error that resulted in the referral letter not being properly received. The Complaints Committee became concerned about the credibility of Dr. Gill's explanation and his level of cooperation and decided to refer the complaint to the Investigation Committee for a more formal review. The investigation was identified as IC3192.

The notice of referral letter for IC3192 was sent to Dr. Gill on May 30, 2018. Dr. Gill was asked to explain delays leading up to his March 22, 2018, response and to provide Electronic Medical Record ("EMR") audit trail data for the referral letter and his response letter to CPSM. He did not provide a response by the deadline and a reminder letter was sent on July 5, 2018. The Registrar referred to the Investigation Committee Dr. Gill's failure to respond. The new investigation was identified as IC3882.

By letter dated August 15, 2018, Dr. Gill was informed of the referral of IC3882. The Complaints Coordinator was not able to get in contact with Dr. Gill until September 10, 2018. Dr. Gill asked that the August 15 letter be re-sent, which was done. Dr. Gill provided a response on September 11, 2018, advising that he had not received the mailed copies of the May and July 2018 letters and that his last correspondence was with Dr. Campbell when he delivered his reply and had asked Dr. Campbell that he be contacted by email with any updates.

On October 10, 2018, in advance of an interview scheduled for the following day, Dr. Gill's lawyer provided explanations and documentation related to outstanding delay and cooperation issues that were under investigation:

(a) Day sheets were submitted that indicate that Dr. Gill was providing services to Seven Oaks hospital on October 9, 2017;

(b) Dr. Gill left Winnipeg February 5, 2018, and was in St. Maarten and then Anguilla on February 6, 2018. He returned February 14. Dr. Gill returned to Anguilla on March 14, 2018, and then left St. Maarten on March 20, 2018;

(c) Dr. Gill's lawyer identified that, "In terms of his February 12, 2018, response to the College, it was never entered into the EMR. Dr. Gill did not consider a complaint regarding his conduct as being appropriate to enter into the EMR for Patient 8. Dr. Gill prepared the letter himself outside of the Clinic EMR system.";

(d) Dr. Gill was asked to provide a copy of the request he stated he sent to Dr. Campbell regarding further correspondence to be sent by email. He could not find an email and believed he made the request when they spoke; and

(e) As to delay between May and September 2018, Dr. Gill advised that he had significant issues with respect to delivery of mail to his home address as the mail directed to his address was placed in another mail slot for an address that was unoccupied. He provided emails from Doctors Manitoba dated September 19 through 25, 2018 confirming that Doctors Manitoba mail

directed to Dr. Gill had been returned to Doctors Manitoba. He also provided correspondence from RBC Direct Investing Inc. from July 2018 and correspondence to his mother from August 2018 directed to his home address which were returned to sender and marked as such. Dr. Gill provided copies of the envelopes marked with his address crossed out with an “X” and “RTS unclaimed” (but did not have a yellow sticker from Canada Post).

Information was obtained from Canada Post regarding their process for mail that was un-claimed. If a community mailbox is full, Canada Post would not routinely process those as “return to senders”. They would keep the mail at the depot for the recipient to pick up. Regarding the RTS issue, if a person got someone else’s mail because it was put in the wrong mailbox and they wrote RTS on it and stuck those in the mailbox, they would go through Canada Post and they would have a yellow sticker applied and returned to the original sender.

At an interview that took place on October 11, 2018, Dr. Gill indicated:

(a) He would have created the referral for Patient 8 outside the EMR on his own personal computer while working at Seven Oaks Hospital on October 9, 2017. He did not use remote access to Accuro (an electronic medical record platform used in medical offices) as it was too slow. In the circumstances, there would be no audit trail data;

(b) He probably tried faxing the referral letter himself. There must have been an error when he or staff at the hospital tried to fax the letter either because

they did not fax it properly or the Cardiac Lab either did not receive it or misplaced it;

(c) Because his assistant was not involved, she was unaware that the referral had not been properly sent when she spoke with Patient 8 or his wife and advised them that it had not been done in October 2017;

(d) The usual approach would have been for staff to scan a copy of the letter into the EMR. And Dr. Gill was not clear why this would not have happened;

(e) After the Complaints Committee asked for a copy of the referral letter, Dr. Gill then took a copy from his laptop, along with all the other notes for Patient 8, and pasted the letter into the EMR; and

(f) Dr. Gill stated he told his assistant to leave this EMR alone in the context of CPSM's investigation, which may explain why it was not scanned in.

Respecting delay in responding to Patient 8's complaint, Dr. Gill stated:

(a) He did not receive the complaint until January 23, 2018;

(b) On March 5, 2018, Dr. Gill believed he became busy with patient care and failed to send the response;

(c) On March 7, Dr. Gill believed he told his assistant to send whatever was in the EMR and that he would get the letter in soon afterward. He confirmed no letter of response was sent by him and that there was only a plan for sending the patient record while he was away, which was not done either;

(d) On March 20, 2018, an email was received by CPSM from Dr. Gill inaccurately stating he sent in the response quite some time ago;

(e) In respect to his response letter received by CPSM on March 22, 2018, the letter was written a day or before delivery to CPSM and that it was written partly in Anguilla and partly while traveling. It was dated February 12, 2018, as he would have started the letter at that time while he was in Anguilla but finished it at the later date. He has his laptop with him and would have had remote access to the EMR. He did not send it at that time as he wanted to have the whole package sent together.

On March 29, 2019, in response to a request from the October 11, 2018, interview, Dr. Gill provided what he said was the original letter that had been created on his personal laptop and subsequently printed at Seven Oaks Hospital. It would normally have been scanned into the EMR, but he said, as per his instructions to leave this EMR alone, this had not been done. There was no adequate explanation as to the stamp indicating “FAXED”. The whereabouts of the letter in the meanwhile was not explained.

Dr. Gill was interviewed on July 10, 2019. Dr. Gill noted there would have been several possibilities that could have resulted in the “FAXED” stamp which is present on the letter he provided. This includes the possibility that he faxed it himself or that he obtained the assistance of one of the secretaries at Seven Oaks Hospital. The stamp is available at the fax machine. Dr. Gill did not have any retained copies of a paper indicating that the fax was sent. Dr. Gill acknowledged that he has no way to verify when this letter was written. It was created outside of the EMR, and no audit trail exists. He stated he had

since deleted documents from his personal computer that were printed and scanned for transfer into the EMR. He noted that at the time, his assistant was behind in her scanning.

Dr. Gill's medical office assistant at Clinic A and Clinic B was contacted. She provided the following information:

(a) If Dr. Gill made a referral to another physician, he would do this on his own;

(b) Dr. Gill sometimes worked offsite on a laptop. He occasionally would prepare letters and bring them to the office to be scanned, but not often. If he brought something in, she confirmed that the timelines were up-to-date, and they would be scanned "right away":

(c) She was asked if she was aware of patients who were unhappy with timeline or delay issues. She advised that she would get calls about concerns about delays for referrals, tests, etc., in general, once or twice a day, and there were repeated calls and people would be calling her back indicating that they had not heard either from Dr. Gill or the physician to whom they were referred or from the hospital if it was for a test. Because she could not answer the questions because of her lack of involvement, she would relay the message to Dr. Gill for him to address; and

(d) She could not remember the specific situation with Patient 8.

Clinic A provided information from their EMR and audit trail data regarding Patient 8. This data demonstrated the following:

(a) The copy of the referral letter (stamped “faxed”) that Dr. Gill produced to CPSM on March 29, 2019, was not part of the EMR records;

(b) All of Patient 8’s clinical encounters dating back to November 2016, and the letter of referral for an internal defibrillator were all created in the EMR on March 21, 2018; and

(c) Dr. Gill’s response to CPSM was created on March 21, 2018.

CPSM contacted several health care providers about whether they received consult letters from Dr. Gill relating to Patient 8. Only Patient’s 8 primary care provider had information in her chart relating to Dr. Gill. It consisted of a referral to Dr. Gill in respect to discharge information from Concordia Hospital from October of 2016.

Expansion of Investigation IC3882

IC3882 was expanded multiple times as a result of the investigation into concerns about Dr. Gill’s care and conduct. Clinic A staff interviewed in the context of IC3192, and Dr. Gill’s delayed responses, indicated general concerns with his practice. These related to the completeness and timeliness of referrals and documentation.

Dr. Gills’ Practice Management in 2018 and prior

Dr. Gill was asked to provide copies of the day sheets from his practice at Clinic A for January and February 2018. In his letter to CPSM received March 22, 2018, Dr. Gill indicated that he had taken most mornings off since December 2017 to address paperwork. Dr. Gill provided copies of day sheets, and these indicated that after January

16, 2018, he began his scheduled appointments at 12:30. Prior to that patients were seen from 9-4.

Concerns were raised at the interview of October 11, 2018, regarding Dr. Gill's system for follow up of diagnostics. Dr. Gill said it was his routine to only look at diagnostic results when a patient came for their appointment. For some diagnostics, his staff would put a reminder in the EMR to look at the result. Periodically Dr. Gill or his secretary would look at the list of diagnostics received to make sure that anything older is followed up to see why the patient has not returned. Dr. Gill acknowledged that some abnormal tests may not be immediately seen. Concerns were raised about the flaws in the system, specifically that it depends on patients to come back. Dr. Gill noted that his patients are told it is part of their responsibility to return for follow-up. He provided further information about how urgent diagnostics are brought to his attention and specific attention is paid to INR (international normalized ratio) results that are expected.

June 2020 Audit

In June 2020, an audit of Dr. Gill's record-keeping was undertaken to see if he was making timely entries in the medical records.

The audit of both Clinic A (select electronic medical records for patients seen between October and December 2018) and Clinic B (between September 2019 and March 2020) documentation confirmed these concerns. Whereas the audit indicated a high number of patients for whom no documentation existed for their encounter, information from Dr. Gill himself and from staff at Clinic A indicated that this issue was widespread. At Clinic B the inappropriate use of pre-populated templates made it

impossible to determine if the documentation was complete and accurate. The audit also identified some patient records where diagnostic results were not reviewed in a timely way.

Dr. Gill's use of the Patient Care Family Conference billing tariff (8473) was considered. The audit showed that for some of the visits where the tariff was used, there was no encounter note or supporting documentation and in others, it was billed separately as a family care conference but should have been a component of the basic medical care provided to the patient.

Dr. Gill was interviewed on September 17, 2020, in respect to the June 2020 audit, among other issues. In summary, Dr. Gill advised that:

(a) In 2014 Clinic A changed from paper charts to Accuro, and he had limited experience and training which resulted in him getting further and further behind in his documentation;

(b) In 2018 the clinic changed to a new system (Libra) and again he had trouble keeping up. He became "months and months" behind in his charting;

(c) Dr. Gill stated he does not know how to type;

(d) Dr. Gill acknowledged that the lack of encounter notes could have a negative impact on patient care;

(e) When he moved to Clinic B, he said it was an opportunity to “reset”. They were using Accuro, and he took time to learn how to use the system efficiently and to a greater potential than he previously had;

(f) By March 2020 there was a significant backlog. He spent time when patients were unable to attend the clinic due to Covid-19 getting caught up and spent the month of April catching up on paperwork. By May 2020, patients were returning to the clinic, and he was using templates that he created electronically;

(g) Prepopulated templates were discussed. Dr. Gill stated that he always asks those questions but can’t guarantee that they reflect the encounter notes He acknowledged that this is a deficiency. He said he originally developed them to be blank where the yes/no response goes, but found that most of the time, the answers were the same, so he made a template that includes the responses;

(h) In terms of diagnostics, he did not routinely look at results until patients return. Patients who are seen yearly and those seen for chronic care management are asked to have blood work done a few weeks prior to their attendance. He looks at the results when they attend. Critical results are phoned to him by the lab, then he contacts patients about the results;

(i) Circumstances where patients are seen for acute issues and who have lab work done were discussed. He did not look at this until they returned;

(j) Dr. Gill acknowledged that he has not had dedicated time to address lab work as he ought to have. Before Covid, he estimated that there were 700 – 750 documents in his inbox. Some of these were duplicates. He got caught up in March and April but fell behind again over time;

(k) At his new clinic Dr. Gill built in time to address documentation. It has taken some time to get the EMR set up and he acknowledged that “not many” of the notes from last week were completed;

(l) Dr. Gill intended to book off 1 week per month to remain caught up. He checked his EMR remotely and indicated that there were 845 items outstanding in his inbox. Some of these will be duplicates but he estimated that there would be at least 650 independent results;

(m) The process for pharmacy faxes at Clinic B was discussed. They arrived as an electronic fax to the clinic and staff were to print them out and provide them to the doctors. He would pick up the paper copies and deal with them. Toward the end of his work at Clinic B Dr. Gill stated he did not believe all the faxed requests that were sent to the clinic were provided to him;

(n) If he knew the patient well, he would not have to look in the chart – he would sign the forms, authorizing a month of medication. He would give the paper to the staff, and they would fax it back to the pharmacy;

(o) It was his usual routine to provide 4 months of medication at the time of a visit. Patients who were being stabilized for various issues would be seen

every 3-4 months and then he would re-issue another Rx. Those who were to be seen yearly for review were also provided with 4 months' worth of medication and told to follow up with their family physician for the remainder of the year's medication;

(i) If the request came to him for authorization, he would give a month at a time in order to bridge any gap in getting the medications from their family doctor;

(ii) Sometimes there was a significant time gap between when he received the request and when he was able to address it. He takes responsibility for the delays. It was not adequate. He inappropriately did not assign enough urgency to this task. He still addressed it and authorized medications, never checking with a pharmacist to see if it was still required;

(iii) Some faxes appeared to have been sent multiple times. Dr. Gill stated he thought some of these have multiple dates because they were not sent on the first date, or second date, and were eventually provided to staff on the third date for them to fax; and

(iv) He noted that if there is more than one page of medications listed, they will be faxed together but billed on separate days because only one Rx can be claimed per day. Dr. Gill considered that two pages are two separate communications. It was pointed out that the second

page was not actually sent on the day that is indicated on the billing submission.

In follow up to the June 2020 audit, full charts for patient care provided by Dr. Gill at Clinic A were obtained in May of 2022 for a more in-depth review. Billing information and audit trail data was also examined. Review of additional records demonstrated that Dr. Gill's record-keeping deficiencies were consistently profound and widespread while he practiced at that location, both among different patients and for multiple visits respecting individual patients.

September 2020, Undertaking

Dr. Gill signed an undertaking in September 2020 (updated June 7, 2021, to reflect a change in practice location) to practice under patient volume limitations and to practice under supervision. The undertaking, which remains in effect, requires that Dr. Gill maintain up to date documentation of his involvement in care and includes timelines for responding to pharmacy requests and diagnostic results. Ongoing monitoring reports from his supervisor indicate that the relevant issues have shown significant improvement.

March 2022 site visit, August 2022 audit and follow up investigations

On March 24, 2022, a site visit to Dr. Gill's then current practice setting was completed as part of CPSM's monitoring of his undertaking. Timely response to review diagnostics and pharmacy requests was noted but Dr. Gill was not maintaining up to date documentation in patient records, which was a requirement of his undertaking. The length of prescriptions Dr. Gill was providing was also an area of concern.

An audit of Dr. Gill's practice was conducted in August of 2022. The audit captured patients cared for by Dr. Gill at the Maples Personal Care Home ("Maples PCH"). A lack of documentation related to Dr. Gill's involvement in care was observed. Further records were requested, and analysis revealed that Dr. Gill routinely failed to adequately document ostensible patient visits in the fall of 2021 and spring of 2020, which may or may not have occurred, including by frequently failing to document any information in the patient record about visits that were recorded to have occurred.

In addition, question was raised as to whether Dr. Gill submitted, or caused to be submitted, inappropriate or unsupported claims to Manitoba Health for insured medical services. Tariffs of concern were for virtual visits and family care conferences. The number of family care conferences and lack of particularity in Dr. Gill's underlying documentation raised red flags. A lack of documentation to support a very high number of virtual visits for Maples PCH patients was observed, raising significant doubt tariff criteria were met. This was the subject of investigation.

All office visits from November 1 and 2, 2021, along with associated audit trail data, were selected to further examine Dr. Gill's use of the family care conference tariff (8473). Review of all audit trail data from two dates supported the conclusion that family care conference billings were likely inappropriate or not supported. Review of Maples PCH charts support the conclusion that many virtual visit claims submitted by Dr. Gill respecting Maples PCH patients were inappropriate or unsupported.

Recent conduct respecting communication with pharmacies

Regarding the 8005 tariff (communication initiated by pharmacists), the physician billing manual specifically states, “This service is not to be used as a routine practice or to authorize repeat prescriptions for which long-term repeats would more properly have been authorized at the time of writing the initial prescription.”

Dr. Gill previously took the approach that a two-page list of medications could be faxed back to the pharmacy and billed as separate communications by submitting billings on two consecutive days. He stated he no longer bills Manitoba Health in this way.

Manitoba Health provided information about Dr. Gill’s total billings for Family Care Conferences (Code 8473) as compared to other internal medicine specialists for the 12-month period ending March 31, 2023. Dr. Gill was the top billing physician at $91,640.00. The second highest was $34,560 and the next highest were 4 physicians who billed between $21,000 – $22,000. For context, Dr. Gill has an office practice and attends a personal care home. The audit shows his patients are not complex. He has limits on the number of patients he can see in a day.

In the same 12-month period, Dr. Gill billed $188,077.50 for communication with pharmacists (i.e., tariff 8005). By comparison, there are two other internal medicine physicians who billed over $100,000 ($143,666 and $103,041 respectively) with the vast majority billing less than $10,000 for prescription refills.

Investigation IC5260

In the context of the June 2020 audit, Clinic B raised concerns about delays in responding to pharmacy requests for refills of prescriptions as well as Dr. Gill's billing practices with respect to pharmacy communication during the period between January 2019 to July 2020. Clinic B also indicated that Dr. Gill routinely only authorized one (1) month of refills on prescription renewal requests, even when respective patients were stable on the chronic medications requested for renewal and did not have an appointment for several months. These concerns were referred to the Investigation Committee for review. The investigation was referred to as IC5260.

The investigation demonstrated significant failures on Dr. Gill's part to meet applicable standards of care and professionalism in relation to his management and prescribing for four (4) patients (Patients 1 to 4) in that Dr. Gill:

(a) provided unnecessarily short approvals for prescription refills;

(b) failed to respond to requests for refills in a timely way, including circumstances where he approved refills so long after the request was made that he knew or ought to have known that his eventual approval was not in the best interests of the patient;

(c) unnecessarily sent approvals in a piecemeal fashion causing delay and the potential for confusion for the purpose of facilitating inappropriate and unethical claims under the HSIA for prescription refills. Dr. Gill's conduct included:

(i) separating the requests from pharmacists that he received for approval of multiple medications for a single patient into multiple pages and submitting claims for each page, such that he was submitting claims for each medication as if pages were approved and transmitted to the pharmacy on different days when in fact they were transmitted on the same date;

(ii) submitting multiple claims for the same responses to requests for prescription refills overtime by modifying the dates to create the appearance of separate requests for approvals; and

(iii) submitting claims for approvals of prescription refill requests from pharmacies that were so long after the request was made that he knew or ought to have known that the request was no longer valid.

Billing concerns were also addressed during the investigation. It was determined that Dr. Gill inappropriately submitted claims for family care conferences under the HSIA for two patients, when no evidence a family member was present, and no evidence that he otherwise provided the necessary services.

Investigation IC5890

Dr. Gill followed Patient 5 for cardiometabolic optimization in the setting of pre-existing metabolic syndrome. A virtual visit with Patient 5 was scheduled for May 10, 2021, but Dr. Gill did not attend. Patient 5 phoned the clinic the following day in an attempt

to determine what happened and make contact with Dr. Gill, though received no follow-up contact.

On May 17, 2021, Patient 5 complained to CPSM about Dr. Gill's lack of attendance at the virtual visit and lack of subsequent contact. The Registrar referred Patient 5's complaint to the Investigation Committee. The investigation was identified as IC5890.

Dr. Gill's response to the complaint is dated June 8, 2021. Dr. Gill said on May 17, 2021, he called Patient 5 once, did not get an answer, and was then distracted by a family emergency. There is no documentation of the call attempt. After Patient 5's complaint was referred for investigation, a re-scheduled visit with Patient 5 occurred on June 8, 2021. Dr. Gill advised that he phoned Patient 5 and addressed relevant issues.

Dr. Gill's documentation in the patient record is difficult to follow as the running list of visit notes in the EMR has standard paragraphs that provide two (2) options for indicating if the visit is virtual or in-person. There is no editing of the paragraphs to reflect what occurred, including whether a visit happened. Actual encounter notes are in another area of the patient record and consist of appropriately completed templates. However, there are no dates indicated on two of the encounter notes (February and June 2021).

Investigation IC5967

Patient 6 saw Dr. Gill for the management of his heart condition. In June of 2021, he complained to CPSM about a delay in receiving prescription refills. The Registrar

referred the complaint to the Investigation Committee. The investigation was identified as IC5967.

Dr. Gill provided a copy of the patient record in his response to the complaint. A review of the patient record revealed that Dr. Gill did not respond to all prescription renewal requests in a timely manner in 2020 and 2021, while some were addressed the same day or within several days. When examined, some of the requests from the pharmacy were confusing in that in March 2020 they appeared to be requesting medications that were just filled. At other times it appears that medications would have run out based on the timing of the refills.

In addition, some of the requests from pharmacies were not addressed, including one on June 21, 2021. In his response, Dr. Gill explained that the June 21, 2021, prescription refill request subject to Patient 6's complaint was errantly marked as being done. However, it is not evident in the patient record that the prescription refill from June 21, 2021, was errantly marked as being done by Dr. Gill.

Overall, the investigation revealed that Dr. Gill was not providing prescriptions in a manner that assured a continuous supply. In February 2021, he provided four (4) months of medications, but only planned to see Patient 6 again in December 2021. In the interim, he would need to be responding to requests for refills where he, with a few exceptions, only authorizes a one-month supply.

Investigation IC5486

Dr. Gill provided care for Patient 7 in relation to symptoms of pre-syncope and she complained about certain aspects of his care. The Registrar referred the complaint to the Investigation Committee for review. The investigation was identified as IC5486.

During the investigation into the concerns raised by Patient 7 (which are not ultimately a part of the June NOI), the Investigation Committee considered that a family care conference was billed in respect to a visit on February 19, 2020, but there is no documentation of same, nor is there any documentation of complex care or rationale regarding the need for a family care conference. Patient 7 advised that she attended all appointments alone.

Investigation IC7170

Dr. Gill provided care for Patient 9 when he practiced at Clinic B (December 2019 to June 2020) and then in his new practice location, Clinic C.

Dr. Gill left Clinic B as a result of a conflict with the pharmacist-owner (the “Owner”). The Owner accused Dr. Gill of a breach of PHIA by looking at consultation requests sent to the clinic and assigning some of them to himself. Dr. Gill raised similar concerns about the clinic doing the same to divert patients from him. When CPSM became aware of the issues the primary concern was about the manner in which patients were being drawn into the conflict. By this time, Dr. Gill began advising patients that breaches of PHIA had occurred at the hands of the Owner and suggested to patients that they complain to the College of Pharmacists of Manitoba (“CPhM”).

CPSM wrote to Dr. Gill on October 29, 2020, advising that CPSM was aware of the conflict and that patients appeared to be being drawn into the dispute between him and Clinic B and the Owner. CPSM advised Dr. Gill to stop involving patients. This included expressing concerns about professional boundaries and not allowing personal interests to come into conflict with the best interests of patients. CPSM requested that Dr. Gill provide evidence of a legitimate PHIA breach and to provide an explanation about his communications with patients regarding same.

Dr. Gill responded on November 15, 2020. He denied that he was involving patients in his dispute with the Owner and made allegations about unauthorized access, use, and disclosure of personal health information and referenced a complaint relating to underlying PHIA issues that was made to the Manitoba Ombudsman's office. He acknowledged that he told his patients about his concerns and that they could consider inquiring further through CPSM/CPhM at their discretion.

On October 15, 2021, during a follow up appointment, Dr. Gill informed Patient 9 about a potential breach of the confidentiality of her personal health information by the Clinic B and Owner. As a result of her conversation with Dr. Gill, Patient 9 notified the Manitoba Ombudsman's office and complained to the CPhM. Patient 9's complaint recounted that Dr. Gill told her that the pharmacist and the pharmacy staff from Clinic B stole over 50,000 patients' medical information around February 2020 to sell to a pharmaceutical company for the purpose of data collection and analysis. Dr. Gill provided her with information how to answer the questionnaire for a Privacy Complaint (which included a copy filled out by Dr. Gill) to the Manitoba Ombudsman under PHIA.

In his reply to the CPhM complaint, the Owner denied breaching Patient 9's confidentiality and shared numerous recriminations implicating Dr. Gill. This included that Dr. Gill was "stealing" patients from cardiologists at Clinic B and that Patient 9 was one of those patients.

In response to the information received from the CPhM process, Patient 9 complained to CPSM about Dr. Gill regarding his potential role in a PHIA breach. Her complaint was referred to the Investigation Committee for review. The matter was designated IC7170.

In his response dated June 16, 2022, Dr. Gill acknowledged that he informed Patient 9 of the alleged PHIA breaches and that he provided her with the Questionnaire so that she had the necessary information if she wished to raise her concerns with the Ombudsman. In a further response dated September 18, 2023, Dr. Gill disputed that he ignored the previous direction of CPSM and advised that at the time, he believed that he was ethically and required by legislation to notify Patient 9 in the case of a suspected PHIA breach. Despite requests from CPSM, the Ombudsman has not provided information regarding the PHIA investigation as it remains ongoing.

THE JOINT RECOMMENDATION

The Panel's task is to determine the appropriate disposition pursuant to section 126 of the Act. The Panel has had the benefit of a Joint Recommendation as to Disposition made by counsel for CPSM and counsel for Dr. Gill.

In assessing whether or not the Joint Recommendation as to Disposition should be accepted and which Order or Orders ought to be granted pursuant to section 126 the Act, the objectives of such Orders need to be considered. On the basis of a review of the relevant authorities, those objectives include but are not limited to:

(d) The protection of the public. Orders under section 126 of the 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;

(e) The punishment of the physician involved;

(f) Specific deterrence, in the sense of preventing the physician involved from committing similar acts of misconduct in the future;

(g) 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;

(h) 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;

(i) The rehabilitation of the physician involved in appropriate cases, recognizing that the public good is served by allowing properly trained and educated physicians to provide medical services to the public;

(j) Proportionality between the conduct of the physician and the orders granted under section 126 of the Act; AND

(k) Additional factors which are relevant in this case are:

(i) The nature and gravity of the misconduct;

(ii) Lack of prior disciplinary record of Dr. Gill;

(iii) The presence or absence of mitigating or aggravating circumstances; and

(iv) The role of the physician in failing to immediately acknowledge what had occurred during the course of the investigations and, in the present case, failing to be forthright with his regulating body.

As outlined earlier in these Reasons, all the charges outlined in the June NOI and October NOI have been proven. Dr. Gill is therefore guilty of professional misconduct, and of contravening the CPSM's By-laws, the Standards of Practice of Medicine and practice directions, the Code of Ethics, and has demonstrated a lack of skill, knowledge, and judgment in the practice of medicine and has further demonstrated an incapacity or unfitness to practice medicine.

Dr. Gill's misconduct and deficiencies are serious and concerning. His failure to adequately document his involvement in patient care and review diagnostic results in a timely way is widespread in terms of the number of years and across his practice. Although patient care may not have been directly compromised in the identifiable cases,

there is the possibility that those deficiencies may have negative consequences in the future. His profound delays in responding to prescription refill requests and practice of providing unnecessarily short approvals for prescription refills resulted in patients being left without necessary medications for days and could have resulted in serious harm to those patients.

Dr. Gill unethically and inappropriately submitted claims, or caused claims to be submitted on his behalf, under HSIA, for his own benefit. This places a significant inappropriate financial burden on the publicly funded health care system and is a betrayal of the public trust.

Dr. Gill's overall practice management showed to be concerning which resulted in him undertaking to improve his practice management in September 2020 (and updated June 2021). However, further audits and investigations determined that he breached aspects of his undertaking and that there were still serious compliance issues.

While Dr. Gill ultimately accepted responsibility, there was a long journey to get there. Dr. Gill misled CPSM in his written communications and in his interviews with the Investigators by providing inaccurate and incomplete information and fabricating documents such as a false referral letter in the EMR. Significant steps had to be undertaken to address the inaccurate and incomplete information which led to additional time and expense of CPSM. This was designed to cover up his own wrongdoing, to avoid accepting responsibility, and also reflected a disrespect for his professional governing body.

The seriousness of Dr. Gill's admitted professional misconduct and admitted incapacity and unfitness to practice medicine, among other breaches of professional standards, must be reflected in the Orders granted by the Panel.

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.

A joint submission on penalty must satisfy the fundamental penalty principles and fall within the spectrum of potential penalties, see *College of Physician and Surgeons of Ontario v. Alexander*, 2022 ONPSDT 41.

The Panel was reminded that the Panel 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, see *R. v. Anthony-Cook*, 2016 SCC 43.

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. Gill's misconduct;

(b) An Order of suspension is a form of punishment and provides a general and specific deterrent, while providing the opportunity for rehabilitation. It holds Dr. Gill accountable for his conduct but also as a general deterrent in that it

imposes serious punishment for serious misconduct, which serves as a warning and education to the public and other physicians as to the consequences of such misconduct. It also maintains public confidence and trust, as CPSM will suspend member to uphold public trust and standards;

(c) The facts of this matter, as set out in detail above, support a serious penalty. A penal consequence, including a fine and costs are warranted given Dr. Gill's breaches of his previous undertaking;

(d) The fundamental objective of the CPSM, as a self-regulated body, is the protection of the public. This objective will be fulfilled by the extensive and detailed conditions to be imposed upon Dr. Gill's certificate of practice once his suspension is completed. The conditions have been designed to address and remediate the deficiencies in Dr. Gill's conduct and practices which were of grave concern to CPSM, and to ensure that patients who attend upon Dr. Gill in the future, will receive competent treatment in conformity with the standards of the profession. They have also been designed to rectify deficiencies in his previous undertaking, such that his charts will be reviewed by his practice supervisor;

(e) The Joint Recommendation provides a pathway to remediation and professional growth and public good in allowing trained and educated doctors to serve the public. Dr. Gill has to complete a course of studies in ethics and professionalism before he returns to practice and has to practice

under supervision which may include a referral to CPSM's Quality Assurance Program for follow up;

(f) The Joint Recommendation proposed and accepted by the Panel will ensure public confidence in the ability of the profession to regulate itself;

(g) The Joint Recommendation also imposes a significant financial consequence against Dr. Gill by being responsible for a significant portion of the costs associated with the investigation and inquiry of the matters before this Panel and to enter into good faith discussions with Manitoba Health to repay improper billings; and

(h) The Joint Recommendation agreed to by Dr. Gill reflects his acceptance of his guilt in these matters and commitment to self-regulation, which spared the CPSM the expense of a full inquiry and is a mitigating factor.

In assessing the appropriateness of the Joint Recommendation in relation to the nature and extent of Dr. Gill's misconduct, and the fundamentally important objective of the protection of the public, the Panel reviewed the authorities submitted to it by the parties and specifically considered the penalties imposed in other cases involving somewhat similar circumstances. The Panel is satisfied that the Joint Recommendation, which includes a reprimand and suspension of Dr. Gill registration with the CPSM, a is within a reasonable range of outcomes as defined by the authorities before the Panel.

In this case, the Panel recognizes that counsel for CPSM and counsel for Dr. Gill are well placed to arrive at a Joint Recommendation that reflects the interests of both the

public, and Dr. Gill. The Panel believes that by accepting and implementing the Joint Recommendation, a properly informed public will be satisfied that the medical profession is able to properly regulate itself.

In this case, the Panel is satisfied that the Joint Recommendation protects the public interest. There is nothing in the Joint Recommendation which would bring the administration of justice into disrepute or is otherwise contrary to the public interest. A properly informed and reasonable member of the public would recognize that the Joint Recommendation fulfills the objectives of Orders under subsection section 126 of the Act.

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. Gill will be accepted. The Panel hereby issues an Order, as more particularly set forth in the Resolution and Order issued concurrently herewith and attached hereto.

November 29, 2024

IN THE MATTER OF:	*The Regulated Health Professions Act,* C.C.S.M., c. R117, Part 8
AND IN THE MATTER OF:	DR. DALJIT SINGH GILL, a member of the College of Physicians and Surgeons of Manitoba
AND IN THE MATTER OF:	Amended Notice of Inquiry, dated June 23, 2023 and Notice of Inquiry dated October 25, 2022

INQUIRY PANEL:

Dr. Clifford Yaffe, Chairperson

Dr. Eric Lane

Sandra Benavidez, Public Representative

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

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RESOLUTION AND ORDER OF THE INQUIRY PANEL

WHEREAS Dr. Daljit Singh Gill ("**Dr. Gill**", a member of the College of Physicians and Surgeons of Manitoba (the "**CPSM**") was charged with professional misconduct, with contravening the CPSM's By-laws, the Standards of Practice of Medicine, practice directions 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 an Amended Notice of Inquiry, dated June 23, 2023 (the "June NOI") and a Notice of Inquiry dated October 25, 2023 (the "October NOI").

AND WHEREAS the Inquiry was originally scheduled to proceed before an Inquiry Panel of the College (the "Panel") commencing on August 23, 2024;

AND WHEREAS on August 23, 2023, the Inquiry was opened and Dr. Gill, through his legal counsel, admitted his membership in CPSM and that the Panel had jurisdiction over the matter;

AND WHEREAS the Inquiry continued before the Panel on October 15, 2024 in the presence of Dr. Gill and his counsel, and in the presence of counsel for CPSM, and Dr. Gill, through his counsel, acknowledged service upon him of the June NOI and October NOI;

AND WHEREAS Dr. Gill, through his counsel waived a reading of the charges as set out in the June NOI and October NOI and entered a plea of guilty and/or admission to all of the counts relating to all of the charges outlined in the June NOI and October NOI;

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. Gill, and received a Joint Recommendation as to Disposition of the charges and allegations outlined in the June NOI and October NOI;

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 subsections 124(2)(a),(b) and (d) of *The Regulated Health Professions Act*, C.C.S.M., c. R117 (the "Act"), Dr. Gill is guilty of committing acts of professional misconduct and breach of the CPSM Bylaws, the Standards of Practice of Medicine and the Code of Ethics, he has further demonstrated a lack of knowledge, skill, and judgment in the practice of medicine as particularized in Count 1 of the June NOI;

2. Pursuant to subsections 124(b) and (d) of the Act, Dr. Gill displayed a lack of skill, knowledge, and judgment in the practice of medicine, and/or contravened CPSM's By-laws, Standards of Practice of Medicine, practice directions, and/or the Code of Ethics as particularized in Count 2 of the June NOI;

3. Pursuant to subsections 124(a), (b) and (d) of the Act, Dr. Gill engaged in professional misconduct and displayed a lack of skill, knowledge, and judgement in the practice of medicine, and contravened CPSM's By-laws, Standards of Practice of Medicine, practice directions, and the Code of Ethics as particularized in Count 3 of the June NOI;

4. Pursuant to subsections 124(a), (b) and (d) of the Act, Dr. Gill engaged in professional misconduct, contravened CPSM's Code of Ethics and demonstrated and unfitness to practice medicine in respect to his conduct and communication with Patient 9 as particularized in Count 1 of the October NOI;

5. Pursuant to subsection 124(2)(e) of the Act, Dr. Gill, as a result of his conduct as set out in Counts 1 to 3 of the June NOI and Count 1 of the October NOI demonstrated an unfitness to practise medicine;

6. Pursuant to subsection 126(1)(a) of the Act, an Order reprimanding Dr. Gill;

7. Pursuant to subsection 126(1)(b) of the Act, an Order suspending Dr. Gill from the practice of medicine for a fixed period of six (6) months;

8. Pursuant to subsection 126(1)(f) of the Act, an Order imposing conditions on Dr. Gill's right to practice, which include practice supervision, volume or practice restrictions, documentation requirements, requirements for managing prescriptions and diagnostic reports, and requirements for communicating with consulting health care providers (the "Agreement and Undertaking");

9. Pursuant to subsection 126(1)(h) of the Act, an Order that Dr. Gill make restitution to Manitoba Health in an amount to be negotiated in good faith between Dr. Gill and Manitoba Health;

10. An Order that Dr. Gill complete a specific course of studies in ethics and professionalism;

11. Pursuant to subsection 126(5) of the Act, an Order that Dr. Gill pay the costs incurred by CPSM in monitoring compliance with the Agreement and Undertaking;

12. Pursuant to subsection 127(1)(a) of the Act, an Order that Dr. Gill pay:

    a. to the CPSM, costs in the amount of $36,126.20, to be paid on or before October 15, 2024; and

    b. the cost of the Inquiry within six (6) months of the Inquiry Panel's order, including fees for retaining a reporter, remuneration and reasonable expenses to members of the Inquiry Panel, and costs incurred by CPSM in providing counsel for the Inquiry Panel;

13. Pursuant to subsection 127(1)(b) of the Act, an order that Dr. Gill pay a fine in the amount of $5,000.00, to be paid on or before the date of the Inquiry; and

14. If there is any disagreement between the parties respecting any aspect of the Inquiry Panel's Order, the matter may be remitted by either party to a panel of the Inquiry Committee for further consideration, and the Inquiry Committee hereby expressly reserves jurisdiction for the purpose of resolving any such disagreement. Costs may be ordered in accordance with section 127 of the RHPA.

November 29, 2024