2024 Professional Conduct Report

College of Physicians & Surgeons of Newfoundland and Labrador

Professional Conduct 2024

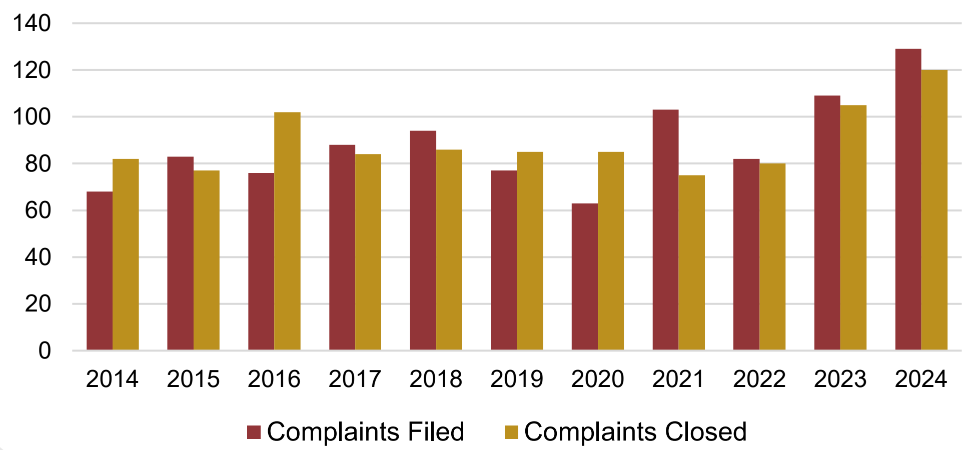
The College's mandate is to regulate the practice of medicine in the public interest. The *Medical Act, 2011*, requires the College to receive, assess, and address all complaints about the professional conduct of current and formerly licensed physicians. We track all complaints-related activity, and the information collected is used to provide guidance to physicians in the delivery of quality care and to improve our workflows.

The Complaints Authorization Committee (CAC) oversees the College's professional conduct complaints process. The CAC includes five elected or appointed physician representatives and two appointed public representatives. In 2024, the CAC held 12 meetings where its work included reviewing complaints filed by members of the public and the Registrar and making decisions on the identified issues of concern.

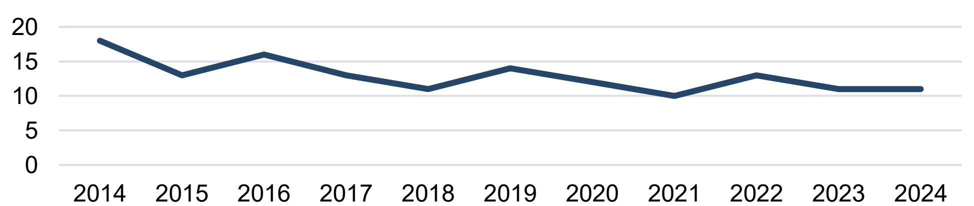
The Professional Conduct Team experienced its busiest year to date with an increase of 18% in complaints filed, as compared to 2023. Despite this increase, the median timeline for file closure was maintained at 11 months. Four tribunal hearings were held before independent panels comprised of physicians and members of the public. A summary of these hearing decisions is provided in this report.

The College held a Professional Conduct Strategic Planning Day in December of 2024. A notable outcome was the hiring of a Professional Conduct Navigator to assist both complainants and physicians in the complaints process. The College continued its focus on early resolution by creating processes to expedite low-risk files and is committed to ensuring the professional conduct process is accessible, efficient, and fair for all parties involved.

Historical Complaint Volume



Median Months for Closure



129
Complaints Opened
+18% YoY*

120
Complaints Closed
+14% YoY*

11
Months Median Timeline to Resolution

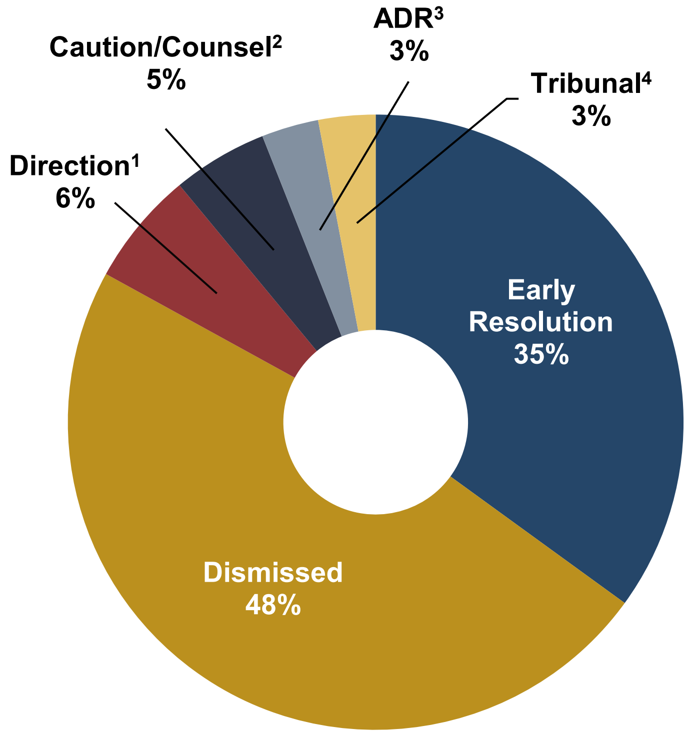
*YoY - Year over year change, a metric used to compare data from the referenced year to the same period in the previous year

Decision Outcomes

The College continues to leverage its Early Resolution process where possible. Early Resolution allows parties to reach a resolution on a file earlier and without the need for a full investigation and CAC decision.

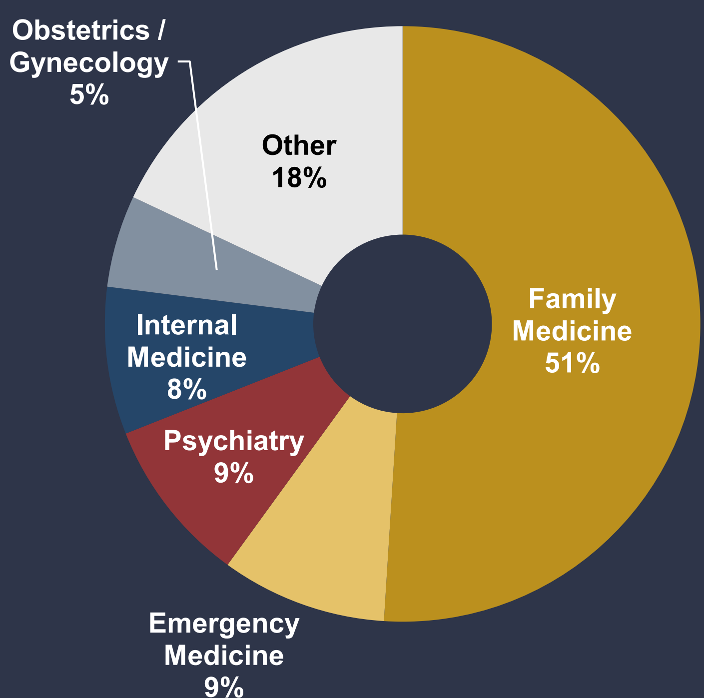
As the Early Resolution process relies on agreement, the complainant must be satisfied that their concern has been addressed. In 2024, 35% of complaints were resolved via Early Resolution, an increase of 1% from 2023.

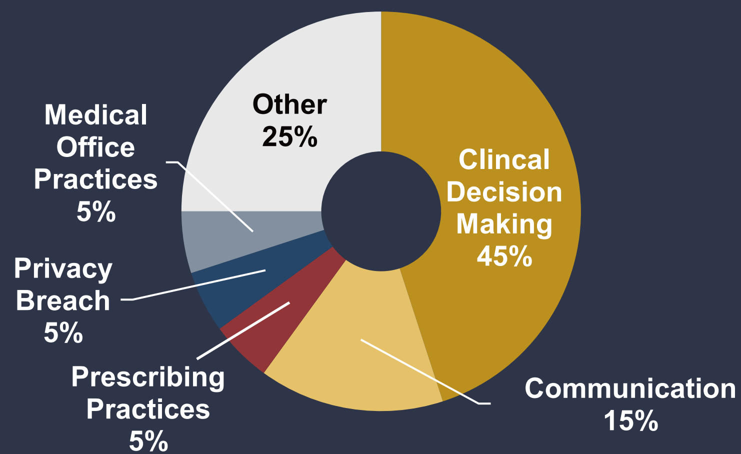
Scan the QR Code with your mobile device to learn more about how the complaints process works.

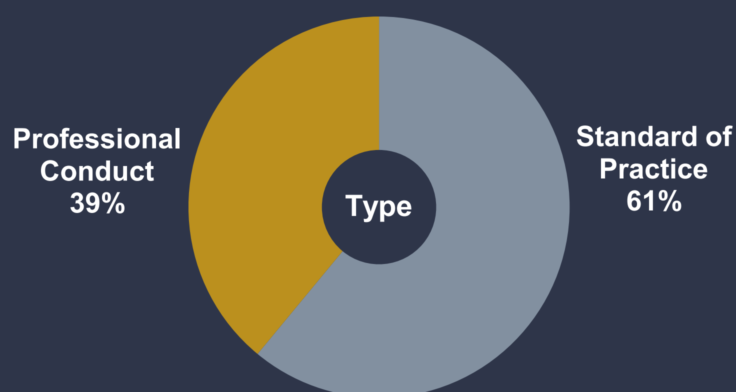


[1]Direction – dismissal of the complaint with specific action required from the physician.
[2]Caution/Counsel – a formal warning to the physician against engaging in similar conduct / an instruction to take positive action in the future.
[3]ADR – alternate dispute resolution, a process for resolving a complaint through a settlement agreement.
[4]Tribunal – referral to a hearing to be held before an independent panel comprised of physicians and members of the public.

Complaints by Area of Practice







Standards & Guidelines

The College promotes high standards of medical practice by creating, reviewing, and regularly updating the standards of practice that licensed physicians must follow and the practice guidelines that practicing physicians should adopt.

A Standard of Practice is the minimum standard of professional behavior and ethical conduct expected by the College on a specific issue.

Areas for improvement are identified as part of a regular review process. Standards and guidelines are also updated when an issue requiring clarification arises, such as a change in the accepted standard.

In 2024, the College sought feedback on three draft Standards of Practice from a wide range of stakeholders. The College received over 250 responses in total, representing diverse demographic perspectives. This feedback was analyzed, and key items were identified and included in the creation of the standard.

Duty to Report a Colleague

Scan the QR Code with your mobile device or click here to learn more about a physician's legal obligation to report a colleague that has engaged in unprofessional or unethical conduct.

New or Updated Standards of Practice

Establishing & Ending the Physician-Patient Relationship

- Patient Selection Process: exceptions to first-come, first-served approach
- Definition of establishing the Physician-Patient relationship
- Physician-patient relationship - natural/expected conclusion situations (e.g. "walk-in" care)
- Reasonable and unreasonable grounds to end the relationship (e.g. relationship breakdown, patient moved away, or reducing practice size)

Consent to Treatment

- Capacity and authority to provide consent including substitute decision makers and a minor's capacity for consent
- Adequate information for informed consent (i.e. diagnosis, treatment, outcomes, risk, consequences of treatment refusal, alternative treatment, and trainee delegation)
- When express oral or written consent is required, consent documentation, and delegating consent
- Medical emergencies and involuntary admission

Interdisciplinary Care & Delegation of Tasks

- Interdisciplinary team responsibility and accountability
- Physician delegation of tasks
- Medical Orders and Directives - written and verbal

New or Updated Standards of Practice

Observing or Shadowing a Physician

- Observer registration and licensure requirements
- Approval to act as an Observer and scope
- Confidentiality
- Patient understanding and consent

All College standards and guidelines can be found on the College website **cpsnl.ca**.

The College has developed **Standards of Practice** or **Practice Guidelines** on the following topics:

- Advertising
- Artificial Intelligence
- Bloodborne Viruses
- Boundary Violations
- Chaperones
- Closing or Taking Leave from a Medical Practice
- Complementary & Alternative Medicine
- Conflict of Interest
- Consent to Treatment
- Continuity of Care
- Disclosure of Harm
- Duty to Report a Colleague
- Establishing & Ending the Physician-Patient Relationship
- Independent Medical Examinations
- Interdisciplinary Care & Delegation of Tasks
- Medical Assistance in Dying
- Medical Records Documentation & Management
- Medical/Surgical Procedures in Private Medical Facilities
- Observing or Shadowing a Physician
- Opioid Prescribing for Opioid Use Disorder
- Physical Examinations
- Physician Treatment of Self, Family Members, or Others Close to Them
- Physician Use of Social Media
- Prescribing & Dispensing Medications
- Professional Responsibilities in Medical Education
- Uninsured Services
- Virtual Care
- Withdrawal of Physician services During Job Action

Cautions and Counsels

A **caution or counsel** expresses the Committee's dissatisfaction with a physician's conduct and warns the physician against engaging in similar conduct in the future or instructs the physician to take positive action with respective to their practice in the future.

Case One: Conduct Unbecoming

The Committee counselled a physician to exercise good judgment and professionalism in their conduct outside of patient encounters to ensure patient safety, public health, and respect for property.

The Committee noted that while the physician's admitted actions took place outside of a physician-patient encounter, they occurred in a common place within their patients' residence, during a time when they were present to provide medical care. The Committee noted that the physician's actions showed significant lack of judgment and professionalism and would reasonably be regarded by medical practitioners as disgraceful, dishonourable, or harmful to the standing or reputation of the medical profession.

Case Two: Failure to Conduct an Examination

The Committee counselled a physician to advise patients on the need for a physical examination in circumstances where the patient's clinical presentation is suggestive of malignancy and to facilitate such exam in a timely manner.

Physician members agreed that the patient's reports of anal pain would warrant a physical examination and possibly further investigations, as deemed necessary following the examination. The Committee agreed that the physician's failure to notify the patient that a physical examination was recommended and failure to document why such an examination was not conducted fell below the expected standard of practice.

Case Three: Billing Practices

The Committee counselled a physician to ensure appropriate familiarity with the process of assigning billing codes to ensure their compliance with the MCP Medical Payment Schedule.
The physician assigned diagnostic codes for malignancy for routine women's wellness examinations in circumstances where the patient had symptoms of a possible malignancy. While Committee members agreed that some variance would be expected between physicians in their billing practices, physician members of the Committee agreed that this would not be considered a reasonable billing practice. The Committee agreed that including these codes could have negative implications for the patients, as it is not possible to retroactively change the billing code if the diagnosis is ruled out.

Case Four: Ending the Physician-Patient Relationship

The Committee counselled a physician to comply with the College's Standard of Practice on Ending the Physician-Patient Relationship in their future practice of medicine.

A patient contacted their family physician's office to make an appointment and was told by the office staff that as they had not visited the clinic in more than three years, their spot was allocated to a new patient. The physician did not have a written policy on discharging patients from their practice on this basis. The Committee agreed that if a physician chooses to discharge a patient based on an absence from practice, the physician must establish a clear office policy and communicate this policy to the patient in advance of termination.

Case Five: Inadequate Eye Examination

The Committee counselled a physician to complete continuing education on the topic of vision screening within 6 months of the date of the Committee’s decision.

The Committee agreed that there were reasonable grounds to believe that the physician performed an inadequate eye examination and provided an inaccurate report to the Motor Registration Division. Committee members noted that the physician recorded the patient’s vision to be worse “with correction” and the visual field was recorded as more than 300 degrees. The Committee agreed that physicians are expected to only practice in areas in which they are competent.

Case Six: Clinical Decision Making

The Committee counselled a physician to diligently advocate for their patients in respect of necessary investigations which they had ordered.

A patient was referred for an investigative procedure but was unable to tolerate the procedure. A repeat of the procedure was recommended, and Committee members noted the particular importance of this follow-up in the context of the patient’s abnormal diagnostic report and continued presentation with concerning symptoms. Committee members agreed that the primary care physician was expected to explain why the investigation was recommended, the potential risk(s) of not completing the investigation, and support the patient in navigating the healthcare system to ensure the investigation was completed.

Settlement Agreements

Case One: Submitting Inaccurate Information

On May 18, 2023, the Registrar of the College filed an allegation against a physician. In this allegation, the Registrar alleged that the physician provided inaccurate and potentially misleading information to the College in their licence renewal application.

The physician admitted that on November 24, 2021, they submitted inaccurate information on their renewal of licence application for the year 2022, when they indicated that they were a member of the College of Family Physicians and of Canada (“CFPC”) for Continuing Professional Development purposes, but their membership had been discontinued by the CFPC on March 31, 2021.

The physician acknowledged that their actions amounted to “professional misconduct”, as defined in s. 2(17) of the College’s *By-Law 5: Code of Ethics.*

The physician and the College agreed to a disposition of the allegation which included the following:

1. The physician will complete a course in medical ethics and professionalism.
2. The College will publish this summary on its website.

College’s By-Law 5: Code of Ethics

This by-law encompasses professional misconduct, conduct unbecoming a medical practitioner, professional incompetence, and incapacity or unfitness to engage in the practice of medicine.

Scan the QR Code with your mobile device or **click here** to learn more.

Case Two: Falsifying Records

On September 8, 2023, the College received reports from a resident’s preceptor and from the Faculty of Medicine, Memorial University. These reports detailed that the resident failed to conduct physical examinations on patients seen during their residency training program and that they documented the completion and results of examinations which were not completed. Four affected patients were initially identified, with two additional patients identified at a later date. All clinical encounters occurred during the time period of July 10, 2023, to August 25, 2023.

The resident admitted that their actions demonstrated that they failed to apply and maintain standards of practice expected by the profession in the branches or areas of medicine in which there were practicing and that they falsified records relating to their medical practice. The resident acknowledged that their actions amounted to “professional misconduct”, as defined in s. 2(6) and 2(24) of the College’s *By-Law 5: Code of Ethics*.

The resident and the College agreed to a disposition of the allegation which included the following:

1. The College reprimanded the resident for their admitted professional misconduct.
2. Prior to applying for re-entry into the practice of medicine under the jurisdiction of the College, the resident will successfully complete a course in medical ethics and professionalism.
3. If a future licence is issued to the resident by the College, it will include a restriction that the resident will be subject to oversight and/or direct supervision of his practice to the satisfaction of the College’s Quality Assurance Committee.
4. The College will publish this summary on its website.

Case Three: Failure to Obtain Consent

On April 19, 2023, the College received an allegation from a former patient of a physician. In this allegation, the patient detailed that she had a clinical interaction with the physician in the emergency department wherein they did not disclose their identity or role in her care. The patient also detailed that the physician did not obtain her express consent prior to performing a sensitive examination, nor before disrobing the patient for the purpose of performing this examination and did not provide a gown or drape or offer to have a chaperone present for the examination.

Following an investigation, the Complaints Authorization Committee of the College referred the allegation back to the Registrar for Alternative Dispute Resolution in accordance with s. 44(1)(a) of the *Medical Act, 2011*.

The physician admitted that their actions demonstrated that they failed to apply and maintain standards of practice expected by the profession in the branches or areas of medicine in which he was practicing. The physician acknowledged that his actions amounted to “professional misconduct”, as defined in s. 2(6) of the College’s *By-Law 5: Code of Ethics*.

The physician, the patient, and the College agreed to a disposition of the allegation which included the following:

1. The College reprimanded the physician for their admitted professional misconduct.
2. The physician will review and agree to comply with the expectations of the College as set out in the following documents:
3. College Standard of Practice: Physical Examinations (2021)
4. College Standard of Practice Chaperones (2021)
5. College Standard of Practice Consent to Treatment (2019)
6. Canadian Medical Association Code of Ethics and Professionalism (2018)
7. The physician will complete a course on successful patient interactions.
8. The physician will provide a written apology to the patient.
9. The College will publish this summary on its website.

Hearings

Dr. Etienne Archambault

An Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador has found Dr. Etienne Archambault guilty of professional misconduct in relation to a complaint filed by a member of the public (the “Complainant”).

The Tribunal’s written decision was released on March 4, 2024.

The Tribunal accepted an agreed statement of facts that was jointly prepared by the College and Dr. Archambault. The date, location, and a brief description of the conduct of Dr. Archambault that was found to be deserving of sanction is as follows:

> Dr. Archambault met the Complainant in February 2020 at a recreational center. Dr. Archambault shared information with the Complainant relating to the use of medications in the context of supporting athletic endeavors.
>
> During a social encounter in March 2020, Dr. Archambault administered an intramuscular injection to the Complainant with a combination of hormonal therapeutic medications. The Complainant did not have knowledge of the specifics of the injection before it occurred. The following day, the Complainant sought additional information from Dr. Archambault as to the specifics of the injection.
>
> The Complainant was aware that Dr. Archambault was a medical resident. Dr. Archambault and the Complainant did not have a physician-patient relationship.

The Tribunal accepted Dr. Archambault’s plea of guilty of professional misconduct in violation of section 2(15) of the College *By-Law No. 5: Code of Ethics* (2020), which is conduct deserving of sanction under the *Medical Act, 2011*. The Tribunal found that Dr. Archambault performed without consent a professional service for which consent is required by law.

The Tribunal accepted a submission for sanctions that was jointly prepared by the College and Dr. Archambault. It then ordered that:

1. Dr. Archambault shall not serve any further period of suspension, having served a period of suspension pending a disciplinary hearing, made pursuant to an Order of the Complaints Authorization Committee effective October 6, 2021.
2. Dr. Archambault is eligible to apply for reinstatement to the Educational Register as of the date of the Tribunal’s order or decision.
3. Prior to applying for reinstatement on the Educational Register, Dr. Archambault must successfully complete, at his cost, a course acceptable to the Registrar on the subject of professional ethics.
4. Dr. Archambault will pay the costs of the College of the hearing in accordance with the Tariff of Costs.
5. The decision or order of the Tribunal will be published. Publication will take place in the forms and locations set out in the *Medical Act, 2011* and in the College By-Laws.

Discipline Decisions

The College posts and retains the results of discipline decisions online for a period of ten years following the date of the decision. **Click here** to view.

Dr. Todd Young

An Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador has found Dr. Todd Kevin Young guilty of professional misconduct in relation to two complaints filed by the Registrar of the College.

The Tribunal's written decision was released on November 8, 2024.

The Tribunal accepted two agreed statements of fact that were jointly prepared by the College and Dr. Young. The dates, locations, and a brief description of the conduct of Dr. Young that was found to be deserving of sanction is as follows:

Charges 1-5

A patient ("Patient A") presented to their family physician on April 13, 2020, and was prescribed hydromorphone. On April 15, 2020, Dr. Young saw Patient A, via telemedicine. During that visit, he prescribed Maxeran, hydromorphone, and Tramacet.

In response to an allegation filed against him by the Registrar on May 12, 2020, Dr. Young provided a copy of his medical file for Patient A. This file contained a clinic note for the April 15, 2020, visit, a copy of a letter from Dr. Young to Patient A's family physician dated April 15, 2020, and copies of prescriptions for Maxeran, hydromorphone and Tramacet. The word "cancel" was handwritten on the hydromorphone prescription and the word "hydromorph" was crossed out. Dr. Young advised the College that "the hydromorph was cancelled" and that "the hydromorph prescribed by the family physician, referred to in the complaint, is not noted on HealtheNL nor was it mentioned by the pharmacists when I called."

The following information was detailed in the College's investigative report:

- Patient A's family physician did not receive correspondence from Dr. Young regarding his treatment of Patient A.
- The prescription written by Patient A's family physician for hydromorphone on April 13, 2020, was available for viewing in HealtheNL on April 15, 2020.
- There was no indication of a cancellation of the hydromorphone prescription at the pharmacy and that the prescription remained active in the pharmacy system.
- Dr. Young reported that he had communicated with the College in an "accurate and honest manner".
- An audit of Dr. Young's electronic medical record revealed that:
    - Dr. Young edited Patient A's clinic note on May 24, 2020, to add a subjective note, an objective note, and an assessment note.
    - Dr. Young authored the letter to Patient A's family physician, dated April 15, 2020, on May 25, 2020.
    - The hydromorphone prescription written for Patient A was uploaded to Dr. Young's Electronic Medical Record on June 9, 2020. The uploaded prescription did not include any handwritten annotations.

Charge 6

Patient B came under the care of Dr. Young beginning in June 2023 for treatment of opioid use disorder. Dr. Young started Patient B on methadone at 30 mg and titrated their dose up to 135 mg. Patient B received this medication through supervised doses on Monday to Saturday of each week, and an unsupervised dose on Sundays due to the pharmacy's closure on that day of the week.

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In late June 2023, Patient B was scheduled to travel for work for a job where they performed duties which carried potential safety risks. Dr. Young switched Patient B from liquid methadone to Metadol tablets. Patient B was instructed to take three tablets three times a day, which had the effect of increasing Patient B's daily intake from 135mg to 225mg. Dr. Young prescribed a seven-day supply of Metadol tablets to take during upcoming work travel and continued this prescription for an additional eight days upon return. Patient B's medical record reflects that during this time, they advised Dr. Young that they had taken fentanyl.

Patient B was scheduled to travel again for work in early August 2023. Dr. Young continued the Metadol prescription for an additional 30 days, resulting in 270 tablets of Metadol 25 mg being dispensed to Patient B. Two days later, Patient B arrived at a remote worksite outside of the province. The following morning, Patient B was found unconscious. Several doses of Narcan were administered and Patient B was transported by Medevac to hospital for emergency medical treatment.

Charge 7

Patient C came under the care of Dr. Young beginning in June 2016 for treatment of opioid use disorder. From June 2016 through July 2023, Dr. Young prescribed Suboxone to Patient C. In late July 2023, Dr. Young substituted Patient C's prescription with methadone 30 mg. Dr. Young titrated the dosage of methadone up to 85 mg by early August 2023.Patient C received methadone through supervised dosage at the pharmacy.

In early August 2023, Patient C was scheduled to travel for work for a job where they performed duties which carried potential safety risks. Patient C's urine drug screening collected at this time showed the presence of morphine, fentanyl, and methadone. Dr. Young proceeded to switch Patient C from liquid methadone to Metadol tablets. Patient C was instructed to take one 25 mg tablet, three times a day and was provided with a 28- day supply. 84 tablets of Metadol 25mg were dispensed to Patient C. Two days later, Patient C travelled to a remote worksite outside of the province. Four days after arriving, Patient C was brought to the onsite medical clinic with signs of decreased or lost consciousness. After receiving several doses of Narcan, Patient C was transported by Medevac to hospital for emergency medical treatment.

The Tribunal accepted Dr. Young's plea of guilty of professional misconduct in respect of the complaints. In this plea, Dr. Young agreed that he:

1. prescribed two narcotic medications, being Tramacet and hydromorphone, to a patient without either personally examining the patient or being in direct communication with another licensed health-care practitioner who had examined the patient, contrary to the College's Standard of Practice: Telemedicine (2017); and further that the departure from the Standard of Practice: Telemedicine (2017) was not made in accordance with the conditions set out in section 2(9) of By-Law No. 5: Code of Ethics (2020);
2. signed and/or issued a document that Dr. Young knew, or ought to have known, was false or misleading, by providing to the College, during an investigation into an allegation against him, a letter to another physician authored by Dr. Young on May 25, 2020, which purported to be dated "April 15, 2020";
3. made a misrepresentation to the College investigator by providing an inaccurate copy of his clinic record dated April 15, 2020, to the College in the context of its investigation into an allegation, in that the said clinic record contained (i) a letter to another physician written on May 25, 2020, which bore the date of "April 15, 2020"; (ii) a prescription for hydromorphone dated April 15, 2020 which bore a handwritten alteration of "cancel", which prescription had been amended after it was sent to the pharmacy; and (iii) a non-contemporaneous clinic note which had been altered by Dr. Young on or about May 24, 2020;

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4. altered a record relating to his medical practice other than in the manner prescribed by the CPSNL By-Law No. 6: Medical Records (2020), when on May 24, 2020 he altered a clinic record relating to a visit with a patient on April 15, 2020 to remove, delete, erase, or render illegible each previously existing record, without retaining any indication of the previously existing record or the nature and date of the amendment;
5. falsified a record relating to his medical practice by writing “cancel” on a handwritten prescription numbered 4786266 issued by Dr. Todd Young for hydromorphone dated April 15, 2020, and providing such false document to the College during an investigation into an allegation against him.
6. provided treatment to each of Patient B and Patient C with respect to their treatment with Metadol which did not meet the standard of care expected of a family physician in Dr. Young’s circumstances.

The Tribunal accepted a submission for sanctions that was jointly prepared by the College and Dr. Young. It then ordered that:

1. Dr. Young’s medical licence will be suspended for a duration of four (4) months, to be served in blocks with each not less than one (1) month at a time, within 12 months of the date of this Order.
2. Dr. Young will complete remedial education and professional development in the area of addictions medicine for a period of not less than three weeks, including the following:
    a) A two-week observership with a physician practicing in the area of addictions medicine;
    b) A one-week period of self-study and mentorship with a qualified physician, based on addictions medicine; and
    c) In-person attendance at the Canadian Society of Addiction Medicine Conference in November 2024.
3. Dr. Young’s medical licence will contain a restriction which prohibits him from prescribing narcotics, including opioids, until he has provided the Registrar with written confirmation of completion of the requirements in paragraphs 2 a), b), and c) above.
4. Within 6 months of the date of the Adjudication Tribunal’s decision or order, Dr. Young will complete continuing professional development courses acceptable to the Registrar on the following subjects:
    a) Professional ethics; and
    b) Medical record-keeping.
5. Dr. Young will undergo mandatory referral to the Physician Care Network program pursuant to the Memorandum of Understanding between the Newfoundland and Labrador Medical Association and the College.
6. The cost of implementing paragraphs 2, 4, and 5 will be borne by Dr. Young.
7. Dr. Young will pay the costs of the College’s investigation and hearing in accordance with the College’s Tariff of Costs.
8. The Adjudication Tribunal’s decision and/or order will be published in keeping with the By-Laws of the College and section 50 of the Medical Act, 2011.
9. This sanction will take effect beginning not earlier than two weeks from the date of this hearing.

Dr. Eric Elli

An Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador has found Dr. Eric Elli guilty of professional misconduct and professional incompetence in relation to two complaints filed by the Registrar of the College.

The Tribunal's written decision was released on November 22, 2024.

The Tribunal accepted two agreed statements of fact that were jointly prepared by the College and Dr. Elli. The dates, locations, and a brief description of the conduct of Dr. Elli that was found to be deserving of sanction is as follows:

Charges 1-2

Dr. Elli submitted Annual Licence Renewal Applications to the College for the calendar years 2020 through 2024. On these applications, he attested that he was and would continue to be a full member, or member for Continuing Professional Development purposes, with the College of Family Physicians of Canada.

In February 2024, the College of Family Physicians of Canada advised that Dr. Elli was discontinued from the Continuing Professional Development program in 2019 and has not been re-instated.

Charge 3

At the direction of the Complaints Authorization Committee, Dr. Elli underwent a practice review conducted by two independent family physicians in February 2024. The practice reviewers concluded that Dr. Elli's competence to practice medicine is not in accordance with the expected standards of quality and safety, in particular:

- Dr. Elli's medical documentation was scant, with limited details regarding the presenting complaint;
- Dr. Elli's medical records were not legible in many circumstances;
- Dr. Elli's ongoing reliance on phone visits as opposed to in-person office visits was in contradiction to current Public Health guidelines;
- Dr. Elli failed to conduct physical assessments in cases where a physical examination was clearly indicated;
- Dr. Elli's documentation does not indicate that he considered differential diagnoses in the assessment of his patients;
- Dr. Elli's documentation of management plans for his patients was extremely limited;
- Dr. Elli did not apply an organized evidence-based approach to chronic disease management and age-related screening;
- Dr. Elli did not ensure that adult immunizations were current for his patients;
- Dr. Elli failed to follow up on abnormal test results, with the assumption that the patient would raise the red flag if the concern was persisting;
- Dr. Elli failed to attempt to manage conditions that should have been managed in the family practice setting;
- Dr. Elli failed to appropriately work up patients prior to referring them to a consultant;
- Dr. Elli did not provide appropriate continuity of care for 'walk-in' patients;
- Dr. Elli's prescribing practices were not in keeping with current standards of practice;
- Dr. Elli's clinical knowledge and judgement were not at the expected level for a practicing family physician; and,
- Dr. Elli displayed limited insight into his gaps in documentation, clinical care, and practice management.

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The Tribunal accepted a submission for sanctions that was jointly prepared by the College and Dr. Elli. It then ordered that:

1. Dr. Elli is reprimanded by the Tribunal for his conduct.
2. Within 4 months of the date of the Order of the Tribunal, Dr. Elli shall successfully complete, at his own expense, not fewer than three educational or coaching sessions on ethics and professionalism, which shall be structured as one-on-one meetings with a qualified professional who is acceptable to the Registrar.
3. The parties agree that a suspension is an appropriate sanction in response to Dr. Elli's acknowledged conduct in the nature of professional misconduct. The parties further agree that the appropriate period of suspension of Dr. Elli's medical licence is one month.
4. Dr. Elli shall be credited with the required one-month suspension and shall not serve any further period of suspension, by reason that he has already served a period of suspension pursuant to an Order of the Complaints Authorization Committee effective July 5, 2024.
5. As of the date of this Order, Dr. Elli is eligible to return to practice with the conditions and restrictions on licensure and in accordance with the process described in Schedule "A" of the Joint Submission on Sanction. This process includes an initial period of practising only under direct supervision followed by an independent evaluation.
6. Dr. Elli and the College will enter into a written agreement acknowledging Dr. Elli's obligations to the College during the Evaluation Period and the Supervision Period as defined in Schedule A to the Joint Submission on Sanction.
7. Dr. Elli will post signage in his clinic waiting room advising patients of the restrictions on his medical licence during the Evaluation Period as defined in Schedule A to the Joint Submission on Sanction.
8. Dr. Elli shall be responsible for the costs associated with implementing all aspects of this sanction, save and except for costs associated with publication, including any costs associated with his return to practice pursuant to the processes described in Schedule A to the Joint Submission on Sanction.
9. Dr. Elli shall pay the costs of the College in relation to this matter in keeping with the College's Tariff of Costs.
10. The decision or order of the Tribunal will be published. Publication will take place in the forms and locations set out in the Medical Act, 2011 and in the College By-Laws.

Dr. Zaira Azher

An Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador has found Dr. Zaira Azher guilty of professional misconduct in relation to two complaints filed by the Registrar of the College.

The Tribunal's written decision was released on December 11, 2024.

The Tribunal accepted an agreed statement of facts that was jointly prepared by the College and Dr. Azher. The dates, locations, and a brief description of the conduct of Dr. Azher that was found to be deserving of sanction is as follows:

> In late 2021, a Patient filed an allegation against Dr. Azher. In her written response to the allegation, Dr. Azher quoted a passage from the Patient's medical record in support of her response to the allegation. In the same written response, Dr. Azher stated that "I have no specific recollection of my treatment discussions with [Patient] in late 2018 and early 2019. As such, I am relying on what is documented in my medical records for that time period."
>
> As part of the investigation into the Patient's allegation, the College's investigator obtained an audit history listing every access to the Patient's medical record, including the time, date, author, and content of any amendments to the medical record. The audit history indicated that Dr. Azher had amended the Patient's medical record after receiving notice of the Patient's complaint. The amendments included adding, deleting, and replacing text from the original medical record.

The Tribunal accepted Dr. Azher's pleas of guilty of professional misconduct in respect of the complaints. In these pleas, Dr. Azher agreed that she:

1. amended a Patient's medical records to remove, delete, erase, or render illegible each previously existing record, without retaining any indication of the previously existing records or the nature and date of the amendments; and
2. made a misrepresentation to the College when she provided altered medical records in response to the Patient's allegation without advising the College that the medical records had been altered by her, and by advising the College that she relied on the truth and accuracy of the medical records in her response to the Patient's allegation.

The Tribunal accepted a submission for sanctions that was jointly prepared by the College and Dr. Azher. It then ordered that:

1. Dr. Azher is reprimanded by the Tribunal for her conduct.
2. Dr. Azher will serve a period of suspension of her medical license for a duration of one month. The suspension will take place within three months of the date of the Tribunal's order.
3. Dr. Azher is required to satisfactorily complete continuing professional development, which is satisfactory to the Registrar, at her own expense, on the following topics:
    a) Medical record-keeping; and
    b) Professional ethics.
4. Dr. Azher shall pay the costs of the College in relation to this matter in keeping with the College's Tariff of Costs.
5. The decision or order of the Tribunal will be published. Publication will take place in the forms and locations set out in the Medical Act, 2011 and in the College By-Laws.

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