



Ontario College
of Pharmacists

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APPENDIX A

DISCIPLINE CASE SUMMARIES 2017



A notation and summary of the discipline finding is available on the pharmacy professional's profile on the Find a Pharmacy or Pharmacy Professional tool on the College's website. Once complete, the full written decision for each hearing is available on www.canlii.org.

Andrew Ng (OCP #75035)

At a hearing on January 31, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Ng with respect to the following incidents:

- That he failed to keep records as required with respect to 13 identified MedsCheck reviews, in or about December 2010 – August 2015
- That he failed to conduct inventory reconciliations for narcotics and other controlled substances and/or to report any losses to Health Canada as required, in or about June 2015 – September 2015

In particular, it the Panel found that he

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration requiring the Member:
 - a. to review specific College policies, procedures, guidelines and recommendations regarding inventory reconciliations for narcotics and other controlled substances, as identified by the College;
 - b. to complete, after review of the publications, two comprehensive inventory reconciliations for all narcotics and other controlled substances in his current pharmacy, with the first inventory reconciliation to be completed and submitted to the College no later than two months from the date of this Order (i.e., by March 31, 2017) and the second inventory reconciliation to be performed and submitted to the College

six months after the first (i.e., by September 30, 2017), with the inventory reconciliations to cover the six-month period preceding each inventory reconciliation.

3. Directing the Registrar to suspend the Member's certificate of registration for a period of one (1) month, with the suspension to be fully remitted on condition the Member complete the remedial exercise specified in paragraph 2 above. If the Member is required to serve the suspension, the suspension shall commence on December 1, 2017 and continue without interruption until December 31, 2017
4. Costs to the College in the amount of \$2,000.

In its reprimand, the Panel noted that integrity and trust are paramount to the profession of Pharmacy, and that pharmacists are held in high regard for the role they play in the provision of health care in Ontario. The Panel expressed its disappointment in the Member's actions. The Panel suggested that the Member's disregard for proper narcotics control was shocking. The Panel expressed its dissatisfaction with the Member's continued lack of adherence to the standards of the profession, especially after these issues were brought to his attention and in light of narcotic diversion concerns in Ontario. The Panel related its expectation that the remediation ordered will assist the Member to improve his conduct and that he will not appear before the Discipline Committee again.

Trevor Scott Sweazey, R.Ph. (OCP #104914)

At a hearing on March 7, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Sweazey with respect to the following incidents:

- In or about the period from January 1, 2012, to January 1, 2014, he failed to keep records as required by the College's Medication Procurement and Inventory Management Policy with respect to the inventory of narcotics and controlled drugs
- He failed to take all reasonable steps necessary to protect narcotics on premises or under his control against loss or theft

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession
- Contravened section 43 of the Narcotics Control Regulations, C.R.C., c. 1041
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as unprofessional

v. require the practice mentor to report the results of the mentorship meetings to the Manager, Investigations and Resolutions at the College, after their completion, which shall be no later than twelve (12) months from the date of this Order.

The Panel imposed an Order which included as follows:

1. A reprimand
2. That the Registrar is directed to impose specified terms, conditions or limitations on the Member’s Certificate of Registration, and in particular:
 - a) That the Member:
 - i. retain, at the Member’s expense, a practice mentor acceptable to the College, within three (3) months of the date of this Order;
 - ii. meet at least two (2) times with the practice mentor, at the mentor’s place of practice, for the purpose of reviewing the Member’s practice with respect to protecting against narcotics loss and theft, and identifying areas in the Member’s practice with respect to these issues that require remediation; to this end, the Member shall provide the practice mentor with the following documents related to this proceeding:
 1. a copy of the Notice of Hearing;
 2. a copy of the Agreed Statement of Facts;
 3. a copy of this Joint Submission on Order;
 4. a copy of the Report of Investigation; and
 5. a copy of the Decision and Reasons, when available.
 - iii. develop a learning plan to address the areas requiring remediation;
 - iv. demonstrate to the practice mentor that the Member has achieved success in meeting the goals established in the learning plan; and

3. That the Registrar will be directed to suspend the Member’s certificate of registration for a period of three (3) months, with one (1) month of the suspension to be remitted on condition that the Member complete the remedial training specified in sub-paragraph 2 (a) above. The suspension shall commence on March 8, 2017 and shall continue until May 7, 2017, inclusive. If the balance of the suspension is required to be served by the Member because he fails to complete the remedial training specified in subparagraph 2(a) above, the balance of the suspension shall commence on March 9, 2018 and continue until April 8, 2018, inclusive.
4. That the Registrar is empowered, in her discretion, to grant a request for an extension of time or a change of mentor in relation to the administration of this Order, if she is of the view that it is in the interests of fairness to do so and that is it not contrary to the College’s mandate to serve and protect the public interest.
5. Costs to the College in the amount of \$3,500.00

In its reprimand, the Panel observed that the Member is part of the highly respected profession of pharmacy and that practice standards require the safe and secure management of narcotics and controlled substances. The Panel indicated that it was troubled by the inadequacies in the Member’s policies and procedures, which permitted a scale of theft that went unnoticed for a sustained period of time. The Panel acknowledged the Member’s efforts to remedy the problem, but noted that it was the thefts that highlighted the lack of management regarding the required policies and procedures for appropriate narcotic reconciliation. The Panel expressed its expectation that this has been a learning experience and that the Member will continue to take the necessary steps to improve his practice and ensure that this type of loss will not reoccur.

James Ying (OCP #609598)

At a hearing on March 17, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Ying with respect to the following incidents:

- That he failed to maintain the professional boundaries of the pharmacist-patient relationship when he developed a non-professional, personal relationship with the patient or former patient, [the Patient] in or about January 2013 to June 2013, and continued to pursue that relationship thereafter, until in or about June 2014; and/or
- That he engaged in sexual abuse of the patient, [the Patient], on one or more occasions, in or about January 2013 to June 2013.

In particular, the Panel found that he

- sexually abused a patient
- failed to maintain a standard of practice of the profession
- abused a patient, verbally or physically
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. an Order directing the Registrar to revoke the Member's certificate of registration; and
3. Costs to the College in the amount of \$15,000.00

In its reprimand, the Panel observed that Mr. Ying admitted to an appalling breach of the standards of practice of the profession, and to conduct that members of the profession would view as disgraceful, dishonourable, and unprofessional. The Panel noted that Mr. Ying failed in his moral obligation to conduct himself in a manner that is professional and maintains public confidence.

The Panel noted that pharmacists are expected to demonstrate personal and professional integrity and to maintain professional boundaries at all times; these boundaries are based on trust, respect and the appropriate use of power. The

Panel expressed its view that Mr. Ying's conduct undermined the foundation of the trust that exists between pharmacy professionals and their patients.

The Panel noted that it has an obligation to ensure that the penalty is appropriate to the findings. The Panel expressed its view that Mr. Ying's actions constitute one of the most serious manifestations of professional misconduct and therefore the legislated mandatory revocation is warranted.

Emad Abdel Sayed (OCP #610270)

At a hearing on March 27, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Abdel Sayed in that:

- Between about March 3, 2014 and September 21, 2015, he dispensed narcotics pursuant to invalid prescriptions, without taking and/or documenting adequate steps to verify the validity of the prescriptions;
- He dispensed drugs in doses, quantities, and/or frequencies that were unsafe and/or inappropriate;
- He failed to adequately document the steps taken and/or the clinical reasoning that justified dispensing drugs in exceptionally high doses, quantities, and/or frequencies;
- In the two-year period preceding approximately December 23, 2015, he failed to perform, and/or maintain a record of, adequate narcotic inventory counts and/or reconciliations;
- He failed to ensure that a patient identifying number was recorded on the prescription and/or failed to keep a record of that patient identifying number as recorded on the prescription before dispensing the prescription;
- He dispensed narcotics in advance of the interval specified by the prescriber for dispensing, without taking adequate steps to communicate with the prescriber and/or documenting the communication or the reasons for early dispensing;
- He dispensed narcotics to a single patient pursuant to prescriptions from two different prescribers without taking adequate steps and/or documenting those steps taken to verify the legitimacy of the prescriptions

In particular, it is alleged that he

- Failed to maintain a standard of practice of the profession
- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, section 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular:
 - o He contravened section 31 of the Narcotic Control Regulations, C.R.C., c.1041, as amended, under the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended, when between about March 3, 2014 and September 21, 2015, he dispensed narcotics pursuant to invalid prescriptions, without taking and/or documenting adequate steps to verify the validity of the prescriptions;
 - o He contravened section 11 of the Narcotic Safety and Awareness Act, 2010, S.O. 2010, c. 22, when he failed to ensure that a patient identifying number was recorded on the prescription and/or failed to keep a record of that patient identifying number as recorded on the prescription before dispensing the prescription;
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as dishonourable or unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular, requiring:
 - a. that the Member complete successfully with an unconditional pass, at his own expense, within 12 months of the date of this Order, the ProBE course and any related evaluations offered by the Centre for

Personalized Education for Physicians;

- b. that the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College in such number and at such time or times as the College may determine, for a period of 36 months from the date of this order. The 36-month period shall be suspended during any period of time during which the Member is not actively practising pharmacy and shall resume when the Member resumes the practice of pharmacy. The Member shall cooperate with the College during the inspections and, further, shall pay to the College in respect of the cost of monitoring, the amount of \$1,000.00 per inspection to a maximum of 3 inspections, such amount to be paid immediately after completion of each of the inspections.
3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 5 months, with 2 months of the suspension to be remitted on condition that the Member complete the remedial training as specified in paragraph 2(a) above. The suspension shall commence on March 27, 2017 and continue until June 26, 2017, inclusive. If the balance of the suspension is required to be served by the Member because he fails to complete the remedial training specified in paragraph 2(a) above, the balance of the suspension shall commence on March 27, 2018, and continue until May 26, 2018, inclusive.
 4. Clarity Note: The requirement to complete the remedial training specified above in paragraph 2(a) as terms, conditions or limitations on the Member's Certificate of Registration cannot be relieved by serving the remitted portion of the suspension referred to in paragraph 3 above.
 5. The Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in paragraphs 2(a) and 2(b) and/or to make any related necessary adjustments to the dates upon which the Member is to serve his suspension set out in paragraph 3, if the Registrar is of the view that it is in the interests of fairness to do so and that it is not contrary to the College's mandate to serve and protect the public interest.
 6. Costs to the College in the amount of \$3,500.

In its reprimand, the Panel noted that practice standards require the safe and secure management of narcotics and controlled substances. The Panel pointed

out that these practice standards are designed to prevent the abuse, misuse, and diversion of substances that are regulated due to their high potential for addiction and toxicity.

The Panel acknowledged the Member's cooperation and efforts to correct any deficiencies, but observed that, as Designated Manager, the Member's lack of adherence to standards of practice and procedures for appropriate narcotic reconciliation could not be ignored. The Panel pointed out that the Member's failure to follow College guidelines related to the identification of forgeries and fraudulent prescriptions was particularly alarming. The Panel expressed its expectation that the Member will continue to improve his practice.

Dilip Jain (OCP#204400)

At a hearing on April 10, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Jain with respect to the following incidents:

- Between about 2009 and 2013, he dispensed prescriptions issued by prescriber [Name] to herself and/or to members of the prescriber's family, and/or failed to take and/or document any steps to verify the propriety of the prescriptions;
- Between about 2009 and 2013, he dispensed prescriptions that were clinically inappropriate, having regard to the quantities and/or combinations of drugs dispensed and/or the frequency of dispensing, and/or failed to take and/or document any steps to verify the propriety of the prescriptions, with respect to the prescriptions issued by prescriber [Name], for herself and/or for members of the prescriber's family;
- On about November 10, 2011, he dispensed a prescription while inaccurately recording the directions for use and/or recording improper directions for use;
- As Designated Manager of the Pharmacy, and majority owner and director of the corporation that owned the Pharmacy, he permitted a prescriber, [Name], and members of her family, to have sufficient interest in and authority over the affairs of the Pharmacy that a reasonable person informed of the facts would perceive a conflict of interest; and

- As a majority owner and director of the corporation that owned the Pharmacy, he operated the pharmacy and/or permitted it to operate while the pharmacy was in a conflict of interest as defined in s. 53 of O. Reg. 58/11.

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession
- Practised the profession while in a conflict of interest
- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 155 and/or 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
 - a. that the Member complete successfully, with an unconditional pass, at his own expense, the ProBE course offered by the Centre for Personalized Education for Physicians, before the Member resumes the practice of pharmacy;
 - b. that the Member shall be prohibited from having any proprietary interest in, or acting as a Designated Manager in, any pharmacy, for 5 years from the time the Member obtains an active Certificate of Registration;
3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 12 months, or until such time as the Member successfully completes the ProBE course as set out in subparagraph 2(a) above, whichever is longer. The period of suspension shall start to run upon the Member obtaining an active Certificate of Registration.

4. Costs to the College in the amount of \$5,000.

In its reprimand, the Panel noted that members of the profession are held in high regard, and that Mr. Jain failed in his professional obligation to conduct himself in a manner that was respectable, responsible, and maintained public confidence. The Panel noted that pharmacy is a self-regulating profession and that there is an obligation to ensure that the public is protected and that public confidence in the profession’s ability to govern its members is maintained. The Panel expressed its expectation that pharmacists engaged in the business side of the profession will have a keen awareness for conflicts of interest and will make any necessary adjustments to avoid such situations. The Panel related its hope that Mr. Jain will take the necessary steps to improve his practice, should he decide to return to the profession.

Bhavesh Kothari (OCP #217389)

At a hearing on April 12, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Kothari with respect to the following incidents:

- That he failed to comply with the Order of the Discipline Committee Panel of the Ontario College of Pharmacists (the “College”) dated September 24, 2015 (the “Order”) and, in particular, failed to pay costs to the College as required by subparagraph (4) of the Order; and/or
- That he failed to respond to the College’s communications to him from in or about September, 2015 to in or about January, 2016 regarding the Order and his obligation to pay costs pursuant to the Order.

In particular, the Panel found that he

- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional.

The Panel imposed an Order which included as follows:

1. A reprimand

2. The Registrar is directed to suspend the Member’s certificate of registration for a minimum of four (4) months, the suspension to commence on April 26, 2017 and run without interruption until August 25, 2017. As of August 26, 2017, the suspension shall be suspended, and shall remain suspended, providing the Member has met/meets the following conditions:

- i. On or before August 25, 2017, the Member pays to the College, in a single lump sum by certified cheque, the sum of \$40,000, on account of the costs award in paragraph 4 of the Discipline Committee’s September 24, 2015 Order.
- ii. On or before October 1, 2017, and on or before the first day of each and every subsequent month, up to and including April 1, 2018, the Member pays the sum of \$20,000 to the College, in a single lump sum by certified cheque, on account of the costs award in paragraph 4 of the Discipline Committee’s September 24, 2015 Order, such that the total sum of \$180,000 has been paid to the College under paragraphs 2(i) and 2(ii) of this Order as of April 1, 2018.

In the event that the Member fails to meet any of the conditions set out in paragraphs 2(i) and 2(ii) of this Order, the Member’s suspension shall not be suspended (or shall cease to be suspended, as the case may be), and shall continue to run until such time as the Member has paid to the College the entire balance of the costs award in paragraph 4 of the Discipline Committee’s September 24, 2015 Order.

In any event, the suspension shall end on the later of August 26, 2017, or the date on which the Member has paid to the College the entire balance of the costs award in paragraph 4 of the Discipline Committee’s September 24, 2015 Order.

3. Costs to the College in the amount of \$15,000.00

In its reprimand, the Panel noted that the Member, through his actions, tainted the entire profession in the eyes of the public and completely disregarded the governing authority of the College. The Panel pointed out that the practice of Pharmacy is a privilege that carries with it significant obligations to the public, the profession, and oneself, and that through his misconduct the Member has eroded the public trust in the pharmacy profession and cast a shadow over his own integrity. The Panel expressed its hope that this hearing has given the Member the opportunity to pause for reflection and move forward in practising

pharmacy within the standards of the profession, and that he will not appear before a panel of the Discipline Committee again.

John Gerges, R.Ph. (OCP #613990)

At a hearing on April 28, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Gerges with respect to incidents set out in four referrals by the Inquiries, Complaints and Reports Committee.

Regarding the first referral, the Panel made findings against Mr. Gerges with respect to the following incidents:

- Between about June 2014 and about December 2014, he dispensed to a patient, [Patient 1], quantities of letrozole, a generic substitute for Femara, whereas [Patient 1] had in fact been prescribed a different medication, namely Feramax 150mg;
- In the fall of 2014, he dispensed medications to [Patient 1] in the form of dosettes that did not contain a correct set of tablets, having regard to [Patient 1]'s prescriptions;
- He did not maintain accurate records of prescriptions dispensed to [Patient 1] between about June 2014 and December 2014;
- He signed a patient record for [Patient 1] dated January 20, 2015, which suggested that the medications had been dispensed by Mill Street to [Patient 1] throughout the summer of 2014, whereas he ought to have known that [Patient 1] had not attended the Pharmacy during the summer of 2014, but rather that Mill Street had dispensed a long-term supply of medications to [Patient 1] in or about June 2014; and
- In or about January and February 2015, while [Patient 1]'s complaint to the College was being investigated, and without being solicited to do so, he offered significant compensation to [Patient 1] in respect of the Feramax 150mg dispensing error, and repeatedly contacted her and attempted to contact her to discuss the offer.

In particular, with respect to the first referral, the Panel found that he:

- Failed to maintain the standards of the profession;

- Failed to keep records as required respecting his patients; and
- Engaged in conduct relevant to the practice of pharmacy that, having regard to all of the circumstances, would reasonably be regarded by members of the profession as unprofessional and, with respect to the offer of compensation only, dishonourable.

Regarding the second referral, the Panel made findings against Mr. Gerges with respect to the following incidents:

- On July 25, 2014, August 28, 2014, and September 18, 2014, he submitted claims to third party insurers regarding certain identified items that were not dispensed to patients;
- On July 25, 2014, August 28, 2014, and September 18, 2014, he created records of dispensing and/or billing transactions in relation to the claims submitted to third party insurers that he ought to have known were false or misleading; and
- He ought to have known that these claims were false and/or misleading, and that these records contained a false and/or misleading statement.

In particular, with respect to the second referral, the Panel found that he:

- Failed to maintain a standard of practice of the profession
- Engaged in conduct relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional

Regarding the third referral, the Panel made findings against Mr. Gerges with respect to the following incidents:

- In August 2015, before filling a purported prescription for narcotics issued to [Patient 2], he failed to take steps to verify the prescription with the apparent prescriber, whereas verification was warranted in the circumstances;
- Between at least April 2014 and April 2016, he failed to ensure that Mill St. Pharmacy had policies and procedures in place to ensure the safe and accurate preparation of compliance packages;

- Between at least April 2014 and April 2016, he failed to ensure that Mill St. Pharmacy had policies and procedures in place to ensure that the billing of medications contained in compliance packages corresponded to the dates on which those medications were dispensed;
- Between at least April 2014 and April 2016, he failed to ensure that Mill St. Pharmacy had policies and procedures in place to ensure adequate recordkeeping in respect of medications dispensed in the form of compliance packages;
- He did not maintain accurate records of prescriptions dispensed to a patient, [Patient 1], between about June 2014 and December 2014, including:
 - i. no record of prescriber authorization or other reason for refills of Tecta dispensed in June and July 2014;
 - ii. hardcopies indicating “new Rx” for TevaRosuvastatin and Mylan-Paroxetine dispensed November 21, 2014, but no actual prescription or other authorization;
 - iii. no hardcopies for certain items on [Patient 1]’s Patient Medical Record;
 - iv. duplicate hardcopies for certain items on [Patient 1]’s Patient Medical Record;
- Between at least June 2014 and December 2014, he created records in respect of a patient, [Patient 1], which suggested that medications were dispensed by Mill St. Pharmacy to [Patient 1] in the form of a one-week supply on a weekly basis, whereas the medications were dispensed to [Patient 1] in the form of a longer-term supply, on less frequent basis
- Between at least June 2014 and December 2014, he submitted claims to the Ontario Drug Benefit Program in respect of a patient, [Patient 1], which suggested that medications were dispensed by Mill St. Pharmacy to [Patient 1] in the form of a one-week supply on a weekly basis, whereas he ought to have known that the submitted claims were false or misleading because medications were dispensed to [Patient 1] in the form of a longer-term supply, on a less frequent basis; and
- Between at least June 2014 and December 2014, he created records of

dispensing and/or billing transactions in relation to the claims submitted to the Ontario Drug Benefit Program in respect of [Patient 1] that he ought to have known were false or misleading.

In particular, with respect to the third referral, the Panel found that he:

- Failed to maintain the standards of the profession
- Failed to keep records as required respecting his patients
- Engaged in conduct relevant to the practice of pharmacy that, having regard to all of the circumstances, would reasonably be regarded by members of the profession as unprofessional

Regarding the fourth referral, the Panel made findings against Mr. Gerges with respect to the following incidents:

- Between at least January 2015 and April 2016, he failed to ensure that Mill St. Pharmacy in Tilbury, Ontario (“the Pharmacy”) had policies and procedures in place to ensure the safe and accurate preparation of compliance packages, including policies and procedures to ensure that changes to a patient’s prescriptions were noted and reflected in the patient’s compliance packages in a timely fashion;
- Between at least January 2015 and April 2016, he failed to ensure that the Pharmacy had policies and procedures in place to ensure that the billing of medications contained in compliance packages corresponded to the dates on which those medications were dispensed;
- Between at least January 2015 and April 2016, he failed to ensure that the Pharmacy had policies and procedures in place to ensure adequate recordkeeping in respect of medications dispensed in the form of compliance packages;
- In June 2015, on successive days, he filled two prescriptions for Tecta 40mg for the same patient, [Patient 3], that were written by different prescribers;
- He did not maintain accurate records of prescriptions dispensed to a patient, [Patient 3], between about January 2015 and June 2015, including:

i. [Patient 3]’s Patient Medical Record did not accurately reflect the dates on which medications were dispensed to the patient;

ii. No hardcopies for certain items listed on [Patient 3]’s Patient Medical Record;

- Between at least January 2015 and June 2015, he created records in respect of a patient, [Patient 3], which suggested that medications were dispensed by the Pharmacy to [Patient 3] in the form of a one-week supply on a weekly basis, whereas the medications were dispensed to [Patient 3] in the form of a longer-term supply, on a less frequent basis;
- Between at least January 2015 and June 2015, he submitted claims to the Ontario Drug Benefit Program in respect of a patient, [Patient 3], which suggested that medications were dispensed by the Pharmacy to [Patient 3] in the form of a one-week supply on a weekly basis, whereas he ought to have known that the submitted claims were false or misleading because the medications were dispensed to [Patient 3] in the form of a longer-term supply, on a less frequent basis; and
- Between at least June 2014 and December 2014, he created records of dispensing and/or billing transactions in relation to the claims submitted to the Ontario Drug Benefit Program in respect of [Patient 3] that he ought to have known were false or misleading.

In particular, with respect to the fourth referral, the Panel found that he:

- Failed to maintain the standards of the profession
- Failed to keep records as required respecting his patients
- Engaged in conduct relevant to the practice of pharmacy that, having regard to all of the circumstances, would reasonably be regarded by members of the profession as unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand;
2. That the Registrar be directed to suspend the Member’s certificate of registration for five (5) months, one (1) month of which to be remitted if the

Member satisfies all of the conditions set out in paragraph 3a., b. and c. The suspension shall commence on May 1, 2017, and run until August 31, 2017, inclusive. If the remitted portion of the suspension is required to be served by the Member because he fails to satisfy the conditions set out in paragraph 3a., b. and c., that portion of the suspension shall commence on April 29, 2020 and shall continue until May 28, 2020, inclusive;

3. That the Registrar be directed to impose the following conditions and limitation on the Member’s certificate of registration:
 - a. that the Member shall complete successfully, at his own expense and within twelve (12) months of the date of this Order, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals, with an unconditional pass;
 - b. that the Member successfully complete, within eighteen (18) months of the date of the Order, if he has not already done so within the twelve (12) months prior to the date of this Order, a review of his practice pursuant to the Medication System Safety Review for a Community Pharmacist On-Site Assessment program of ISMP Canada, which shall include delivery of the reviewer’s report to the Registrar. The review will take place at the Member’s practice site at Mill St. Pharmacy in Tilbury, Ontario. The Member shall be responsible for the cost of the review;
 - c. that the Member successfully complete, within three (3) years of the date of this order, the following courses (or, if these courses are no longer available at the relevant time, a comparable course of study approved in advance by the Registrar):
 - i. CPS I – Toronto Module 3 (Professional Practice & Pharmacy Management I) from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto;
 - ii. CPS II – Toronto Module 3 (Professional Practice & Pharmacy Management II) from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto;
 - d. That the Member:

- i. retain, at the Member's expense, a practice mentor acceptable to the College, who is a Designated Manager, within three (3) months of the date of this Order;
 - ii. meet at least six (6) times with the practice mentor, at the mentor's place of practice, for
 - iii. the purpose of reviewing the Member's practice with respect to
 - a. appropriate billing to ODB and other third party insurers;
 - b. appropriate refill reminder practice;
 - c. general supervision of a pharmacy, including supervision of pharmacy staff;
 - d. and any other matter that the mentor determines is appropriate.
 - iv. to this end, the Member shall provide the practice mentor with the following documents related to this proceeding:
 - 1. a copy of the Notices of Hearing;
 - 2. a copy of the Agreed Statement of Facts;
 - 3. a copy of this Joint Submission on Order; and
 - 4. a copy of the Decision and Reasons, when available.
 - v. develop a learning plan to address the areas requiring remediation;
 - vi. demonstrate to the practice mentor that the Member has achieved success in meeting the goals established in the learning plan; and
 - vii. direct the practice mentor to provide a report to the Manager, Investigations and Resolutions at the College, identifying the learning plan and the mentor's assessment of whether the Member has satisfactorily completed the learning plan, no later than eighteen (18) months from the date of this Order.
- e. that the Member be prohibited from acting as a Designated Manager

for any pharmacy, for a period of three (3) years from the date the Order is imposed, with one year of this restriction to be remitted on condition that the Member successfully complete the learning plan described in paragraph 3(d), as reported by the mentor to the College.

- f. For a period of three (3) years following the period of restriction described in paragraph 3(e), the Member be prohibited from acting as Designated Manager for more than two (2) pharmacies at any given time. If the Registrar is satisfied with the results of the assessments described in paragraph 3(g), below, this term, condition or limitation will be lifted at the end of this three (3) year period. If the Registrar is not satisfied with the results of the assessments described in paragraph 3(g), below, this term, condition or limitation will remain on the Member's certificate of registration, and may only be varied on application by the Member to the Discipline Committee.
 - g. For a period of three (3) years following the end of the period of restriction described in paragraph 3(e), the Member's practice and all activities at any pharmacies in which the Member has a proprietary interest of any kind shall be monitored by the College by means of unannounced practice assessments by a representative or representatives of the College to a maximum of three (3) inspections across all pharmacies. The practice assessments may be in addition to any of the routine inspections conducted by the College pursuant to the authority of section 148 of the Drug and Pharmacies Regulation Act. The Member shall cooperate with the College during the practice assessments and, further, shall pay to the College in respect of the cost of monitoring, the amount of \$1,000.00 per assessment, such amount to be paid immediately after completion of each of the assessments.
 - h. That the Member ensure that, at any pharmacy of which he is a shareholder, director, or Designated Manager, refills of medication are not billed until the pharmacy staff have confirmed that the refill is required.
4. Costs to the College in the amount of \$10,000.

In its reprimand, the Panel noted that the practice of pharmacy is a privilege that carries with it significant obligations to the public, the profession and to oneself. The Panel expressed its view that the Member's conduct was totally unacceptable to his fellow pharmacists and fell well below the standards

of practice expected of pharmacists and Designated Managers. The Panel indicated that it was necessary to impress upon the Member the seriousness of his misconduct.

The Panel agreed that the Member's conduct was unprofessional and in some circumstances dishonourable. The Panel expressed its expectation that the remediation ordered will result in improvement to the Member's practice as a pharmacist and a Designated Manager, and will also ensure that the public interest will be safeguarded. The Panel related its expectation that the Member will make the necessary adjustments to his practice, and will not appear before the Discipline Committee of the Ontario College of Pharmacists again.

Alexandre Mihaila, R.Ph. (OCP #219201)

At a hearing on May 8, 2017 a Panel of the Discipline Committee made findings of professional misconduct against Mr. Mihaila with respect to the following incidents:

- That he failed to actively and effectively participate in the day-to-day management of the Pharmacy, including but not limited to, drug procurement and inventory management, record keeping and documentation, and professional supervision of the pharmacy;
- That he failed to ensure that the Pharmacy complied with all legal requirements, including but not limited to, requirements regarding record keeping and documentation;
- That he falsified pharmacy records relating to his practice, in relation to prescriptions for domperidone and/or Parsitan; and/or
- That he misappropriated and/or obtained domperidone and/or Parsitan from the Pharmacy that had not been prescribed for him.

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession
- Dispensed or sold drugs for an improper purpose
- Failed to keep records as required respecting patients

- Falsified a record relating to his practice
- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement
- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991 and/or the regulations under those Acts, including but not limited to sections 140, 155, 156, and 166 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4, as amended
- Contravened, while engaged in the practice of pharmacy, any federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, namely section C.01.041 of the Food and Drug Regulations, C.R.C., c. 870, as amended
- Knowingly permitted the premises in which the pharmacy is located to be used for unlawful purposes
- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as dishonourable or unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. An Order directing the Registrar to suspend the Member's certificate of registration for a period of six (6) months, with one (1) month of the suspension to be remitted on the condition that the Member completes the remedial training specified in paragraph 3(i) below. This suspension shall commence on May 9, 2017 and shall continue until October 8, 2017, inclusive. If the remitted portion of the suspension is required to be served by the Member because he fails to complete the remedial training as specified in paragraph 3(i), that portion of the suspension shall commence on May 9, 2018 and shall continue until June 8, 2018, inclusive;
3. an Order directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration as follows:
 - (i) within twelve (12) months of the date when this Order is imposed, the

Member must successfully complete, at his own expense:

- a) the PROBE Program on Professional/ Problem-Based Ethics for healthcare professionals offered by the Center for Personalized Education for Physicians, with an unconditional pass; and
 - b) the College’s Jurisprudence e-learning modules and examination;
- (ii) for a period of three (3) years from the date when this Order is imposed:
- a) the Member shall be prohibited from acting as a Designated Manager at any pharmacy; and
 - b) the Member shall be prohibited from having, keeping or acquiring any ownership interest, direct or indirect, controlling or otherwise in any pharmacy in the Province of Ontario, either outright or as a shareholder of a corporation that owns a pharmacy, or as a director of a corporation that owns a pharmacy in the Province of Ontario, excepting only that he may be permitted to own shares in a publicly traded corporation that has an interest in a pharmacy;
- (iii) for a period of three (3) years from the date when this Order is imposed:
- a) the Member shall only engage in the practice of pharmacy if he has notified the College in writing of any employment in any pharmacy, which notification shall include the name, address, and telephone number of the employer and the date on which he began or is to begin employment, within seven (7) days of commencing such employment; and
 - b) the Member shall only engage in the practice of pharmacy for an employer in a pharmacy who provides confirmation in writing from the Designated Manager of that pharmacy (and any subsequent Designated Manager, if there is a change in the Designated Manager at the same pharmacy during the Member’s tenure) to the College, within seven (7) days of the Member’s commencement of employment at the pharmacy (and within seven (7) days of a change in Designated Manager), that the Designated Manager received and reviewed a copy of this Order and the Decision and Reasons of the

Discipline Committee in this matter before the Member commenced his employment;

- c) with one year of these restrictions, as set out in paragraphs 3(iii)(a) and 3(iii)(b) above, to be remitted on condition that the Member complete the programs, modules and examinations set out in paragraph 3(i) above as specified; and

4. Costs to the College in the amount of \$3,500.

In its reprimand, the Panel noted that, through his actions, the Member failed to maintain the responsibilities and obligations that are expected of him as a member of this profession. The Panel observed that the Member breached the standards of practice, regulations, and pharmacy legislation.

The Panel pointed out that pharmacy is a self-regulated profession, the practice of which is a privilege, and which comes with significant obligations to the public, the profession, and oneself.

The Panel related that the Member’s actions may have, in his opinion, been conducted on compassionate grounds, however, he have failed to meet the expected standards of practice of this profession.

The Panel observed that, in the future, the Member is expected to practice pharmacy within the standards of the profession. The Panel expressed its trust that the Member will take this opportunity to reflect on his actions and complete the required remediation, and that in so doing, he will change the way he practices and will not appear before a panel of the Discipline Committee again.

Neda Toeg, R.Ph. (OCP #606687)

At a hearing on May 9, 2017 a Panel of the Discipline Committee made findings of professional misconduct against Ms. Toeg with respect to the following incidents:

- That she admitted the patients, [Patient 1] and/or [Patient 2], to the dispensary area of the Pharmacy on several occasions, in or about July 2014; and/or
- That she dispensed methadone that had not been prescribed, and/or

failed to supervise dispensing of methadone to the patient, [Patient 2], on or about May 2, 2014.

In particular, it is alleged that she

- Failed to maintain a standard of practice of the profession
- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, section 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended, and/or section 4 of O.Reg. 58/11
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, section C.01.041 of the Food and Drug Regulations, C.R.C., c. 870, as amended, under the Food and Drugs Act, and/or sections 31 and/or 43 of the Narcotic Control Regulations, C.R.C., c.1041, as amended
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration requiring:
 - (a) that the Member successfully complete, within 6 months of the date of the order, a course with Gail E. Siskind Consulting Services, or another professional ethics consultant chosen by the College, to be designed by the consultant, with the purpose of addressing the professional misconduct issues raised in this case; the following terms shall apply to the course:
 1. the number of sessions shall be at the discretion of the consultant, but shall be a minimum of 2 meetings and a maximum of 3 meetings;

2. the manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member and the consultant, but shall ultimately be at the discretion of the consultant;
 3. the Member shall be responsible for the cost of the course;
 4. the Member shall provide to the consultant the following documents, in advance of the course, to facilitate the design of the course:
 - a. the Notice of Hearing;
 - b. the Agreed Statement of Facts;
 - c. this Joint Submission on Order; and
 - d. the Panel's Decision and Reasons, when available; and
 5. the consultant shall agree to confirm to the College once the Member has completed the course to the satisfaction of the consultant within 6 months of the date of this Order;
3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of one (1) month with the suspension to commence on May 10, 2017 and to continue without interruption until June 9, 2017.
 4. Costs to the College in the amount of \$2,500.00.

In its reprimand, the Panel noted that pharmacists provide care to the public and in return are held in high regard for the role played in the provision of healthcare in Ontario. The Panel noted that, though this was the Member's first appearance in front of the Discipline Committee, the allegations she admitted to were of concern, and her actions with respect to the allegations were not consistent with the Standards of Practice for pharmacists.

The Panel pointed out that all health care professionals are expected to conduct themselves in a manner that maintains public confidence and safety. The Panel expressed its expectation that the remediation ordered will result in improvement to the Member's practice as a pharmacist and that the public interest will be safeguarded, and that the Member will not appear before the Discipline Committee of the Ontario College of Pharmacists again.

Ayman Mikhael (OCP #111279)

At a hearing on May 17, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Mikhael with respect to incidents set out in two referrals by the Inquiries, Complaints and Reports Committee.

Regarding the first referral, the Panel made findings against Mr. Michael with respect to the following incidents:

- That he submitted accounts or charges for services that he knew were false or misleading to the Ontario Drug Benefit program for one or more drugs and/or products, from on or about November 1, 2009 to on or about October 31, 2011; and/or
- That he falsified pharmacy records relating to his practice in relation to claims made to the Ontario Drug Benefit program for one or more drugs and/or products, from on or about November 1, 2009 to on or about October 31, 2011; and/or
- That he failed to keep records of monthly Ontario drug benefit eligibility cards or a copy of the cards with respect to each person for whom a drug was dispensed, as required by section 29 of Ontario Regulation 201/96, under the Ontario Drug Benefits Act, R.S.O. 1990, c. O.10, as amended, from on or October 1, 2011 to on or about October 31, 2011.

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession;
- Failed to keep records as required respecting his patients;
- Falsified records relating to his practice;
- Submitted accounts or charges for services that he knew to be false or misleading;
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular sections 5 and 15(1)(b) of the Ontario Drug Benefits Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96

made thereunder; and/or section 29 of Ontario Regulation 201/96, under the Ontario Drug Benefits Act, R.S.O. 1990, c. O.10, as amended;

- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regarding to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional.

Regarding the second referral, the Panel made findings against Mr. Michael with respect to the following incidents:

- That he failed to report to the Registrar that he had been charged with offences under the Criminal Code of Canada in February of 2014
- That he failed to report to the Registrar that he had been convicted of an offence under the Criminal Code of Canada on July 14, 2015
- That he submitted false or inaccurate information in response to questions on the annual renewal application submitted to the College in March of 2014 regarding the charges under the Criminal Code of Canada in February of 2014

In particular, the Panel found that he

- Contravened a term, condition or limitation imposed on his certificate of registration
- Failed to maintain a standard of practice of the profession
- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional
- Was found guilty of an offence relevant to his suitability to practise

The Panel imposed an Order which included as follows:

- A reprimand
- Directing the Registrar to revoke the Member's certificate of registration
- Costs to the College in the amount of \$40,000.00

In its reprimand, the Panel indicated that they were appalled by the facts presented to them. The Panel observed that Mr. Mikhael put his own personal needs ahead of the trust of his patients and took advantage of his position in society.

The Panel pointed out that Mr. Mikhael's decision to defraud the public purse of millions of dollars was deliberate, and that such conduct significantly impacts the profession and its ability to provide healthcare to the most vulnerable patients. The Panel observed that Mr. Mikhael's actions jeopardized the public's trust in all pharmacists and that he betrayed the people of Ontario.

The Panel expressed its view that the public and the members of the profession are well served by the revocation of Mr. Mikhael's licence to practice.

Abhaya Dixit, R.Ph. (OCP #214669)

At a hearing on June 20, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Dixit with respect to the following incidents:

- That he falsified pharmacy records relating to his practice in connection with certain identified claims made for drugs and/or other products;
- That he signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement in connection with certain identified claims made for drugs and/or other products;
- That he submitted an account or charge for services that he knew was false or misleading in connection with certain identified claims made for the drugs and/or other products

In particular, the Panel found that he

- Failed to maintain the standards of practice of the profession

- Falsified pharmacy records relating to his practice
- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement
- Submitted an account or charge for services that he knew was false or misleading
- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 155 and 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, sections 5, and 15(1) of the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as dishonourable or unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. That the Registrar is directed to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
 - (a) that the Member shall be prohibited, for a period of 3 years to commence on June 20, 2017, from:
 - (i) Having any proprietary interest in a pharmacy of any kind;
 - (ii) Acting as a Designated Manager in any pharmacy;
 - (iii) Receiving any remuneration for his work as a pharmacist other than remuneration based only on hourly or weekly rates, and not on the basis of any incentive or bonus for prescription sales.

- (b) that the Member shall be required, for a period of three years commencing on June 20, 2017, to notify the College in writing of any employment in a pharmacy.
 - (c) that the Member, for a period of three years commencing on June 20, 2017, shall ensure that his employer has confirmed in writing to the College that they have received and reviewed a copy of the Discipline Committee Panel’s decision and order in this matter, and confirming the nature of the Member’s remuneration. This term is only applicable where the member is employed by a pharmacy, in the pharmaceutical industry, or otherwise employed as a pharmacist.
3. That the Registrar suspend the Member’s Certificate of Registration for a period of 14 months. The suspension shall commence on June 20, 2017 and shall continue until August 19, 2018, inclusive.
 4. Costs to the College in the amount of \$3,500.00

In its reprimand, the Panel noted that integrity and trust are paramount to the profession of pharmacy, and that, in return, pharmacists are held in high regard for the role they play in the provision of healthcare in Ontario.

The Panel expressed its disappointment in the Member’s actions, and observed that he committed professional misconduct and knowingly submitted false claims and billings to the Ontario Drug Benefit Program for reimbursement. The Panel pointed out that the volume of the inappropriate activities, to the order of approximately \$238,000 over a two-year period of time, is an example of the Member’s disregard for the trust that has been placed on the profession of Pharmacy.

The Panel acknowledged the Member’s efforts to atone for his misdeeds, and encouraged him to keep on that path of professional improvement. The Panel expressed its expectation that the Member will never appear before a panel of the Discipline Committee again.

George Oduro, R.Ph. (OCP #215645)

At a hearing on November 18, 2016, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Oduro with respect to the following incidents:

- That he failed to provide details to the Registrar of charges relating to four offences under the Criminal Code of Canada made in or about December 2011, including but not limited to in responses to questions for the annual renewal applications submitted to the College in 2012, 2013, and 2014
- That he submitted false or inaccurate information in response to questions on the annual renewal applications submitted to the College in March of 2012, March of 2013, and March of 2014 regarding these charges under the Criminal Code of Canada and the current proceedings in respect of them
- That he was found guilty of uttering a threat to cause bodily harm to a person, which is an offence contrary to section 264.1(1)(a) of the Criminal Code of Canada, and assault, which is an offence contrary to section 266 of the Criminal Code of Canada
- That he failed to provide details to the Registrar of findings of guilt relating to two offences under the Criminal Code of Canada made on or about June 14, 2014
- That he submitted false or inaccurate information in response to questions on the Self-Reporting Form submitted to the College in March of 2015 regarding these findings of guilt of offences under the Criminal Code of Canada

In particular, the Panel found that he

- Was found guilty of offences that are relevant to his suitability to practise
- Contravened a term, condition or limitation imposed on his certificate of registration
- Failed to maintain a standard of practice of the profession
- Falsified a record relating to his practice
- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement
- Contravened the Act and/or the Regulated Health Professions Act, 1991 and/or the regulations under those Acts, including subsection 5(1) of

Ontario Regulation 202/94 under the Act

- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional

In a decision dated May 19, 2017, a Panel of the Discipline Committee imposed an Order against Mr. Oduro which included as follows:

1. A reprimand
2. Directing the Registrar to suspend the Member's certificate of registration for a period of three (3) months, with one (1) month of the suspension to be remitted on the condition that the Member completes the course specified in paragraph (3)(a) below. The suspension shall be served commencing on June 21, 2017 and shall continue until August 20, 2017, inclusive. If the balance of the suspension is required to be served by the Member because he fails to complete the course as specified in paragraph 3(a), that portion of the suspension shall commence on June 21, 2018 and shall continue until July 20, 2018, inclusive.
3. Directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration as follows:
 - a) the Member must successfully complete, within twelve (12) months of the date that this Order is imposed, a course with Gail E. Siskind Consulting Services, or another professional ethics consultant acceptable to the College, to be designed by the consultant, with the purpose of addressing the professional misconduct issues raised in this case, and the following terms shall apply to that course:
 - i. the number of sessions shall be at the discretion of the consultant;
 - ii. the manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member and the consultant, but shall ultimately be at the discretion of the consultant;
 - iii. the Member shall be responsible for the cost of the course; and

- iv. the consultant shall agree to confirm to the College once the Member has completed the course to the satisfaction of the consultant; and

4. Costs to the College in the amount of \$3,500.00

In its reprimand, delivered on June 20, 2017, the Panel noted that members of the profession of pharmacy are held to a high standard of conduct and ethics, which is expected not only by the profession of but also the public of Ontario. Integrity, trust, and conduct as a professional are at the very core of the practice of pharmacy and the delivery of care to the public.

The Panel observed that the pharmacy is a self-regulated profession and to practice as a pharmacist is not a right but a privilege. All Members of the College bear the responsibility to ensure the practice of pharmacy is conducted at a high standard.

The Panel noted that the Member was charged and convicted of offences contrary to the Criminal Code of Canada. The Panel expressed its view that such a conviction is disgraceful, dishonourable, and unprofessional. The Panel indicated that the Member tarnished his image as a pharmacist and the profession as a whole. The Panel reported that although this did not involve a patient or pharmacy personnel, this conviction reflects poorly on the Member as an individual and on his future practice as a pharmacist.

The Panel observed that the remaining matters have to do with the Member's intentional non-reporting of the criminal charges to the Ontario College of Pharmacists.

The Panel explained that Ontario College of Pharmacists is responsible for the practice of Pharmacy in this province. In order to do this effectively the College depends on an honour system to report to the College when a member has been charged with any offence in any jurisdiction. The Panel noted that a charge under the Criminal Code is serious and must be reported.

The Panel related that the questions asked during the Annual Renewal related to findings of guilt or current proceedings are straightforward, and that answering "No" for three consecutive years at the time of licence renewal is unacceptable and unprofessional.

The Panel noted that the vast majority of pharmacists would never expect to

receive a reprimand during their careers. The Panel expressed its expectation that the Member will make amends for his past actions and work to restore his reputation as a pharmacist.

Eiman Amin, R.Ph. (OCP #202872)

At a hearing on June 21, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Amin with respect to the following incidents:

- That she falsified pharmacy records relating to the practice in connection with claims made for certain identified drugs and/or other products;
- That she signed or issued, in her professional capacity, a document that she knew contained a false or misleading statement in connection with claims made for certain identified drugs and/or other products;
- That she submitted an account or charge for services that she knew was false or misleading in connection with claims made for certain identified drugs and/or other products;
- That she altered purchase invoices, purportedly from McKesson Canada and Bayer Inc. and bearing dates ranging from September 9, 2010 to September 25, 2012, and provided them to the Ministry between October 4, 2012 and November 2, 2012;
- That she failed to submit accurate information to the Narcotics Monitoring System, in particular the correct prescriber registration number, in respect of certain identified prescriptions

In particular, the Panel found that she

- Failed to maintain the standards of practice
- Falsified pharmacy records relating to her practice
- Signed or issued, in her professional capacity, a document that she knew contained a false or misleading statement
- Submitted an account or charge for services that she knew was false or

misleading

- Contravened, while engaged in the practice of pharmacy, a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular:
 - o Sections 5, and 15(1) of the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended;
 - o Section 8 of the Narcotics Safety and Awareness Act, 2010, S.O. 2010, c. 22
- Permitted, consented to or approved, either expressly or by implication, the commission of an offence against any Act relating to the practice of pharmacy or to the sale of drugs by a corporation of which she was a director in particular:
 - o An offence pursuant to s. 15(1) of the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. That the Registrar is directed to impose specified terms, conditions or limitations on the Member’s Certificate of Registration, and in particular:
 - a. that the Member complete successfully with an unconditional pass, at her own expense, within 12 months of the date of this Order, the ProBE Program on professional/problem-based ethics for health care professionals;
 - b. the member shall be prohibited having any proprietary interest in a pharmacy as a sole proprietor or partner, or director or shareholder in a corporation that owns a pharmacy, or in any other capacity, and/or receiving remuneration for her work as pharmacist other than

remuneration based on hourly or weekly rates only, for a period of five (5) years from the date the Order is imposed;

- c. that the Member be prohibited, for a period of five (5) years from the date of this Order from acting as a Designated Manager for any pharmacy;
 - d. that for a period of five (5) years from the date the Order is imposed, the Member shall be required to notify the College in writing of the name(s), address(es) and telephone number(s) of all pharmacy employer(s) ("employers") within fourteen (14) days of commencing employment in a pharmacy;
 - e. that for a period of five (5) years from the date the Order is imposed, the Member shall provide her employer with a copy of the Discipline Committee Panel's decision in this matter and its Order
3. A suspension of sixteen months, with two months of the suspension to be remitted on condition that the Member complete the remedial training specified in subparagraph 2(a) above.
4. Costs to the College in the amount of \$5,000.00

In its reprimand, the Panel noted that integrity and trust are paramount to the profession of pharmacy and that, in return, pharmacists are held in high regard by the public for the role they play in the provision of healthcare in Ontario.

The Panel expressed its disappointment with the Member's actions. The Panel noted that, as a Designated Manager, the Member was entrusted by this College and the public to operate in a manner that is honest and ethical. The Panel pointed out that the Member's actions violated the standards of practice and the code of ethics expected by the public and the profession.

The Panel pointed to the volume of these inappropriate activities, to the order of approximately \$900,000 over a two-year period of time, as an example of the Member's disregard for the trust that has been placed on the profession of Pharmacy.

The Panel acknowledged that the Member has made restitution. It expressed its expectation that she will practice pharmacy within the standards of this profession and the code of ethics, and its hope that she will take this opportunity to reflect on her actions and complete the required remediation.

Naresh Jain, R.Ph. (OCP #604710)

At a hearing on June 22, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Jain with respect to the following incidents:

- That a finding of guilt was made on February 4, 2011 by the United States District Court for the Middle District of Florida in relation to embezzling more than \$1000 from the United States
- That he failed to report to the College that he had been convicted of a criminal offence in the United States District Court in February, 2011 and/or that he had been the subject of a professional misconduct proceeding before the Florida Board of Pharmacy beginning in November, 2011, and/or that he had been found to have committed professional misconduct by a Final Order of the Florida Board of Pharmacy dated December 26, 2014
- That on his annual renewal forms submitted in 2011, 2012, 2013, 2014, and/or 2015, he falsely answered "no" to the questions asking whether in the past 12 months he had been the subject of criminal or professional misconduct proceedings or findings

In particular, the Panel found that he

- Was found guilty of an offence that is relevant to his suitability to practise
- Contravened a term, condition or limitation imposed on his certificate of registration
- Failed to maintain a standard of practice of the profession
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. That the Registrar is directed to impose specified terms, conditions or

limitations on the Member's Certificate of Registration, and in particular: that the Member complete successfully with an unconditional pass, at his own expense, within 12 months of the date of this Order, the ProBE Program on professional/problem-based ethics for health care professionals.

3. That the Registrar suspend the Member's Certificate of Registration for a period of two months, with one month of the suspension to be suspended on condition that the Member complete the remedial training specified in paragraph 2, above.
4. Costs to the College in the amount of \$3,500.00

In its reprimand, the Panel noted that the practice of pharmacy is a privilege that comes with obligations. The Panel noted that the Member did not uphold these obligations and, as a result, compromised the integrity of the profession.

The Panel pointed out that the mandatory reporting requirements rely heavily on the honour system, and that any violation is of significant concern to both the College and the public. The Panel noted that the process is not open to interpretation as to what should be reported. The Panel emphasized that the onus and accountability to report truthfully and accurately is on the Member alone.

The Panel expressed its belief that the Member now realizes the importance of this responsibility and that he will benefit from the professional ethics course he has agreed to participate in. The Panel indicated its confidence that he will return to the profession with honour and integrity and will not appear a panel of the discipline committee again.

Nancy Mousa, R.Ph. (OCP #216717)

At a hearing on June 28, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Mousa with respect to the following incidents:

- That she submitted claims, and/or failed to cancel and/or reverse such claims, for prescriptions that were not picked up by certain identified patients, in or about January 2014-January 2015

In particular, the Panel found that she

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required respecting her patients
- Charged a fee that was excessive in relation to the service provided
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration requiring:
 - (a) that the Member successfully complete, within six (6) months of the date of the order, a course with Gail E. Siskind Consulting Services, or another professional ethics consultant chosen by the College, to be designed by the consultant, for the purpose of addressing the professional and ethical obligations with respect to maintaining accurate records; and the following terms shall apply to the course:
 - i. the number of sessions shall be at the discretion of the consultant, but shall be a minimum of 2 meetings and a maximum of 3 meetings;
 - ii. the manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member and the consultant, but shall ultimately be at the discretion of the consultant;
 - iii. the Member shall be responsible for the cost of the course;
 - iv. the Member shall provide to the consultant the following documents, in advance of the course, to facilitate the design of the course:
 1. the Notice of Hearing;
 2. the Agreed Statement of Facts;

- 3. this Joint Submission on Order; and
 - 4. the Panel's Decision and Reasons, if and when available; and
 - v. the consultant shall agree to confirm to the College once the Member has completed the course to the satisfaction of the consultant within six (6) months of the date of this Order.
3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of two (2) months, with one (1) month of the suspension to be remitted on condition the Member complete the remedial training program as specified in paragraph 2 above.
 4. Costs to the College in the amount of \$3,000.00

In its reprimand, the Panel noted that the Member failed to maintain the responsibilities and obligations expected of her as a member of this profession, and as a Designated Manager.

The Panel noted that pharmacy is a self-regulated profession, which bears the responsibility to ensure that it maintains the trust of the public. The Panel explained that the practice of pharmacy is a privilege and it comes with significant obligations to the public, the profession, and oneself.

The Panel expressed its expectation that the Member will practice pharmacy within the standards of this profession, and that she will take this opportunity to reflect on her actions and complete the required remediation. The Panel related its belief that the Member will change the way she practices and that she will not be seen again in front of a panel of the Discipline Committee.

Yogesh Patel (OCP #604597)

Findings of Professional Misconduct

At a hearing on July 24, 2017 a Panel of the Discipline Committee made findings of professional misconduct against Mr. Patel with respect to the following incidents:

- That he was found guilty on April 19, 2017, of criminal offences, and in particular:

- o Trafficking of a controlled substance (fentanyl) contrary to s. 5(1) of the Controlled Drugs and Substances Act, S.C., 1996, c. 19;
- o Possession of a controlled substance for the purpose of trafficking x3 (fentanyl, hydromorphone and morphine) contrary to s.5(2) of the Controlled Drugs and Substances Act, S.C., 1996, c. 19;
- o Knowingly forging a document as if it were genuine (a prescription) contrary to section 368(1)(a) of the Criminal Code of Canada;
- o Fraud over \$5,000 (against Rexall Pharmacy), contrary to section 380(1)(a) of the Criminal Code of Canada; and,
- o Theft over \$5,000 x2 (against Rexall Pharmacy and the Ontario Drug Benefit Plan), contrary to section 334(a) of the Criminal Code of Canada;

In particular, the Panel found that he:

- Was found guilty of criminal offences relevant to his suitability to practise;
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular:
 - o section 5(1) of the Controlled Drugs and Substances Act, S.C., 1996, c. 19;
 - o section 5(2) of the Controlled Drugs and Substances Act, S.C., 1996, c. 19;
 - o section 368(1)(a) of the Criminal Code of Canada;
 - o section 380(1)(a) of the Criminal Code of Canada; and/or,
 - o section 334(a) of the Criminal Code of Canada; and
- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional.

The Panel imposed an Order which included as follows:

- 1. A reprimand;
- 2. Directing the Registrar to revoke the Member’s certificate of registration; and
- 3. Costs to the College in the amount of \$2,500.

In its reprimand, the Panel noted that integrity, trust, and professional conduct are the core of the practice of pharmacy and the delivery of the care to the public, and that, in return, the profession is held in high regard by the people of Ontario.

The Panel observed that Pharmacy is a self-regulated profession and must ensure that it maintains the trust of its members and the public it serves. The practice of pharmacy is a privilege that carries with it significant obligations to the public, the profession, and to oneself.

The Panel expressed its view that Mr. Patel’s conduct demonstrated flagrant disregard for the privilege of practising pharmacy. The Panel pointed out that trafficking in narcotic and controlled substances is antithetical to the pharmacist’s role and has the potential to be injurious and destructive to individuals and the community.

The Panel indicated that Mr. Patel’s conduct was deserving of revocation.

Lisa Galassi, R.Ph. (OCP #115525)

At a hearing on July 26, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Galassi with respect to the following incidents:

- That between 2012 and 2016, she made inaccurate or false declarations on her Annual Renewal form by declaring that she met the criteria for eligibility as a Part A pharmacist when she did not meet the requirements of s. 45(3) of O. Reg. 202/94; and/or
- That between 2006 and 2016, she made inaccurate or false declarations on her Annual Renewal form by failing to fully and accurately provide the

name and address of each business for which she engaged in the practice of pharmacy, or to notify the College of changes to such information.

In particular, the Panel found that she

- Signed or issued, in her professional capacity, a document that she knew contained a false or misleading statement; and
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable and unprofessional

The Panel imposed an Order which included as follows:

- 1. A reprimand
- 2. Directing the Registrar to impose specified terms, conditions or limitations on the Member’s certificate of registration requiring that:
 - (a) the Member successfully complete, within six (6) months of the date of the order, a course with Gail E. Siskind Consulting Services, or another professional ethics consultant chosen by the College, to be designed by the consultant, for the purpose of addressing the professional and ethical obligations with respect to providing mandated information to the College; and the following terms shall apply to the course:
 - i. the number of sessions shall be at the discretion of the consultant, but shall be a minimum of 2 meetings and a maximum of 3 meetings;
 - ii. the manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member and the consultant, but shall ultimately be at the discretion of the consultant;
 - iii. the Member shall be responsible for the cost of the course;
 - iv. the Member shall provide to the consultant the following documents, in advance of the course, to facilitate the design of the course:
 - a. the Notice of Hearing;

- b. the Agreed Statement of Facts;
 - c. this Joint Submission on Order; and
 - d. the Panel’s Decision and Reasons, if and when available; and
 - v. the Member will request a report from the consultant confirming that the Member has completed the course to the satisfaction of the consultant, and the Member will provide a copy of the report to the College within six (6) months of the date of this Order.
- (b) the Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in paragraph 2(a), if the Registrar is of the view that it would be in the interests of fairness to do so and that it would not be contrary to the College’s mandate to serve and protect the public interest.
3. Directing the Registrar to suspend the Member’s Certificate of Registration for a period of three (3) months, with one (1) month of the suspension to be remitted on condition the Member complete the remedial training program as specified in paragraph 2 above. The suspension shall commence on July 27, 2017 and continue without interruption until September 26, 2017. If the remitted portion of the suspension has to be served, the further suspension shall commence on January 27, 2018 and continue without interruption until February 26, 2018, unless the time for completing the remedial steps in paragraph 2(a), above, is extended by the Registrar, in which case, the date the remitted portion of the suspension shall commence, if required, shall be adjusted accordingly.
4. Costs to the College in the amount of \$2,000.00

In its reprimand, the Panel noted that the public register of the College helps to tell the world who pharmacists are, and tells the public what pharmacists, as health care professionals, are legally entitled to do.

The Panel observed that the Member was listed in Part A of the College’s public register, and that she misled the public about who she was, what she was legally entitled to do, and where she worked. The Panel observed that this misconduct was carried over for a number of years, that numerous annual opportunities to update and correct the information were not utilized, and the erroneous information essentially became further from the truth each year.

The Panel noted that as a registered health care professional, the Member should not have been holding herself out to be a duly licensed health care practitioner, with all of the privileges, rights, and legalities associated with that specific designation. The Panel expressed its view that doing so put the public at risk.

The Panel related that while serving her suspension, the Member is not permitted to call herself a pharmacist, and that the suspension removes her identity as a pharmacist and the privileges that come with being a legally registered member of this College.

The Panel expressed its expectation that the Member will not appear before a Panel of the Discipline Committee again.

Akop Shaboian (OCP #215101)

Findings of Professional Misconduct

At a hearing on September 7, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Shaboian with respect to the following incidents:

- a) He dispensed certain identified products in a different quantity than the quantity indicated as dispensed on pharmacy records;
- b) He falsified pharmacy records and/or information recorded on the prescription relating to the dispensing of certain identified prescription drugs;
- c) He charged dispensing fees for the dispensing of certain identified products in less than the full amount prescribed without informed authorization or proper justification;
- d) He dispensed prescription drugs without a prescription and/or proper authorization with respect to certain identified products;
- e) Between in or about November 2014 and in or about February 2016, he falsified oral prescriptions and dispensed prescription drugs when no

prescription was ordered with respect to certain identified products;

- f) In or about April 2016, he charged dispensing fees for certain identified products without dispensing the products;
- g) He did not maintain accurate records of prescriptions dispensed to [Patient] in that pharmacy records indicate that a different quantity of product was dispensed than was actually dispensed for certain identified products;
- h) He failed to keep records with respect to certain identified products in accordance with the requirements of section 37 and 38 of the General Regulation

In particular, the Panel found that he:

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required respecting his patient
- Falsified a record relating to his practice
- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement
- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional

Acknowledgment & Undertaking

Mr. Shaboian entered into an Acknowledgment & Undertaking as part of the resolution of allegations of professional misconduct at a hearing of before a Panel of the Discipline Committee.

Pursuant to the Acknowledgment & Undertaking dated April 25, 2017, Mr. Shaboian undertook to permanently resign as a member of the College, effective September 7, 2017.

Order

The Panel imposed an Order which included as follows:

1. A reprimand
2. Costs to the College in the amount of \$5,000

In its reprimand, the Panel pointed out that members of the public hold pharmacists in high regard, and that Mr. Shaboian failed in his professional obligation to conduct himself in a manner that is respectable, responsible, and maintains public confidence.

The Panel noted that pharmacy is a self-regulated profession. Members have a responsibility to ensure that the public is adequately protected and to maintain the public’s confidence in their ability to govern themselves.

The Panel expressed its view that, as a result of his misconduct, Mr. Shaboian has let down the public, the pharmacy profession, and himself. The Panel expressed its confidence that Mr. Shaboian’s decision to resign will ensure the public is protected.

Murray Salomon, R.Ph. (OCP #67393)

At a hearing on September 5, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Salomon with respect to the following incidents:

- That he failed to obtain and/or document the consent of patients for the delegated controlled acts of performing a procedure below the dermis in relation to the INR blood tests performed by pharmacists, including for approximately 180 of the 215 patients for whom the tests were performed on or about December 23, 2013; December 27, 2013; December 30, 2013; January 2, 2014; and/or January 16, 2014;
- That he failed to obtain and/or document the required information and records in relation to MedsCheck and Pharmaceutical Opinion Program services claimed for all patients, including the following information regarding approximately 290 MedsCheck and/or 275 Pharmaceutical Opinion Program services claimed for 345 patients on or about December 23, 2013; December 27, 2013; December 30, 2013; January 2, 2014; and/or January 16, 2014:

- o for the MedsCheck services, the standard disclaimer, patient gender, primary prescriber information, and/or medication details (including generic or brand drug name, strength, dosage form, quantity, date dispensed and/or directions for use); and/or
- o for the Pharmaceutical Opinion Program services, the original or refill prescriptions to be attached or cross-referenced; and/or
- That he failed to keep records as required in relation to other discrepancies in the documentation for MedsCheck and Pharmaceutical Opinion Program services claimed for patients.

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required respecting his patients
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration and, in particular, requiring the Member to:
 - (a) retain, at the Member's expense, a practice mentor, approved by the College, within three (3) months of the date of this Order;
 - (b) meet at least five (5) times with the practice mentor, at a place to be determined by the practice mentor, for the purpose of reviewing the Member's ethical and professional obligations in relation to consents, compliance with program claim requirements, maintaining accurate records, and any other issues raised by the facts and findings of professional misconduct in this case, and identifying areas in the Member's practice with respect to these issues that require remediation. These meetings shall take place from time to time, at the discretion of

the practice mentor, for a period of twelve (12) months from the date of this Order;

- (c) provide the practice mentor with the following documents related to this proceeding:
 - i. the Notice of Hearing;
 - ii. the Agreed Statement of Facts;
 - iii. the Joint Submission on Order; and
 - iv. the Panel's Decision and Reasons, if and when available.
 - (d) develop with the practice mentor a learning plan to address the areas of the Member's practice requiring remediation;
 - (e) demonstrate to the practice mentor, in a manner directed by and acceptable to the practice mentor, that the Member has achieved success in meeting the goals established in the learning plan;
 - (f) ensure that the practice mentor reports the results of the mentorship program to the Manager, Investigations and Resolutions at the College, after its completion, which shall be no later than twelve (12) months from the date of this Order;
 - (g) refrain from acting as Designated Manager at any pharmacy until the mentorship program has been completed to the satisfaction of the practice mentor; and
 - (h) the Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in it would be in the interests of fairness to do so and that it would not be contrary to the College's mandate to serve and protect the public interest.
3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of four (4) months, with one (1) month of the suspension to be remitted on condition the Member complete the mentorship program as specified in paragraph 2 above. The suspension shall commence on September 6, 2017 and continue without interruption until December 5, 2017. If the remitted portion of the suspension has to be served, the

further suspension shall commence on September 6, 2018 and continue without interruption until October 5, 2018, unless the time for completing the remedial steps in paragraph 2 above is extended by the Registrar, in which case, the date the remitted portion of the suspension shall commence, if required, shall be adjusted accordingly.

4. Costs to the College in the amount of \$4,000.00.

In its reprimand, the Panel noted that the practice of pharmacy is a privilege that carries with it significant obligations to the public, the profession, and oneself. Through his conduct, the Member put public confidence in the profession in jeopardy, and brought discredit to the pharmacy profession and himself.

The Panel expressed its view that the Member's conduct was totally unacceptable to his fellow pharmacists. The Panel pointed out that when the College identified documentation deficiencies in his practice in 2013, the Member assured the College that these were anomalies and corrective action would take place. This Panel viewed the failure to take said corrective action very seriously.

The Panel observed that this was not the Member's first appearance in front of a panel of the Discipline Committee. The Panel expressed its trust that this disciplinary process has caused the Member to reflect on his practice and will motivate him to make changes, and that this will be the last time he appears before a panel of the Discipline Committee of the Ontario College of Pharmacists.

Abdul Baqi, R.Ph. (OCP #214965)

At a hearing on October 12, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Baqi with respect to the following incidents:

- That he submitted accounts or charges for services that he knew were false or misleading to the Ontario Drug Benefit program for one or more certain identified drugs and/or products, from on or about November 1, 2013 to on or about June 30, 2014,
- That he falsified pharmacy records relating to his practice in relation to the dispensing of and/or claims made to the Ontario Drug Benefit program

for one or more certain identified drugs and/or products, from on or about November 1, 2013 to on or about June 30, 2014,

- That he failed to ensure that the Pharmacy complied with all legal requirements, including but not limited to, requirements regarding record keeping, documentation, and billing the Ontario Drug Benefit Plan; and/or
- That he failed to actively and effectively participate in the day-to-day management of the Pharmacy, including but not limited to, drug procurement and inventory management, record keeping and documentation, professional supervision of pharmacy personnel and billing

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession
- Falsified records relating to his practice
- Submitted accounts or charges for services that he knew to be false or misleading
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular:
 - Sections 5, 6 and 15(1)(b) of the Ontario Drug Benefits Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder
- Permitted, consented to or approved, either expressly or by implication, the contravention of a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular:
 - Sections 5, 6 and 15(1)(b) of the Ontario Drug Benefits Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder
- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable

and unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. a 12 month suspension of the Member's certificate of registration, with 1 month of the suspension to be remitted on condition that the Member complete the remedial training specified below. The suspension shall commence on October 12, 2017, and shall run without interruption until September 11, 2018, inclusive. If the Member is required to serve the balance of the suspension, then the remitted portion shall commence on September 12, 2018, and shall run without interruption until October 13, 2018, inclusive;
3. an Order directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration as follows:
 - i. the Member must successfully complete, with an unconditional pass, at his own expense and within 11 months of the date the Order is imposed, the ProBE Program on professional / problem-based ethics for health care professionals offered by the Centre for Personalized Education for Physicians.

The Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial training set out in paragraph 3(a) and/or to make any related necessary adjustments to the dates upon which the Member is to serve the remitted portion of his suspension set out in paragraph 2, if the Registrar is of the view that it is in the interests of fairness to do so and that it is not contrary to the College's mandate to serve and protect the public interest;

- ii. The Member shall be prohibited from having any proprietary interest in a pharmacy of any kind and/or receiving remuneration for his work as a pharmacist other than remuneration based on hourly, or weekly rates only, provided that this term, condition and limitation may be removed by an Order of a panel of the Discipline Committee, upon application by the Member, such application not to be made sooner than four (4) years from the date the Order is imposed;
 - iii. For a period of four (4) years from the date the Order is imposed, the

Member shall be prohibited from acting as a Designated Manager in any pharmacy;

- iv. For a period of four (4) years from the date the Order is imposed, the Member shall be required to notify the College in writing of the names(s), address(s) and telephone numbers(s) of all employer(s) within fourteen (14) days of commencing employment in a pharmacy;
 - v. For a period of four (4) years from the date the Order is imposed, the Member shall provide his pharmacy employer with a copy of the Discipline Committee Panel's decision in this matter and its Order; and
 - vi. For a period of four (4) years from the date the Order is imposed, the Member shall only engage in the practice of pharmacy for an employer who agrees to write to the College within fourteen (14) days of the Member's commencing employment, confirming that it has received a copy of the required documents identified above, and confirming the nature of the Member's remuneration.
 - vii. For a period of four (4) years from the date the Order is imposed, the Member shall not work at nor be employed by any pharmacy in which a family member has a proprietary interest.

4. Costs to the College in the amount of \$12,500.

In its reprimand, the Panel noted that integrity and trust are paramount to the profession of pharmacy, and that pharmacists are held in high esteem for the role they play in the provision of healthcare in Ontario.

The Panel expressed its disappointment with the Member's actions. The Panel pointed out that the Ontario Drug Benefit Program is publically funded and operates on an honour system, and that submitting claims that were false or misleading shows a lack of integrity.

The Panel suggested that the Member's acts were unbecoming of a pharmacist. The Panel expressed its expectation that the Member has learned from this process, that he will improve his practice of pharmacy, and that he will work hard to regain the trust he has lost through his actions.

The Panel indicated its expectation that the Member will never again appear before a panel of the Discipline Committee.

**Allen Kula, R.Ph. (OCP #28479) and
W.J. Gagne Drugs Limited, c.o.b.
as Romana Pharmacy (#303221)**

At a hearing on October 26, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Kula with respect to the following incidents, in that he:

- Charged excessive dispensing fees and/or co-payments for dispensing less than the full quantity of the drugs prescribed for the patient, [Patient], without agreement of the patient or other valid authorization, in or about August–November 2013

In particular, the Panel found that he

- Failed to maintain the standards of practice of the profession
- Dispensed or sold drugs for an improper purpose
- Charged a fee that is excessive in relation to the service provided
- Contravened, while engaged in the practice of pharmacy, a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, including sections 4, 5, 6 and/or 15 of the Ontario Drug Benefits Act, R.S.O. 1990, Ch. O.10, as amended; sections 18 and/or 20.2 of O.Reg. 201/96, as amended; and/or section 9 of Drug Interchangeability and Dispensing Fee Act, R.S.O. 1990, c.P.23, as amended
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful

At the same hearing on October 26, 2017, the Panel made findings of professional misconduct against Mr. Kula with respect to the following incidents, in that he:

- Dispensed and/or billed prescription and non-prescription medications, without authorization, for certain identified patients, in or about February–August 2014
- Failed to keep records of prescriptions dispensed for certain identified patients, in or about April–September 2014
- Failed to document renewals of prescriptions by a pharmacist for certain identified patients, in or about May–September 2014;
- Dispensed and/or billed prescription and non-prescription medications, without authorization, by relying on “blanket authorizations” from Dr. [Name] to renew prescriptions for certain identified patients, on or about May 27-28, 2014;
- Failed to keep records as required regarding current prescriptions but instead “piggybacking” on old prescriptions for certain identified patients, in or about June–November 2014;
- Falsified claims for medications dispensed to patients at less frequent intervals than claimed for billing purposes for certain identified patients, in or about January–November 2014;
- Dispensed lesser quantities of medications than prescribed without the written agreement of the patients, or failed to keep records of any such agreements, for certain identified patients, in or about January–November 2014;
- Billed and/or dispensed quantities of medications in excess of the quantities required for certain identified patients, in or about April–July 2014;
- Billed and/or dispensed medications for certain identified patients, after the Pharmacy had been advised that the patients were deceased, in or about June–August 2014;
- Failed to provide prescription receipts for medications dispensed for certain identified patients, on or about August 7, 2014;
- Billed for MedsCheck Reviews without justification, or without documenting any such justification, for certain identified patients, on or about January 22, 2014;

- Dispensed medications to patients other than the specific medications identified in the prescription records, including ferrous gluconate and/or risperidone, in or about January-August 2014;
- Failed to sign prescription hardcopies by a pharmacist for as many as 1,115 dispensing or billing transactions for up to 116 patients, in or about April-November 2014;
- Failed to maintain prescription records in a readily-retrievable manner, including the records for certain identified prescriptions;
- Failed to maintain records regarding authorizations for medications dispensed to patients in retirement homes, and/or prescription hardcopies signed by a pharmacist for such transactions, in or about July-August 2014;
- Permitted non-pharmacist staff, [Staff Person 1] and/or [Staff Person 2], to process claims outside the Pharmacy for medications for certain identified patients, in or about April-July 2014

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required respecting his patients
- Falsified a record relating to his practice
- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement
- Submitted an account or charge for services that he knew was false or misleading
- Charged a fee that was excessive in relation to the service provided
- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, section 4 of the Pharmacy Act, 1991 S.O. 1991, c. 36, as amended; sections 36, 37 and/or 38 of O.Reg. 202/94, as amended; sections 150, 155 and/or 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4 as amended; and/or sections 54,

55, 56 and/or 57 of O.Reg.58/11, as amended

- Contravened, while in engaged in the practice of pharmacy, a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, section 9 of the Food and Drugs Act, R.S.C. 1985, c.F-27, as amended; section C.01.041 of the Food and Drug Regulations, C.R.C., c. 870, as amended; sections 9 and/or 10 of the Drug Interchangeability and Dispensing Fee Act, R.S.O. 1990, c.P.23, as amended; section 4 of Ontario Regulation 936, as amended; and/or sections 5, 6 and/or 15 of the Ontario Drug Benefit Act, R.S.O. 1990, c.O.10, as amended; and/or sections 27 and/or 29 of O.Reg. 201/96, as amended
- Permitted, consented to or approved, either expressly or by implication, the commission of an offence against any Act relating to the practice of pharmacy or to the sale of drugs by a corporation of which he was a director
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful

At the same hearing on October 26, 2017, the Panel made findings of proprietary misconduct against Allen Kula, as director of W.J. Gagne Drugs Limited, c.o.b. as Romana Pharmacy, and/or Designated Manager of Romana Pharmacy in Keswick, Ontario with respect to the following incidents, in that he:

- Failed to keep records of prescriptions dispensed for certain identified patients, in or about April-September 2014
- Failed to keep records as required regarding current prescriptions but instead “piggybacking” on old prescriptions for certain identified patients, in or about June-November 2014
- Dispensed medications to patients other than the specific medications identified in the prescription records, including ferrous gluconate and/or risperidone, in or about January-August 2014
- Failed to sign prescription hardcopies by a pharmacist for as many as 1,115 dispensing or billing transactions for up to 116 patients, in or about April-November 2014

- Failed to maintain certain identified prescription records in a readily-retrievable manner
- Failed to maintain records regarding authorizations for medications dispensed to patients in retirement homes, and/or prescription hardcopies signed by a pharmacist for such transactions, in or about July-August 2014.
- Dispensed and/or billed prescription and non-prescription medications, without authorization, for certain identified patients, in or about February-August 2014
- Falsified claims for medications dispensed to patients at less frequent intervals than claimed for billing purposes for certain identified patients, in or about January-November 2014
- Dispensed lesser quantities of medications than prescribed without the written agreement of the patients, or failed to keep records of any such agreements, for certain identified patients, in or about January-November 2014;
- Dispensed and/or billed prescription and non-prescription medications, without authorization, by relying on "blanket authorizations" from Dr. [Name] to renew prescriptions for certain identified patients, on or about May 27-28, 2014

In particular, the Panel found that Mr. Kula and W.J. Gagne Drugs Limited, as holder of Certificate of Accreditation #303221 for Romana Pharmacy in Keswick, Ontario,

- Failed to keep records required to be kept by the pharmacy respecting the patients and the practice of the pharmacy
- Falsified a record of the pharmacy
- Signed or issued a document that contained a false or misleading statement
- Submitted an account or charge which was false or misleading
- Charged a fee or an amount that was excessive in relation to the service or product provided

- Contravened the Act or the regulations made under the Act, and in particular, sections 150, 155 and/or 156 of the Act, and/or sections 54, 55, 56 and/or 57 of O.Reg. 58/11
- Contravened a law of Canada or Ontario or any municipal by-law with respect to the distribution, purchase, sale or dispensing of any drugs or product in a pharmacy, and in particular, section 9 of the Food and Drugs Act, R.S.C. 1985, c.F-27, as amended; section C.01.041 of the Food and Drug Regulations, C.R.C., c. 870, as amended; sections 9 and/or 10 of the Drug Interchangeability and Dispensing Fee Act, R.S.O. 1990, c.P.23, as amended; sections 5, 6 and/or 15 of the Ontario Drug Benefit Act, R.S.O. 1990, C.O.10, as amended, and/or sections 27 and/or 29 of O.Reg.201/96, as amended
- Engaged in conduct or performed an act relevant to the business of a pharmacy that would reasonably be regarded by members as disgraceful

The Panel imposed an Order which included as follows:

1. A reprimand, to be scheduled within six months of the date of the Order.
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration requiring:
 - a. that the Member shall complete successfully, at his own expense and within twelve (12) months of the date of this Order, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals, with an unconditional pass;
 - b. that the Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in subparagraph 2(a), if the Registrar is of the view that it would be in the interests of fairness to do so and that it would not be contrary to the College's mandate to serve and protect the public interest; and
 - c. that the Member shall be prohibited from acting as the Designated Manager at any pharmacy for a period of two (2) years from the date of this Order.
3. Directing the Registrar to impose specified terms, conditions or limitations on the Certificate of Accreditation for Romana Pharmacy requiring that the

practice of pharmacy and related business activities at Romana Pharmacy be monitored by the College for a period of two (2) years from the date of this Order by means of inspections of a representative of the College at such times as the College may determine. The monitoring inspections may be in addition to any of the routine inspections conducted by the College pursuant to the authority of section 148 of the Drug and Pharmacies Regulation Act. Pharmacy staff shall cooperate fully with the College during the inspections. The Pharmacy shall pay to the College in respect of such monitoring the amount of \$1,000.00 per inspection, such amount to be paid immediately after each inspection, with the total number of inspections for which the Pharmacy is required to pay, not to exceed four (4) regardless of the number of inspections.

4. Directing the Registrar to suspend the Member's Certificate of Registration for a period of three (3) months, with one (1) month of the suspension to be remitted on condition the Member complete the remedial training program as specified in subparagraph 2(a) above. The suspension shall commence on November 2, 2017 and continue without interruption until January 1, 2018, inclusive. If the remitted portion of the suspension has to be served, the further suspension shall commence on October 27, 2018 and continue without interruption until November 26, 2018, inclusive, unless the time for completing the remedial steps in subparagraph 2(a) above is extended by the Registrar, in which case, the date on which the remitted portion of the suspension shall commence, if required, shall be adjusted accordingly.

5. Costs to the College in the amount of \$20,000.00.

In its reprimand, the Panel noted that the Member admitted to numerous acts of misconduct.

The Panel observed that there are many terms that can be used to define the term "disgraceful", and that in this case the definition of "shockingly unacceptable" certainly applies.

The Panel observed that, as the Designated Manager, the Member is expected to supervise his staff and provide guidance about the correct policies and procedures to follow. The Panel expressed its view that the Member failed in his role as a Designated Manager and as a pharmacist.

The Panel further noted that the public expects a high level of professionalism, attention to detail, adherence to legislation, and accuracy in the care they

receive from the Member, as a pharmacist. The Panel explained that, again, the Member failed.

The Panel noted that the lack of procedures in the pharmacy resulted in inaccurate billings to the Ontario Drug Benefit program, and therefore the public was falsely billed, and that this was a direct failure to the public whom the Member is supposed to serve.

The Panel related that, as a pharmacist with over 40 years of experience, the Member ought to have set an example of proper conduct for new practitioners to emulate, and, unfortunately, he failed.

The Panel expressed its view that the Member only regarded a pharmacy as a business and forgot that this business is highly regulated in order to meet the high standards demanded by the public. The Panel pointed out that the code of conduct expected of a healthcare professional managing a proprietary business is one with a high standard, and that the Member failed at meeting this standard.

George Politis, R.Ph. (OCP #68632)

At a hearing on November 6, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Politis with respect to the following incidents:

- On November 17, 2015, he attended a shiatsu massage spa with [Name], an employee of the Pharmacy, during work hours, in circumstances where he ought to have known that doing so would make [Name] uncomfortable.

In particular, the Panel found that he:

- Failed to maintain the standards of the profession
- Engaged in conduct relevant to the practice of pharmacy that, having regard to all of the circumstances, would reasonably be regarded by members of the profession as unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand

- 2. That the Registrar be directed to impose the following conditions on the Member's certificate of registration:
 - a. that the Member successfully complete, within twelve (12) months of the date of this Order, a course with Gail E. Siskind Consulting Services, or another professional ethics consultant acceptable to the College, to be designed by the consultant, with the purpose of addressing the professional misconduct issues raised in this case; the following terms shall apply to the course:
 - i. the number of sessions shall be at the discretion of the consultant, but shall be a minimum of 2, and maximum of 3;
 - ii. the manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member and the consultant, but shall ultimately be at the discretion of the consultant;
 - iii. Successful completion of the course will include completion of an essay, acceptable to the Registrar, addressing the objectives of professional regulation and the importance to the public interest of maintaining professional conduct towards colleagues;
 - iv. The essay shall be at least 1000 words in length. The Member shall be responsible for the cost of review by the consultant to assist the Registrar to determine whether the essay is acceptable, up to a maximum of \$500;
 - v. the Member shall be responsible for the cost of the course;
 - vi. the Member will request a report from the consultant confirming that the Member has completed the course to the satisfaction of the consultant, and the Member will provide a copy of the report to the College within twelve (12) months of the date of this Order;
 - b. the Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in subparagraph 2(a) if the Registrar is of the view that it would be in the interests of fairness to do so and that it would not be contrary to the College's mandate to serve and protect the public interest;

- c. that the Member be prohibited from acting as a Designated Manager for any pharmacy, from December 1, 2017 until he has completed the remedial training specified in subparagraph 2(a), as confirmed by the consultant;
- 3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 2 months, 1 month of which shall be remitted upon the Member successfully completing the remedial training as specified in subparagraph 2(a) above. The suspension shall commence on December 1, 2017, and run until December 31, 2017, inclusive. If the remitted portion of the suspension is required to be served by the Member because he fails to complete the remedial training specified in subparagraph 2(a) above within the time specified, the remainder of the suspension shall commence on November 6, 2018, and continue until December 5, 2018, inclusive unless the time for completing the remedial steps in subparagraph 2(a), above, is extended by the Registrar, in which case, the date the remitted portion of the suspension shall commence, if required, shall be adjusted accordingly;
- 4. Costs to the College in the amount of \$10,000.00.

In its reprimand, the Panel noted that, as a member of this profession, the Member is held in high regard by the public, and that he has a moral obligation to conduct himself in a manner that is professional, ethical, and serves the public interest.

The Panel indicated that pharmacists are expected to demonstrate personal and professional integrity and to maintain professional boundaries at all times. These boundaries are based on trust, respect, and the appropriate use of power.

The Panel expressed its hope that the Member has had a chance to reflect on his conduct and that he understands its impact on his colleagues, the profession, and the public. The Panel indicated its expectation that the ethics course ordered will serve as an opportunity for remediation and that it will provide the Member with insight into personal and professional boundaries.

Mamdouh Soliman (OCP #114278)

At a hearing on November 17, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Soliman with respect to the

following incidents:

- He made making unwelcome comments of a sexual nature towards his co-worker and patient, [Name]; and/or
- He verbally abused, swore at and/or yelled at his co-worker and patient, [Name]; and/or
- On one or more occasions, he touched inappropriately or attempted to touch inappropriately his co-worker and patient, [Name]; and/or
- In or about December 2014, he wrote his co-worker and patient, [Name], a note in which he said “fuck you” or words to that effect.

In particular, the Panel found that he

- Sexually abused a patient
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional

The Panel imposed an Order which included as follows:

- A reprimand

In its reprimand, the Panel observed that members of the public hold pharmacists in high regard. Pharmacists have a moral obligation to conduct themselves in a manner that is professional and maintains public confidence.

The Panel indicated that pharmacists are expected to demonstrate personal and professional integrity and to maintain professional boundaries at all times. These boundaries are based on trust, respect, and the appropriate use of power. These standards are high.

The Panel explained that, had Mr. Soliman not resigned from practice for the other matters that were drawn to their attention, the Panel would likely have accepted other elements of an order, such as a term of suspension, remediation coursework, costs, and perhaps other components.

The Panel related that, given Mr. Soliman’s signed acknowledgement and

undertaking, which irrevocably surrendered his certificate of registration, it accepted the Agreed Statement of Facts, his admission of misconduct, and the Joint Submission on Order.

Niloofer Saiy (OCP #608704)

At a hearing on November 21, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Saiy with respect to the following incidents:

- She inappropriately provided pharmaceutical treatment to herself and certain identified family members, contrary to the College’s Policy on Treating Self and Family Members
- She dispensed prescription medications without valid authorization in respect of certain identified patients and transactions
- She falsified pharmacy records in respect certain identified prescription transactions
- She failed to keep records as required in respect of certain identified patients

In particular, the Panel found that she

- Failed to maintain the standards of practice of the profession
- Failed to keep records as required
- Falsified a record relating to her practice
- Signed or issued, in her professional capacity, a document that she knew contained a false or misleading statement
- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, section 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended
- Engaged in conduct or performed an act relevant to the practice of

pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as dishonourable and unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. That the Registrar is directed to impose specified terms, conditions or limitations on the Member’s Certificate of Registration, and in particular:
 - a. that the Member complete successfully with an unconditional pass, at her own expense, and within 12 months of the date the Order is imposed, the ProBE Program on Professional / Problem-based Ethics for Health Care Professionals offered by the Center for Personalized Education for Physicians; and,
 - b. that the Member complete successfully, at her own expense and within 12 months of the date of this Order, the Ontario College of Pharmacists’ Jurisprudence Exam;
 - c. that the Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in subparagraphs 2(a) and/or 2(b), if the Registrar is of the view that it would be in the interests of fairness to do so and that it would not be contrary to the College’s mandate to serve and protect the public interest;
3. That the Registrar suspend the Member’s Certificate of Registration for a period of three months, with one month of the suspension to be remitted on condition that the Member complete the remedial training as specified in paragraph 2. The suspension shall commence on November 26, 2017, and shall continue until January 25, 2018, inclusive. If the remitted portion of the suspension is required to be served by the Member because she fails to complete the remedial training as specified in paragraph 2, that portion of the suspension shall commence on November 21, 2018, and shall continue until December 20, 2018, inclusive, unless the time for completing the remedial steps in subparagraphs 2(a) and/or 2(b), above is extended by the Registrar, in which case, the date on which the remitted portion of the suspension shall commence, if required, shall be adjusted accordingly.

4. Costs to the College in the amount of \$6,000.

In its reprimand, the Panel noted that through this professional misconduct, the Member failed in her obligations to adhere to the standards of practice. The Panel pointed out that the Member knowingly breached the public’s trust and, in doing so, let down the profession of pharmacy.

The Panel related that the standards of practice demand that pharmacists practice to a very high standard, and that this type of conduct can cause the public to mistrust and lose confidence in the profession, and is a risk to the privilege of being a self-regulated profession.

The Panel expressed its trust that the Member has learned from this experience, that she will appropriately change her practice standards, and that she will never again appear before a panel of the Discipline Committee.

Safaa Eskander (OCP #116661)

At a hearing on November 27, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Eskander with respect to the following incidents:

- That she submitted accounts or charges for services that she knew were false or misleading to the Ontario Drug Benefit program for:
 - o one or more of certain identified drugs and/or products, from on or about July 1, 2010 to on or about June 30, 2012,
 - o Ventolin HFA, from on or about July 1, 2010 to on or about June 30, 2012, in circumstances where interchangeable products were dispensed; and/or
 - o one or more of the drugs and/or products transferred from Wilson Medical Pharmacy between on or about February 22, 2012 and on or about August 1, 2014;
- That she falsified pharmacy records relating to her practice in relation to the dispensing of and/or claims made to the Ontario Drug Benefit program for:
 - o one or more of certain identified drugs and/or products, from on or

about July 1, 2010 to on or about June 30, 2012,

o Ventolin HFA, from on or about July 1, 2010 to on or about June 30, 2012, in circumstances where interchangeable products were dispensed; and/or

o drugs and/or products transferred from Wilson Medical Pharmacy between on or about February 22, 2012 and on or about August 1, 2014;

- That she failed to ensure that the Pharmacy complied with all legal requirements, including but not limited to, requirements regarding record keeping, documentation, and billing the Ontario Drug Benefit Plan; and/or
- That she failed to actively and effectively participate in the day-to-day management of the Pharmacy, including but not limited to, drug procurement and inventory management, record keeping and documentation, professional supervision of pharmacy personnel and billing.

In particular, the Panel found that the Member

- Failed to maintain a standard of practice of the profession;
- Falsified records relating to her practice;
- Signed or issued, in her professional capacity, a document that she knew contained a false or misleading statement;
- Failed to keep records as required respecting her patients;
- Submitted accounts or charges for services that she knew to be false or misleading;
- Contravened the Pharmacy Act, 1991 the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991 or the regulations under those Acts and in particular:
 - o Sections 155 and 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended, in connection with prescription information and container identification markings;

- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular:
 - o Sections 5, 6 and 15(1)(b) of the Ontario Drug Benefits Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder with respect to submitting claims for payment to the Ontario Drug Benefit program where no payment was required, and/or that she knew or reasonably ought to have known were false, inaccurate or misleading claims;
 - o Sections 155 and 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended, in connection with prescription information and container identification markings;
 - o Sections 8, 10 and 11 of the Narcotics Safety and Awareness Act, 2010 SO 2010, c 22, with respect to making disclosures to the Narcotic Monitoring System between on or about May 14, 2012 to on or about July 23, 2013 which did not contain the required information regarding the prescriber of the drug dispensed;
- Permitted, consented to or approved, either expressly or by implication, the contravention of a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs and in particular:
 - o Sections 5, 6 and 15(1)(b) of the Ontario Drug Benefits Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder with respect to submitting claims for payment to the Ontario Drug Benefit program where no payment was required, and/or that she knew or reasonably ought to have known were false, inaccurate or misleading claims;
 - o Sections 155 and 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended, in connection with prescription information and container identification markings;
 - o Sections 8, 10 and 11 of the Narcotics Safety and Awareness Act, 2010 SO 2010, c 22, with respect to making disclosures to the Narcotic Monitoring System between on or about May 14, 2012 to on or about July 23, 2013 which did not contain the required information

regarding the prescriber of the drug dispensed;

- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional.

The Panel imposed an Order which included as follows:

- (i) A reprimand;
- (ii) A 14 month suspension of the Member’s certificate of registration, with 2 months of the suspension to be remitted on condition that the Member complete the remedial training specified below ;
- (iii) An Order directing the Registrar to impose specified terms, conditions or limitations on the Member’s certificate of registration as follows:
 - i. the Member must successfully complete with an unconditional pass, at her own expense and within 12 months of the date the Order is imposed, the ProBE Program on professional / problem-based ethics for health care professionals offered by the Centre for Personalized Education for Physicians;
 - ii. for a period of three (3) years the Member shall be prohibited from having a proprietary interest of any kind in a pharmacy, and the Member shall have 60 days from the date of this Order to divest herself of any such proprietary interests, at which time the three year period shall commence;
 - iii. following the expiry of the three-year period referred to in subparagraph (b) above, the Member’s practice and all activities at any pharmacies in which the Member has a proprietary interest of any kind shall be monitored for a period of two (2) years by the College, by means of practice assessments by a representative or representatives of the College in such number and at such time or times as the College may determine. The practice assessments may be in addition to any of the routine inspections conducted by the College pursuant to the authority of section 148 of the Drug and Pharmacies Regulation Act. The Member shall cooperate with the College during the practice assessments and, further, shall pay to the College in respect of the cost

of monitoring, the amount of \$1000.00 per assessment, such amount to be paid immediately after completion of each of the assessments, with the total amount paid by the member not to exceed \$10,000.00, regardless of the number of assessments;

- iv. for a period of five years from the date the Order is imposed, the Member shall be prohibited from:
 - 1. acting as a Designated Manager in any pharmacy; and,
 - 2. receiving any remuneration for her work as a pharmacist other than remuneration based on hourly or weekly rates only or (subject to paragraph (b) above) by reason of having a proprietary interest in a pharmacy;
- v. for a period of five years from the date the Order is imposed, the Member shall be required to notify the College in writing of the name(s), address(es) and telephone number(s) of all pharmacy employer(s) within fourteen days of commencing employment in a pharmacy;
- vi. for a period of five years from the date the Order is imposed, the Member shall provide her pharmacy employer with a copy of the Discipline Committee Panel’s decision in this matter and its Order; and
- vii. for a period of five years from the date the Order is imposed, the Member shall only engage in the practice of pharmacy for an employer who agrees to write to the College within fourteen days of the Member’s commencing employment, confirming that it has received a copy of the required documents identified above, and confirming the nature of the Member’s remuneration;
- (iv) Costs to the College in the amount of \$15,000.

In its reprimand, the Panel noted that the Member failed to maintain the responsibilities and obligations expected of her as a member of this profession. The Panel indicated that the volume of unsubstantiated claims over a two-year period of time, which amounted to \$162,000, is an example of her disregard for the trust that has been placed in her by the public and the profession.

The Panel pointed out that the Member billed claims on behalf of another pharmacy, falsified pharmacy records, and failed as designated manager to

participate in the day to day management of the pharmacy, and related that these actions are not acceptable for a member of this profession.

The Panel explained that pharmacy is a self-regulated profession and that pharmacists bear the responsibility to ensure that they maintain the trust of the public and of members. The Panel noted that the practice of pharmacy is a privilege and comes with significant obligations to the public, the profession, and oneself.

The Panel expressed its expectation that, in the future, the Member will practice pharmacy within the standards of this profession, and that she will take this opportunity to reflect on her actions and complete the required remediation. The Panel related its further expectation that, in doing so, she will change the way she practices and will not appear again before a panel of the Discipline Committee.

John Shenouda (OCP #218737)

At a hearing on December 5, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Shenouda with respect to the following incidents:

- He disclosed personal health information of the Pharmacy’s patients by posting prescriptions on Facebook, without consent or other authorization, in respect of:
 - i. [Patient 1], in or about February, 2016;
 - ii. [Patient 2], on or about February 20, 2015; and/or
 - iii. [Patient 3], on or about March 31, 2016;
- He inappropriately consulted on Facebook about prescriptions for the Pharmacy’s patients, instead of with the physicians and other appropriate resources, in respect of:
 - i. [Patient 1], in or about February, 2016;
 - ii. [Patient 2], on or about February 20, 2015; and/or

- iii. [Patient 3], on or about March 31, 2016; and/or
- On or before May 11, 2016, the Pharmacy’s website made the following offers:
 - i. “Transfer your prescription today and get your gift”; and/or
 - ii. “Thursday Special – Hollandview Pharmacy waives the dispensing fee for all patients who do not have drug plans.”

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession
- Offered or distributed, directly or indirectly, a gift, rebate, bonus or other inducement with respect to a prescription or prescription services
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable and unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member’s Certificate of Registration requiring:
 - (a) that the Member successfully complete, within six (6) months of the date of the order, a course with Gail E. Siskind Consulting Services, or another professional ethics consultant chosen by the College, to be designed by the consultant, for the purpose of addressing the professional and ethical obligations with respect to confidentiality of personal health information; and the following terms shall apply to the course:
 - (i) the number of sessions shall be at the discretion of the consultant, but shall be at least 3 meetings;
 - (ii) the manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member

and the consultant, but shall ultimately be at the discretion of the consultant;

- (iii) the Member shall be responsible for the cost of the course;
- (iv) the Member shall provide to the consultant the following documents, in advance of the course, to facilitate the design of the course:
 - a) the Notice of Hearing;
 - b) the Agreed Statement of Facts;
 - c) this Joint Submission on Order; and
 - d) the Panel's Decision and Reasons, if and when available; and
- (v) the Member will request a report from the consultant confirming that the Member has completed the course to the satisfaction of the consultant, and the Member will provide a copy of the report to the College within six (6) months of the date of this Order;

(b) that the Member:

- (i) retain, at the Member's expense, a practice mentor acceptable to the College, within three (3) months of the date of this Order;
- (ii) meet at least three (3) times with the practice mentor, at the Member's place of practice, for the purpose of observing him interacting with patients during the dispensing process and to assess his clinical knowledge and judgment, and to identify areas in the Member's practice with respect to these issues that require remediation;
- (iii) the Member shall provide the practice mentor the following documents in advance of the meetings, to facilitate the design of a learning plan:
 - a) the Notice of Hearing;
 - b) the Agreed Statement of Facts;
 - c) this Joint Submission on Order; and

d) the Panel's Decision and Reasons, if and when available;

- (iv) develop a learning plan, together with the mentor, to address the areas requiring remediation;
 - (v) demonstrate to the practice mentor that the Member has achieved success in meeting the goals established in the learning plan; and
 - (vi) request a report from the practice mentor to report the results of the mentorship meetings to the Manager, Investigations and Resolutions at the College, after their completion, which shall be no later than twelve (12) months from the date of this Order;
- (c) that the Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in subparagraphs 2(a) and 2(b) if the Registrar is of the view that it would be in the interests of fairness to do so and that it would not be contrary to the College's mandate to serve and protect the public interest.

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of three (3) months, with two (2) months of the suspension to be remitted on condition the Member complete the ethics course and mentorship program as specified in subparagraphs 2(a) and 2(b) above. The suspension shall commence on January 4, 2018 and continue without interruption until February 3, 2018. If the remitted portion of the suspension has to be served because the Member fails to complete the course specified in paragraph 2(a) as required, then the further suspension shall commence on June 5, 2018 and shall continue to run without interruption until August 4, 2018, inclusive. If the remitted portion of the suspension has to be served because the Member fails to complete the mentorship specified in paragraph 2(b) as required, then the further suspension shall commence on December 5, 2018 and shall continue to run without interruption until February 4, 2019, inclusive. In either case, if the time for completing the remedial steps in subparagraphs 2(a) and 2(b) above is extended by the Registrar, the date on which the remitted portion of the suspension shall commence, if required, shall be adjusted accordingly.

4. Costs to the College in the amount of \$5,000.

In its reprimand, the Panel noted that pharmacy is a self regulated profession, which bears the responsibility to ensure that the trust of members is maintained and the public served. The practice of pharmacy is a privilege, which carries

with its significant obligations to the public, the profession, and to oneself.

The Panel expressed its view that the misconduct to which the Member admitted is unacceptable to the public and to his fellow pharmacy professionals. Of particular concern to the Panel was the fact that the Member's misconduct involved patient privacy breaches and the offering of inducements for the purpose of soliciting patients. The Panel indicated that Facebook is not a private forum. Facebook, and other online forums, should never take the place of proper consultation with other healthcare professionals within the circle of care.

The Panel expressed its trust that the Member now realizes the importance of this responsibility as a member of this College and that he will benefit from the remediation in which he has agreed to participate. The Panel voiced its confidence that the Member will return to the profession with more honour and integrity, and that he will not appear before a panel of the Discipline Committee again.

Jayant Patel (OCP #96288)

At a hearing on November 1, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Patel with respect to the following incidents, in that he:

- Failed to comply with the decision of the Inquiries, Complaints and Reports Committee dated September 16, 2015 ("ICRC decision") requiring him to complete a specified continuing education or remediation program ("SCERP") by September 16, 2016;
- Failed to access and read encrypted email communications sent to him by the College regarding the ICRC decision and SCERP on September 16, 2015; October 20, 2015; March 15, 2016; and/or October 7, 2016;
- Failed to respond to the College's inquiries to him regarding the ICRC decision and SCERP by telephone messages left for him on May 4, May 10, October 4, October 5 and/or October 6, 2016; and/or
- Failed to comply with the commitment he communicated to the College by email on September 29, 2016 that he would ensure he completed the SCERP as soon as possible and provide confirmation to the College that he had.

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional

After further arguments with respect to the Order to be made which were heard on December 14, 2017, the Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to suspend the Member's Certificate of Registration for a period of twelve (12) months or until such time as the Member successfully completes the remedial components set out in paragraphs 3(a), 3(b), and 3(c), below, whichever is later. The suspension shall commence on the date this Order becomes final.
3. Directing the Registrar to impose the following specified terms, conditions or limitations on the Member's Certificate of Registration:
 - a. the Member shall complete successfully, within twelve (12) months from the date this Order becomes final, a remedial program with Gail E. Siskind Consulting Services or another professional ethics consultant to be chosen by the College ("the Consultant"), to be designed by the consultant, regarding the issues raised by the facts and findings of professional misconduct in this case; and the following terms shall apply to the course:
 - i. the number of sessions shall be at the discretion of the Consultant, but shall be a minimum of three (3) meetings.
 - ii. the manner of attendance at the sessions shall be in person.
 - iii. the Member shall be responsible for the cost of the program.
 - iv. the Member shall provide to the Consultant the following documents, in advance of the program, to facilitate the design of the program:
 1. the Notice of Hearing;

- 2. the Agreed Statement of Facts; and
- 3. the Panel’s Decision and Reasons, if and when available; and
- v. the Member will request a report from the Consultant confirming that the Member has completed the course to the satisfaction of the Consultant, and the Member will provide a copy of the report to the College within twelve (12) months of the date this Order becomes final;
- b. the Member shall complete successfully, at his own expense, within twelve (12) months of the date this Order becomes final, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals by the Center for Personalized Education for Physicians, with an unconditional pass, and the Member shall provide the College with confirmation of such within twelve (12) months of the date this Order becomes final.
- c. the Member shall complete successfully, at his own expense, the Jurisprudence exam offered by the College within twelve (12) months of the date this Order becomes final.
- d. the Member shall complete successfully the Medication System Safety Review for a Community Pharmacist On-Site Assessment program offered by the Institute for Safe Medication Practices Canada, at his own expense, within twelve (12) months following the end of the suspension referred to in paragraph two (2), above.
- e. the Member shall be prohibited, for a period of twenty-four (24) months following the end of the suspension referred to in paragraph two (2), above, from acting as a Designated Manager in any pharmacy.
- f. the Member’s practice shall be monitored by the College by means of practice reviews for a period of twenty-four (24) months following the end of the suspension referred to in paragraph two (2), above. The practice reviews shall be conducted by a representative(s) of the College at such time(s) as the College may determine, to a maximum of four (4) reviews. The Member shall cooperate with the College and its representative(s) during the practice reviews, which shall be at the Member’s expense, up to a maximum of one thousand

dollars (\$1,000.00), per review to be paid immediately after the completion of each practice review. The Member shall complete any reassessments, learning plans or other follow-up steps arising from the practice review, as required, and within the timelines required by the practice review.

- g. the Registrar is empowered, in her discretion, to grant a request for an extension of time, of up to twelve (12) months, to complete the remedial steps set out in paragraphs 3(a), 3(b) and 3(c), if the Registrar is of the view that it would be in the interest of fairness to do so and that it would not be contrary to the College’s mandate to serve and protect the public interest. If the Registrar grants such an extension, the Member’s certificate of registration will remain suspended in the manner described in paragraph two (2), above.

4. Costs to the College in the amount of twenty thousand dollars (\$20,000.00).

In its reprimand, the Panel noted that integrity, trust, and professional conduct are the core of the practice of pharmacy and the delivery of care to the public, and that, in return, the profession is held in high regard by the people of Ontario. The Panel indicated that pharmacy is a self-regulated profession and, as such, it bears the responsibility to ensure that it maintains the trust of its members and the public it serves.

The Panel expressed its view that the Member’s conduct showed persistent disregard to the College, which may put the public at risk. It is a fundamental expectation that all members respond to enquiries of the College in a timely manner.

The Panel voiced its expectation that when a member of the profession indicates to their regulator that they will comply with an order made by their regulator, that they will do so. The Panel pointed out that the Member has clearly failed to do so, and has let the profession down.

The Panel expressed its hope that the Member has learned from these experiences, and that he will take this opportunity to reflect on his actions and complete the required remediation. In doing so, the Panel expects that the Member will change the way he relates and responds to his regulator.

The Panel noted its expectation that the Member will not appear again before a panel of the discipline committee.

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