Dr. Ashwani NARANG

Council Decision

Date Charge(s) Laid:	September 26, 2020
Outcome Date:	September 17, 2021
Hearing:	Completed
Disposition:	Reprimand, Suspension, Conditions, Costs

The Council of the College of Physicians and Surgeons of Saskatchewan imposes the following penalty on Dr. Ashwani Narang pursuant to *The Medical Profession Act, 1981* (the "Act"):

1) Pursuant to Section 54(1)(e) of the Act, the Council hereby reprimands Dr. Narang. The format of that reprimand will be in written format.

2) Pursuant to Section 54(1)(b) of the Act, the Council hereby suspends Dr. Narang for a period of 3 months, such suspension to commence on the 20 September, 2021.

3) Pursuant to Section 54(1)(g) of the Act, the Council requires that Dr. Narang successfully complete a course on medical ethics and professionalism, to be approved in advance by the Registrar, and provide proof of completion. Such course shall be completed at the first available date, but in any case within six months. The courses "Medical Ethics, Boundaries and Professionalism" by Case Western Reserve University, "Probe Program" by CPEP and "Medical Ethics and Professionalism" by PBI Education are ethics programs acceptable to the Registrar.

4) Pursuant to Section 54(1)(g) of the Act, the Council requires that Dr. Narang successfully complete the CMPA online course "Privacy and Confidentiality" within three months, and that he provide proof of successful completion.

5) Pursuant to Section 54(1)(g) of the Act, the Council requires that Dr. Narang successfully complete the Corridor Interactive course "Privacy Awareness in Health Care Training – Canada" within three months, and that he provide proof of successful completion.

6) Pursuant to Section 54(1)(i) of the Act, the Council directs Dr. Narang to pay the costs of and incidental to the investigation and hearing in the amount of $23,597.96. Such payment shall be made in full by January 17, 2022.

7) Pursuant to Section 54(2) of the Act, if Dr. Narang should fail to pay the costs as required by paragraph 6, Dr. Narang's licence shall be suspended until the costs are paid in full.

8) The Council reserves to itself the right to reconsider and amend any of the terms of this penalty decision, upon application by Dr. Narang. Without limiting the authority of the Council, the Council may extend the time for Dr. Narang to pay the costs required by paragraph 6.

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REGISTRAR
KAREN SHAW, M.D.

PERSONAL AND CONFIDENTIAL

22 November, 2021

Dr. A. Narang
[redacted]

Dr. Narang,

On September 17, 2021, the Council of the College of Physicians and Surgeons of Saskatchewan accepted your admission of guilt to charges of misconduct. Following deliberation, penalty was determined partly based on the joint recommendation presented on your behalf by counsel for yourself and the College. One component of that penalty was an official reprimand by the Council.

> *You, Dr. A Narang, having been found guilty of professional misconduct while practicing medicine in the province of Saskatchewan are hereby reprimanded by the Council of the College of Physicians and Surgeons of Saskatchewan.*

You inappropriately accessed the electronic medical records of a number of individuals from the same extended family for personal reasons. You also accessed the records of another group of individuals to whom you have no physician-patient relationship. Some of those individuals were co-workers and their family members. This is a significant breach of the trust reposed on you as a physician. Your actions have had a negative and significant impact on these individuals and in some cases, caused awkward working conditions especially within the context of a small community.

Continued……..

One of the most important statutory functions of the Council is the protection of the public. One of the ways Council achieves this end is to ensure that its members maintain a high standard of ethical and professional behaviour at all times. Your actions fell below that standard. Council therefore considers your actions grievous and unacceptable.

Council considered the mitigating factors put forward by your counsel. Council recognizes that this incident occurred in the early stages of your practice in Saskatchewan; that you accepted full responsibility for your actions and pled guilty for your conduct at the earliest opportunity. Council however considers the issue of privacy and confidentiality so foundational to the practice of medicine that a lack of formal HIPA training is not an acceptable excuse to accessing personal health information inappropriately.

It is the hope of Council that you will reflect and learn from this experience. Council expects that you will not only maintain the utmost professional and ethical standards going forward but that you will work diligently to regain the trust of your colleagues, co-workers and the community you serve.

Council of The College of Physicians and Surgeons of Saskatchewan

In the Matter of a Penalty Hearing before

the Council of the College of Physicians and Surgeons of Saskatchewan

and Dr. Ashwani Narang

September 17, 2021

Summary of the Decision

Dr. Narang appeared before the Council for a penalty hearing on September 17, 2021. Dr. Narang was represented by Ms. Anita Fraser. Ms. Sheila Torrance presented the penalty position of the Registrar's Office.

Dr. Narang admitted to unprofessional conduct in the charge laid by the Council. The conduct which he admitted was accessing the personal health information of a number of individuals when he did not have a patient-physician relationship with them, did not have their consent, and either did not have a legitimate need to know the information or did not exercise due diligence to ensure he had a legitimate need to know the information accessed. The penalty order included a reprimand, a 3-month suspension, the requirement to complete several courses and the payment of costs.

The charge admitted by Dr. Narang

Dr. Narang signed an admission which stated:

> I, Dr. Ashwani Narang, pursuant to section 49 of **The Medical Profession Act, 1981**, admit that I am guilty of unbecoming, improper, unprofessional or discreditable conduct as set out in the charge laid by the Council of the College of Physicians and Surgeons of Saskatchewan which charge states:
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> *The Council of the College of Physicians and Surgeons directs that, pursuant to section 47.5 of **The Medical Profession Act, 1981**, the Discipline Committee hear the following charge against Dr. Ashwani Narang:*
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> *You Dr. Ashwani Narang are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or section 46(p) of **The Medical Profession Act, 1981**, S.S. 1980-81, c. M-10.1, and/or bylaw 8.1(b)(viii), and/or paragraph 31 and/or paragraph 32 and/or paragraph 33 of the Code of Ethics contained in bylaw 7.1 of the bylaws of the College of Physicians and Surgeons of Saskatchewan. The evidence that will be led in support of this charge will include some or all of the following:*
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> 1. *During the period December 1, 2018 to March 31, 2019, you accessed the personal health information of a number of individuals (referred to as "the*

individuals") through the electronic medical record of the Rosetown & District Primary Care Centre;

2. *At the time of accessing those records, you did not have a physician-patient relationship with the individuals.*
3. *You accessed the personal health information of the individuals without their consent.*
4. *You accessed the personal health information of the individuals without a legitimate need to know the information, and/or you failed to exercise due diligence to ensure you had a legitimate need to know the individuals' personal health information that you accessed.*

Agreed Statement of Facts

Dr. Narang and the Registrar's Office provided an agreed statement of facts, which stated:

Agreed Statement of Facts

Dr. Ashwani Narang and the Registrar's Office of the College of Physicians and Surgeons of Saskatchewan (CPSS) agree to the following facts to be considered at the penalty hearing of Dr. Narang without further proof. With respect to the information contained in paragraphs 5-8 and 18, the CPSS is not able to confirm or deny the information but accepts it for the purposes of the penalty hearing.

1. On September 24, 2018, CPSS issued a provisional licence with restrictions to Dr. Narang. Dr. Narang is supervised by Dr. Cooper of Beechy.
2. Dr. Narang received his medical training in India and practiced in both India and the Middle East, before he moved to the United States of America, where he completed qualifying examinations.
3. Dr. Narang moved to Canada in March 2018 and commenced the SIPPA Program in May 2018. He completed the SIPPA Program in August 2018 and started practicing family medicine at the Rosetown & District Primary Health Centre (the "Clinic") on September 24, 2018.
4. The Clinic is operated jointly by Dr. Narang, Dr. Olawale Igbekoyi and the Saskatchewan Health Authority (SHA). It has an Accuro EMR with a common database.
5. On joining the Clinic, Dr. Narang did not receive an orientation or any privacy training from SHA, Dr. Igbekoyi or Dr. Cooper. Further, Dr. Narang did not receive any training on the Accuro EMR from SHA.
6. Dr. Narang did not receive any training on Accuro EMR and minimal information on privacy through the SIPPA Program. He was generally aware of the importance of patient privacy but there were gaps in his knowledge and understanding.
7. When Dr. Narang started at the Clinic, he tried to familiarize himself with the Accuro EMR through trial-and-error and his interactions with the Clinic's Medical Office Assistants (MOAs). He did not have an 'administrator' account for the Accuro EMR, but his account afforded him access to personal health information (PHI) for all patients.

8. In March 2019, Dr. Narang raised concerns about the scheduling of patients for SGI medicals with the MOAs. During this discussion, he disclosed the fact that he had viewed some patient records in the Clinic EMR for purposes of examining his concerns. Thereafter, the MOAs contacted SHA and raised concerns about Dr. Narang's privacy practices.
9. In April 2019, a SHA Privacy and Access Officer audited Dr. Narang's activity in the Clinic EMR from December 1, 2018 to the end of April 2019. The SHA Privacy and Access Officer identified 21 individuals whose PHI had been accessed but were not patients of Dr. Narang.
10. The SHA Privacy and Access Officer investigated and concluded that there were privacy breaches affecting 20 individuals. SHA notified these individuals by letter and reported the matter to the Office of the Saskatchewan Information and Privacy Commissioner (OSIPC) and CPSS.
11. In July 2019, CPSS received complaints from 5 of the 20 affected individuals.
12. On August 7, 2019, Dr. Narang responded to CPSS and relying on his memory, identified the reasons he accessed nine of the 21 individuals. Dr. Narang provided CPSS with apology letters for the five complainants, which CPSS distributed on his behalf.
13. On August 28 and 29, 2019, Dr. Narang received further audit information from SHA to assist him in identifying the reasons he accessed the 20 individuals' PHI. In the process of compiling this further audit information, SHA identified three additional affected individuals, who were then notified by SHA.
14. CPSS formed a Preliminary Inquiry Committee (PIC) to investigate the matter and on July 10, 2020, the PIC released its report. The PIC categorized its findings as follows:
    a. **Appropriate access:** 1 individual, 2 occasions.
    b. **Appropriate access and possible inadvertent accesses:** 1 individual, 3 occasions (appropriate on 1 occasion and possibly inadvertent on 2 occasions).
    c. **Possible inadvertent accesses:** 3 individuals, 3 occasions.
    d. **Appropriate and inappropriate accesses:** 1 individual, 2 occasions.
    e. **Inappropriate and possible inadvertent accesses:** 1 individual, 3 occasions (inappropriate on 1 occasion and possibly inadvertent on 2 occasions)
    f. **Inappropriate accesses**: 16 individuals, 20 occasions.
        i. Dr. Narang accessed PHI for 9 of these 16 individuals in connection with events involving his teenage daughter, outlined below.
15. The average duration of the above-noted occasions with inappropriate accesses was one minute, with a range of 10 seconds to 7 minutes.
16. On or about September 8, 2020, the CPSS received a complaint from one of the three additional affected individuals ("Patient [redacted]") identified by SHA in August 2019. Dr. Narang accessed personal health information for Patient [redacted] on one occasion on March 10, 2019; the access lasted 29 seconds.

17. On or about September 26, 2020, the Council charged Dr. Narang with unprofessional conduct for accessing the PHI without a need to know and/or failing to exercise due diligence to ensure he had a legitimate need to know the individuals' personal health information that he accessed.
18. On January 23, 2019, Dr. Narang's teenage daughter failed to return home as expected, and she was not answering her cellphone. Dr. Narang grew more worried and thought his daughter may be at the home of a male schoolmate. Dr. Narang only knew the schoolmate's surname, and in an effort to find the schoolmate's home address, Dr. Narang accessed records for 9 individuals with his surname. Dr. Narang ultimately obtained the schoolmate's home address from an MOA, who also had a teenage daughter. Dr. Narang accessed records for 4 of these 9 individuals again on January 31, 2019, to confirm the names of the schoolmate and his parents and try and locate a telephone number. His daughter had continued to see the schoolmate and he wanted to telephone the schoolmate's parents to discuss their relationship.
19. Dr. Narang accepts the above-noted findings made by the PIC. In connection with events on January 23, 2019 and January 31, 2019, he acknowledges that he accessed PHI for 9 individuals without their consent and for a purpose not authorized pursuant to *The Health Information and Protection Act* (HIPA). Regarding the remaining individuals and Patient [redacted], Dr. Narang acknowledges that he accessed PHI without the individuals' consent, and he is unable to identify a purpose authorized under HIPA. He further accepts that he did not have a physician-patient relationship with any of the individuals.
20. Dr. Narang cooperated fully with the College's investigation, and the earlier investigation conducted by SHA.
21. Dr. Narang is audited regularly by SHA. There is no evidence from these ongoing audits that Dr. Narang has accessed any PHI inappropriately since March 10, 2019.
22. In May 2019, Dr. Narang completed a CME course on record keeping and now makes a note in the Clinic EMR or creates a task whenever he accesses a record. Dr. Narang also completed a CME course on Privacy and HIPA and has reviewed resources available on the OSIPC website. Both courses were identified and completed on his own initiative.
23. Dr. Narang is extremely remorseful for these events and he recognizes that violating privacy destroys trust, both for the individual physician and the profession as a whole.
24. Understandably, these events have negatively impacted Dr. Narang's standing in the Rosetown community and Dr. Narang is working to regain residents' trust.
25. On or about June 22, 2021, Dr. Narang provided a signed admission of the above-noted charge.

Points in Issue

Dr. Narang and the Registrar's Office did not agree on the appropriate length of suspension. The Registrar's Office took the position that the appropriate range of suspension is from 1to 3 months, while Dr. Narang submits that the facts in the case warrant a suspension of no longer than one month.

The Positions taken by the Parties

The parties jointly submit that the penalty order should include the following:

1) A reprimand in the form directed by the Council (either written or in person at a future Council meeting);
2) Successful completion of a course on medical ethics and professionalism (such as PBI Medical Ethics and Professionalism);
3) Successful completion of the CMPA online course "Privacy and Confidentiality";
4) Successful completion of the Corridor Interactive course "Privacy Awareness in HealthCare Training – Canada";
5) Payment of costs in the amount of $23,597.96, such payment to be made by January 17, 2022.

The Registrar's Office provided a number of case law as listed in document Info 177-21. Based on the analysis of the case law, the Registrar's Office took the position that the appropriate range of suspension should be 1 to 3 months. The *CNO v Evoy* cases involved access of the records of 11 patients, some of whom were colleagues or their family members. This resulted in a 3-month suspension. While none of the cases are exactly the same as Dr. Narang's, at least some of the individuals whose PHI was accessed were known to Dr. Narang. He admitted the deliberate access on two separate dates of the PHI of 9 individuals for a personal reason (related to his daughter spending time with a boy with the same family name). He also accessed PHI for several co-workers, their family members, and a public figure. This is a significant breach of trust. There is no evidence of disclosure, which would have certainly been an aggravating factor.

Dr. Narang also provided cases law, as listed in document Info 178-21, from other regulatory bodies in Canada, which were not cited by the Registrar's Office. Dr. Narang took the position that some of the cases cited by the Registrar's Office had distinguishing and mitigating factors compared to Dr. Narang's case. These are that Dr. Narang made no surreptitious efforts to hide access, he completed relevant courses proactively, he is an IMG new to Canada, he had no privacy training, he had no prior record of discipline, he has no personal relationship with any of the individuals and there was no indication he accessed very sensitive PHI. The underlying conduct was significantly different from the case of *CPSO v Dr. Kaveri*.

With regards to the nature and gravity of the proven allegations, the Registrar's Office took the position that given the number of affected individuals, particularly in the context of a small community, the conduct was very serious and had a significant impact on at least some of the affected individuals. In addition, the Registrar's Office directed Council to the Victim Impact Statements provided by a number of the affected individuals. It is evident that this conduct by Dr. Narang has had a lasting impact on these individuals' trust in the system, their willingness to share information with their physicians, and in the case of [redacted]., had a very negative impact

on [redacted] work environment [redacted].

Dr. Narang took the position that he readily acknowledges that in improperly accessing the individuals' PHI, he breached their privacy. He acknowledges that breaching privacy destroys trust, both for the individual physician, but also for the medical profession as a whole. He has reviewed and reflected on the Victim Impact Statements provided by the Registrar's Office. He is committed to rebuilding trust through dedication to his profession, the community, and ensuring his patients receive the best possible medical care. [redacted]

The Registrar's Office took the position that incidents such as these serve to increase concern among the public about the security of personal health information. It is essential that the penalty serves to demonstrate to the public that this conduct is very serious, and that the consequences of such conduct will have a significant impact on Dr. Narang's continued practice.

Dr. Narang took the position that these events have negatively impacted Dr. Narang's standing in the Rosetown community and Dr. Narang is working to regain the residents' trust. Dr. Narang recently renewed his contract with the SHA and looks forward to serving the residents of Rosetown for several more years.

Both parties submitted an agreed statement of facts that contained most of the mitigating factors in this case.

Decision of Council

> *The Council of the College of Physicians and Surgeons of Saskatchewan imposes the following penalty on Dr. Ashwani Narang pursuant to The Medical Profession Act, 1981 (the "Act"):*
>
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completed at the first available date, but in any case within six months. The courses "Medical Ethics, Boundaries and Professionalism" by Case Western Reserve University, "Probe Program" by CPEP and "Medical Ethics and Professionalism" by PBI Education are ethics programs acceptable to the Registrar.
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7) Pursuant to Section 54(2) of the Act, if Dr. Narang should fail to pay the costs as required by paragraph 6, Dr. Narang's licence shall be suspended until the costs are paid in full.
8) The Council reserves to itself the right to reconsider and amend any of the terms of this penalty decision, upon application by Dr. Narang. Without limiting the authority of the Council, the Council may extend the time for Dr. Narang to pay the costs required by paragraph 6.

Information Considered by Council in Establishing Penalty

1) Written submissions and arguments brought by the Registrar's Office (Info 177_21)
2) Written submissions and arguments brought by Counsel for Dr. Narang (Info 178_21)
3) Written and verbal victim impact statements
4) Letters of apologies to victims submitted by Dr. Narang
5) Verbal address to Council by Dr. Narang

Reasons for Decision

Council deliberated on this matter. Dr. Narang had admitted unprofessional conduct. The main focus of the deliberation was on the length of suspension. Council considered and accepted the mitigating factors put forward by Dr. Narang, including the fact that he had no previous disciplinary record and the fact that he admitted the charges and cooperated fully with the College's investigation. It however could not accept as a mitigating factor the fact that he presumably did not have HIPA training, either through the SIPPA program or the SHA when he started work. It is Council's opinion that the issue of privacy and confidentiality is so foundational and inertly ingrained into the ethos of the medical profession that it is difficult to accept that any physician graduating from any medical school listed on the FAIMER's World Directory of Medical Schools would not understand that it is unprofessional to access patients' personal health information other than for the purpose of providing care to the patient. It is even more egregious when the access is for the physician's own personal benefit. Furthermore, Dr.

Narang opines that he did not have formal training on electronic medical records (EMR) as his medical training was in India where medical records are kept in printable or paper form. Council rejected this as a mitigating factor. The fundamental issue is not the format that records are kept but the breach of access to those records. Dr. Narang however accepted during questioning by Council that medical records should not be treated differently based on the format they are stored in; printable or electronic form.

Council also noted that like most physicians in Saskatchewan, he presumably had access to other electronic platforms where patients' health information is stored (PACS and eHealth). All users sign a confidentiality agreement before gaining access to these platforms. It is basic knowledge that accessing patient health information, except for the purposes of providing care, is unprofessional.

Council considered cases law provided by Dr. Narang and the Registrar's Office. It noted that no particular case was similar to this case in its entirety. The range of suspension was between 1 to 5 months. Council therefore did not put a lot of weight on the case law cited.

Council is well aware of its statutory function to protect the public. Incidences such as this erode the public's confidence in the medical profession and can deter patients from providing personal health information to healthcare providers that is necessary for their care. Council agreed that a suspension is appropriate as a general deterrence. It considered the negative consequences of Dr. Narang's action on a small community like the one he practices in and the public in general, the effects of his action on the victims as eloquently stated in the Victim Impact Statements and the awkward working relationship and additional stress he placed on his co-workers. Council considered all the factors in this case and decided that a 3 month suspension was justifiable.

It is Council's routine practice to issue a reprimand to physicians found guilty of professional misconduct. A written reprimand was acceptable in this case.

Accepted by the Council of the College of Physicians and Surgeons of Saskatchewan: 20 November, 2021