



Dr. Mukhtar ALI

Charges

Date Charge(s) Laid:	September 26, 2026
Charge(s) Amended:	N/A
Hearing:	Pending
Charge(s):	Unprofessional Conduct
Outcome Date:	To be determined

NOTE: Allegations of unprofessional conduct as set out in the charge below have been referred to the discipline committee. The allegations in the charge have not been admitted, nor has there been a hearing before the discipline committee to determine whether the allegations in the charge will be proved.

A physician who denies some or all of the allegations in a charge is entitled to a hearing before the discipline committee to determine if the allegations in the charge are established by the evidence at the hearing.

CHARGE 1

You Dr Mukhtar Ali 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

The evidence that will be led in support of this charge will include one or more of the following:

1. On November 16, 2024, you were the Area Department Lead for Emergency Medicine at Lloydminster Hospital.
2. On November 16, 2024, you were an emergency room physician practising at Lloydminster Hospital.
3. On November 16, 2024 CT services were unavailable at Lloydminster Hospital.
4. On November 16, 2024 a patient identified in this charge as R.O. was injured in a motor vehicle accident.
5. On November 16, 2024, following a multi-casualty motor vehicle collision, you represented to staff that Lloydminster Hospital was on bypass, or otherwise conveyed that trauma patients should be transported to North Battleford rather than Lloydminster Hospital.
6. In particular, you advised, or caused staff to understand, that a patient identified as R.O. should not be transported to Lloydminster Hospital and should instead be transported to North Battleford.

7. On November 16, 2024 R.O. died while being transported by ambulance to the hospital in North Battleford.
8. You failed to fulfill your professional responsibilities as Area Department Lead for Emergency Medicine at Lloydminster Hospital by promoting, supporting, or acquiescing in the practice of diverting trauma patients away from Lloydminster Hospital during periods of CT service disruption rather than ensuring such patients were assessed and stabilized in accordance with accepted trauma-care practices and applicable Saskatchewan Health Authority policies.
9. You failed to fulfill your professional responsibilities as an emergency physician by promoting, supporting, or acquiescing in the practice of diverting trauma patients away from Lloydminster Hospital during periods of CT service disruption rather than ensuring such patients were assessed and stabilized in accordance with accepted trauma-care practices and applicable Saskatchewan Health Authority policies.
10. You participated in discussions and meetings in which you advocated that trauma patients requiring CT imaging should be transported directly to facilities with CT capabilities rather than first being assessed and stabilized at Lloydminster Hospital.
11. You advocated for practices that were inconsistent with Saskatchewan Health Authority policy CS-CP-0041, which provided that a disruption to radiography services alone shall not result in an emergency department service disruption.
12. As Area Department Lead for Emergency Medicine at the Lloydminster Hospital, you failed to provide appropriate leadership and direction regarding the management of trauma patients during CT service disruptions and failed to ensure that physicians and staff had clear expectations respecting the assessment, stabilization, and management of trauma patients.
13. As an emergency room physician practising at Lloydminster Hospital, you failed to provide appropriate leadership and direction regarding the management of trauma patients during CT service disruptions and failed to ensure that physicians and staff had clear expectations respecting the assessment, stabilization, and management of trauma patients.
14. Your conduct contributed to ongoing uncertainty regarding the assessment, stabilization, and transfer of trauma patients during CT service disruptions.
15. Through the foregoing actions and omissions, you failed to fulfill your responsibilities as an emergency physician in relation to trauma care during CT service disruptions.
16. Through the foregoing actions and omissions, you failed to fulfill your responsibilities as an Area Department Lead for Emergency Medicine in relation to trauma care during CT service disruptions.
17. You failed to consider first the well-being of patients to always act to the benefit of patients and to promote the good of patients as required by bylaw 7.1.
18. You failed to provide appropriate care and management across the care continuum as required by bylaw 7.1.
19. You failed to take all reasonable steps to prevent or minimize harm to patients as required by bylaw 7.1.
20. You failed to provide whatever appropriate assistance you could to R.O., who needed emergency medical care as required by bylaw 7.1 paragraph 8.

21. You failed to espouse behaviours that contributed to a positive practice culture as required by bylaw 7.1 paragraph 34.
22. You failed to act, speak, and otherwise behave in the healthcare workplace in a way that promoted safety, high quality patient care and effective collaboration with others on the healthcare team as required by bylaw 7.2 paragraph (a).
23. You failed to ensure patient care and safety assumed the highest priority in the clinical setting as required by bylaw 7.2 paragraph (a).
24. You failed to not accept any arrangement that limited your responsibility to practise medicine ethically and competently as required by bylaw 7.2 paragraph (h).
25. You failed to maintain the standards of practice of the profession contrary to bylaw 8.1(b)(ix).

CHARGE 2

You Dr Mukhtar Ali 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

The evidence that will be led in support of this charge will include one or more of the following:

1. On November 16, 2024, you were the Area Department Lead for Emergency Medicine at Lloydminster Hospital.
2. On November 16, 2024, you were an emergency room physician practising at Lloydminster Hospital.
3. On November 16, 2024 a patient was brought to the emergency department at Lloydminster Hospital after being injured in a motor vehicle accident.
4. The patient was accompanied by a paramedic, referred to in this charge by the initials V.S.
5. You made comments to the effect that you were upset that V.S. had brought his patient to the Lloydminster E.R. and that he should not have done so.
6. You spoke to V.S. in a manner that was scolding, disrespectful and/or dismissive;
7. You would not listen to V.S. when he attempted to provide a clinical handover summary or report for the patient.
8. You would not allow V.S.'s patient to be transferred from the Medavie stretcher to a hospital bed.
9. You made comments to the effect that V.S. would need to stay and wait to take the patient from the hospital.
10. You failed to meet the standards of the profession and failed to communicate respectfully with paramedic staff who brought the patient to the Lloydminster hospital.
11. You failed to demonstrate compassion as required by bylaw 7.1.
12. You failed to consider first the well-being of the patient as required by bylaw 7.1.

13. You failed to treat colleagues with dignity and as persons worthy of respect as required by bylaw 7.1 paragraph 31.
14. You failed to take responsibility for promoting civility within and beyond the profession as required by bylaw 7.1 paragraph 33.
15. You failed to support interdisciplinary team-based practices and foster team collaboration as required by bylaw 7.1 paragraph 36.
16. You failed to contribute, where it was appropriate, to the development of a more cohesive and integrated health system through inter-professional collaboration and, when possible, collaborative models of care as required by bylaw 7.1 paragraph 42.
17. You failed to act, speak, and otherwise behave in the healthcare workplace in a way that promoted safety, high quality patient care and effective collaboration with others on the healthcare team as required by bylaw 7.2 paragraph (a).
18. You failed to Communicate with integrity and compassion as required by bylaw 7.2 paragraph (f).
19. You failed to interact with a healthcare provider with courtesy, honesty, respect, and dignity as required by bylaw 7.2 paragraph (a).
20. You failed to refrain from conduct that may reasonably be considered offensive to others or disruptive to the workplace or patient care as required by bylaw 7.2 paragraph (b).
21. You failed to ensure patient care and safety assumed the highest priority in the clinical setting as required by bylaw 7.2 paragraph (a).
22. You failed to model the concept of professional behavior in clinical practice as required by bylaw 7.2 paragraph (s).
23. You failed to encourage and model language, appearance and demeanor appropriate to the professional healthcare setting as required by bylaw 7.2 paragraph (t).