BRITISH COLUMBIA

# Hospital Appeal Board

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**DECISION NO. 2015-HA-001(a)**
In the matter of an appeal under section 46 of the *Hospital Act*, R.S.B.C. 1996, c. 200.

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| **BETWEEN:** | Dr. Michael Figurski | **APPELLANT** |
| **AND:** | Interior Health Authority | **RESPONDENT** |
| **BEFORE:** | A Panel of the Hospital Appeal Board<br>Charles (Rick) Riley, Panel Chair<br>Dr. Paul Champion, Member<br>Stacy Frank Robertson, Vice-Chair | |
| **DATE:** | May 30, 31 and June 1, 2 and 6, 2016 | |
| **PLACE:** | Vancouver, BC | |
| **APPEARING:** | For the Appellant: | Abigail C.F. Turner, Counsel and Lara Zee, Counsel |
| | For the Respondent: | Penny Washington, Counsel, Melissa Perry, Counsel and Kayla Strong, Articled student |

## APPEAL

[1] This is an appeal brought by Dr. Michael Figurski ("the Appellant"), a general practitioner who held a variety of categories of privileges at the Nicola Valley Regional Hospital and Health Centre ("NVH") in Merritt, BC and practiced emergency medicine over a period of approximately 20 years.

[2] He appeals the December 9, 2014 decision of the Interior Health Authority ("IHA") Board of Directors, approving the November 7, 2014 recommendation of the Health Authority Medical Advisory Committee ("HAMAC"), made in response to concerns and complaints involving patient care provided by the Appellant (the "Decision").

[3] The HAMAC recommendation approved by the Board of Directors was to:

1) summarily suspend the Appellant's privileges to practice medicine in all IHA facilities, as implemented by IHA medical administration on August 21, 2013, and

2) revoke the Appellant's existing privileges held in all IHA facilities.

[4] The Board of Directors also decided that no further application by the Appellant for privileges in IHA facilities would be considered unless the reviewing medical advisory committee is fully informed of the HAMAC's November 7, 2014 reasons for the revocation of the Appellant's privileges.

[5] The Appellant submits that after 20 years of continuous service in the emergency department there has been a very significant impact on him as a result of the Decision: he now has a permanent note on his record; he has faced scrutiny from his regulatory body; he has not been able to work in the emergency department since August 2013; he is not able to apply for locum positions that require hospital privileges; he has to disclose the particulars of the Decision on any future applications for privileges and any applications for licenses to practice in other provinces; it may affect his ability to apply for jobs in non-clinical settings; and without hospital privileges, he is now limited in the areas in which he can practice his profession.

## ISSUES

[6] The primary issue to be determined on this appeal is whether the summary suspension and decision to revoke all of the Appellant's privileges in all IHA facilities was warranted. This issue will be considered under the following sub-issues (which are discussed later in these reasons):

1. Was a summary suspension of the Appellant's privileges (pending a full review of the concerns) justified in the circumstances?

2. What is the appropriate quality of care/standard of care to be applied to the Appellant's conduct in this case?

3. Did the Appellant meet the applicable standard?

4. If not, is remediation appropriate in this case?

## BACKGROUND

### The Appellant

[7] The Appellant received his BSc (Honours) from the University of Manitoba. Subsequently, he undertook medical studies at the University of Manitoba, and a rotating internship in Winnipeg. The Appellant obtained his M.D. in 1986. He completed a ten month rural and remote residency in the intensive care unit and in anaesthesia at the Manitoba Health Sciences Center in 1989.

[8] The Appellant practiced as a general practitioner ("GP") anesthetist in remote Arctic locations between 1988 and 1990. He served as a flight physician during this period. The Appellant was, and remains, qualified in advanced cardiac life support and advanced trauma life support with skills in resuscitation and critical care.

[9] In 1994, the Appellant undertook additional anaesthesia residency training at the University of California, Los Angeles, and its affiliated hospitals.

[10] Also in 1994, the Appellant accepted a position at the NVH in Merritt, BC, as an associate GP. Shortly thereafter, the Appellant established a family medicine clinic at the Big White ski resort near Kelowna, BC, approximately 200 kilometres distant from Merritt. He continued to provide weekend locum coverage at the NVH for three of six family physicians in Merritt, covering their emergency department responsibilities and also their inpatients under the "Rural Locum Program".

[11] The Appellant practiced in this manner for close to 20 years (to 2013), commuting regularly to the NVH from Big White to provide weekend locum coverage. This arrangement was initiated under hospital authorities that predated the IHA.

[12] During the period 1998 to 2005, the Appellant was also enrolled in the University of British Columbia's enhanced skills short-term residency program, and received training in emergency and sports medicine.

## The IHA Decision

[13] The IHA was created in 2001 by the BC provincial government to organize and operate health care services and facilities in the BC interior. The NVH in Merritt was included within the boundaries of the IHA.

[14] The IHA board of management[1] (the "Board of Directors"), in consultation with the executive body of the medical staff, creates bylaws for hospital medical staff: Hospital Act Regulation, B.C. Reg. 121/97, sections 2 and 4. The bylaws relevant to this appeal are the Medical Staff Bylaws for the Interior Health Authority (the "Medical Staff Bylaws"). They state that the IHA Board of Directors has authority over an appointment, and the cancellation, suspension or restriction of an appointment, to the medical staff: Article 3.1.4.

[15] The IHA appoints all members of its medical staffs in all of its hospitals annually. An appointment to the medical staff is valid for a period of one year. Physicians must apply for privileges annually.

[16] The IHA appointed the Appellant as a locum tenens staff member at the NVH each year between 2002 and 2013. Subsequent to his suspension, the Appellant did not apply for renewal of his privileges for 2014, or any following year.

[17] The emergency department (the "ER") at NVH provides emergency health services to address the urgent and emergent health care needs of individuals who

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[1] Section 1 of the *Hospital Act* states that **"board of management"** means the directors, managers, trustees or other body of persons having the control and management of a hospital;

walk into the department or are transported there via ground or air ambulance from in and around the Merritt area. The ER is open 24 hours per day, seven days per week, and is staffed with one Registered Nurse and one physician per shift on an on-call basis.

[18] In the spring of 2013, four cases giving rise for concern about the Appellant's clinical management were brought to the attention of Dr. S, Executive Medical Director of the region in which NVH is located.

[19] Dr. S asked to meet with the Appellant to review the cases, and a tentative meeting was scheduled. The Appellant did not attend as he wanted to review the medical records for the four cases before attending such a meeting and he was not able to access the records in time; they had been held by the Medical Record Department.

[20] On July 19, 2013, Dr. S asked Dr. R, Regional Medical Director of Emergency Services for the IHA, to lead an accountability review of the four cases. Dr. R was asked to provide an opinion on the standard of care provided by the Appellant in the four cases, consulting with another doctor for the rural physician perspective if and when needed. Dr. S also asked Dr. R to answer specific questions about each case on topics such as the Appellant's documentation, his investigation and treatment of the patient, as well as questions about the Appellant's communication, professional conduct and patient handover.

[21] The Appellant was advised that his practice was under review on July 22, 2013.

[22] Dr. R reviewed the files and interviewed the Appellant by telephone. He provided his report to Dr. S on August 21, 2013. In the summary of findings, Dr. R identified general concerns with the Appellant's patient care, which are summarized as follows:

- Emergency department physician documentation (e.g., patient medical history, physical, laboratory and radiology findings and treatment plan) consistently not completed, and very limited progress notes.
- In three of the four cases, documentation (e.g., progress notes) were not made in a timely manner and, in one case, there was no physician documentation in the emergency room record, no admission history and physical, and no handover note.
- Significant issues of handover care in three of the four cases.
- Significant issues of professional conduct and mannerisms towards patients and families in two of the four cases.

[23] Dr. R's summary of findings also set out a list of "significant case specific care issues" which will be discussed later in this decision.

[24] After reviewing Dr. R's report, Dr. Murray, Acting Vice President Medicine and Quality, summarily suspended the Appellant's privileges to practice medicine in all IHA facilities on August 21, 2013. In accordance with Article 11.2.1 of the Medical Staff Bylaws, any summary suspension must be considered at a special meeting of the HAMAC within two weeks of the suspension and the HAMAC is

required to make recommendations to the Board of Directors regarding the suspension after giving the member an opportunity to be heard.

[25] A special meeting of the HAMAC was scheduled. That meeting was postponed at the request of the Appellant's counsel.

[26] In 2014, the HAMAC held three special meetings to consider materials and evidence related to the Appellant's suspension. The meetings occurred on September 25, November 7 and November 28. Witnesses were called and submissions were made during the first two meetings. The third meeting was held for the limited purpose of addressing an objection by counsel for the Appellant.

[27] At the conclusion of the second meeting on November 7, 2014, HAMAC made three recommendations to the IHA Board of Directors. It recommended that:

> (1) the Board support the summary suspension of the Appellant, as implemented by Dr. Murray on August 21, 2013;
>
> (2) the Board revoke all existing privileges currently held by the Appellant in all IHA facilities; and that
>
> (3) no future application by the Appellant for privileges in the IHA be considered unless the reviewing medical advisory committee is fully informed of the reasons for the recommended revocation of his privileges made by the HAMAC during this special meeting of November 7, 2014.[2]

[28] On December 9, 2014, a special meeting of the IHA Board of Directors was held to review the recommendations of the HAMAC regarding the Appellant's privileges. The Appellant and his counsel did not attend the meeting.

[29] At the December 9th meeting, the Board of Directors received the minutes from the three HAMAC meetings, HAMAC's recommendations, and a copy of the submissions made by the Appellant and Dr. S to the HAMAC. The Board of Directors noted that:

> … HAMAC was in unanimous agreement that the four cases reviewed by the HAMAC showed not only serious deficiencies with regard to communications with both staff and patients, and inadequate documentation within the patient charts, but also serious deficiencies with regard to clinical decision making.[3]

[30] At the conclusion of the meeting, the Board of Directors moved, and unanimously approved, the three recommendations of the HAMAC.

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[2] The wording of the third recommendation was changed at HAMAC's third special meeting on November 28, 2014. For convenience, the wording used in this paragraph contains the amended language.

[3] Minutes of the December 9, 2014 In camera Special Board Meeting, page 2.

## Notice of Appeal

[31] Section 46(1) of the *Hospital Act* (the "Act") provides practitioners with a right of appeal to the Hospital Appeal Board (the "HAB") from a decision of a board of management that modifies, refuses, suspends, revokes or fails to renew a practitioner's permit to practice in a hospital.

[32] On February 27, 2015, the Appellant filed a Notice of Appeal against the Board of Director's decision, asking the HAB to set aside the decision, and to order that his privileges be reinstated. The grounds for the appeal are summarized as follows:

- The Board of Directors failed to consider and reject, properly or at all, the flawed or erroneous nature and scope of the review conducted by Dr. R.
- The Board of Directors failed to fully consider and give appropriate weight to the evidence of the Appellant and/or:
    - the expert evidence submitted by the Appellant; and
    - the references and/or evidence provided by nine individuals from the NVH medical and nursing staff.
- There is no objective evidence that would support any restriction on the Appellant's right to practice emergency room medicine in an IHA facility.
- There is no reliable objective or empirical evidence or, in the alternative, insufficient reliable objective evidence, which would justify the Board of Director's decision.
- The Board of Directors failed to meet the requirements of natural justice and fairness.
- The Decision is unreasonable and against the weight of the evidence.
- The external review process was flawed; and
- The Board of Directors erred in failing to consider the best interests of the patients served by the NVH.

## The IHA's response

[33] In a response filed on April 13, 2015, the Respondent asks the HAB to affirm the decision of the Board of Directors.

[34] The Respondent submits that the Board of Director's decision is supported by the evidence, and is justified because the Appellant has compromised the care of his patients as a result of a well-documented pattern of deficiencies in his clinical judgment, communication and documentation. Further, the Respondent submits that previous efforts by the IHA to address concerns with the Appellant's practice have been unsuccessful. The Respondent submits that the Appellant has demonstrated a lack of insight into the issues with his care and has not learned from past efforts at remediation, despite well-documented concerns.

[35] In the alternative, if the Panel finds that the Decision was not justified, the Respondent's position is that there is no present need for the services of a locum

at the NVH, as the present complement of physicians is able to meet the needs of Merritt patients.

## NATURE OF AN APPEAL TO THE HAB

[36] The HAB has broad decision-making powers on an appeal. Section 46(2) of the Act, states that the HAB may "affirm, vary, reverse or substitute its own decision for that of a board of management on the terms and conditions it considers appropriate". Further, pursuant to section 46(2.3) of the Act, "an appeal to the Hospital Appeal Board is a new hearing" of the subject matter of the appeal.

[37] Counsel for both the Appellant and the Respondent acknowledged that a hearing before the HAB is a "hearing *de novo*".

[38] In the HAB decision in *Dr. Timothy Ng v. Richmond Health Services Society*, (BC Hospital Appeal Board, February 6, 2003),("*Ng v. Richmond*") the HAB reviewed the board's powers and at pages 8-9 stated as follows regarding the nature of HAB hearings:

> In *Jain v. North and West Vancouver Hospital Society*, the Board (then known as the Medical Appeal Board) made it clear that:
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> > "In the opinion of the Appeal Board, the appeal of a physician who is dissatisfied with the decision of the Board [of management] is a re-hearing in the full sense of that term."
>
> Accordingly, the Board proceeded to hear evidence and argument in this matter as a hearing *de novo*, essentially ignoring the original decision in all respects.
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> Further, in *Iqbal v. Mission Memorial Hospital* the Board added:
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> > "This board is thus required to consider the application as though it were in fact placed in the shoes of the Board of Management and to consider all of the evidence and, if so warranted, to reverse the earlier decision."
>
> The *de novo* nature of the Board's appellate jurisdiction has been repeatedly confirmed by the Courts …. In *Dupras v. Mason* (1994), 99 B.C.L.R. (2d) 266 (C.A.), the Court of Appeal held that in a hearing *de novo* the question before the decision-maker is the very question that was before the tribunal below. 'A trial *de novo* ignores the original decision in all respects, except possibly for the purposes of cross-examination' (p. 273). The reference to a 'new hearing' in s. 8(8) of the Regulation [now section 46(2.3) of the *Hospital Act*] is a clearly plain language expression of the previous Regulation's reference to a 'hearing de novo'.

[39] The *de novo* nature of an appeal before the HAB means that in a case such as this one involving an appeal of a decision prejudicially affecting privileges, the onus or burden of proof to satisfy the HAB that the decision is appropriate rests with the Respondent Health Authority.

[40] Also in *Ng v. Richmond* the HAB considered whether the new hearing by the HAB could "cure" procedural defects in the hospital's decision-making process. It found on page 11 as follows:

> … the proceedings before this Board are not focused on whether the hearing below was procedurally fair. Any procedural deficiency by the Board has been

> cured by the hearing before this Board, which is intended to provide a new hearing on the merits, taking into account all the evidence including the manner in which privileges are addressed in the Medical Staff By-laws, following which the Board must make its own determination regarding Dr. Ng's privileges. [Emphasis added]

[41] Although some of the grounds of appeal are framed as a breach of procedural fairness in the decision-making process of the Board of Directors, Counsel for both the Respondent and Appellant acknowledge the principle set out above in *Ng v. Richmond*. However the Appellant's counsel submits that the Panel is still entitled to make a finding as to whether the hospital's proceedings afforded procedural fairness and if not, she submits that raises a question as to whether the decision should stand.

[42] In our view, the real issue to be determined in this case is whether, on the facts and evidence presented in this hearing, the decision to suspend and revoke the Appellant's privileges is warranted. As was the case in the *Ng v. Richmond* decision, this Panel finds that any procedural deficiencies before the Board of Directors raised in the Appellant's appeal have been cured by the full hearing of this appeal, and will not be considered further.

[43] The Panel will proceed to consider the Appellant's case as though it were, in fact, placed in the shoes of the Board of Directors and consider the evidence afresh. Accordingly, the Health Authority bears the legal burden of proving, to the satisfaction of the Panel on a balance of probabilities in this hearing, that a decision to suspend and revoke the Appellant's privileges is appropriate.

## THE REGULATORY CONTEXT

*Administration and management of hospitals*

[44] As noted above, the Act requires each hospital to have a board of management and bylaws or rules, including medical staff bylaws, to govern the administration and management of the hospital and the provision of a high standard of care and treatment for patients. The bylaws are not effective until approved by the Minister of Health: Act, section 2.

[45] Since 2001, the functions of boards of management have been exercised in public hospitals by regional health authority boards which control and manage hospitals in their assigned regions (*Health Authorities Act*, R.S.B.C. 1996, c. 180). The regional health authority in this case is the IHA. It is the board of management (e.g., the IHA), in consultation with the executive body of the medical staff, that creates bylaws and rules for hospital medical staff.

[46] In addition to bylaws, the IHA Board of Directors has also approved Medical Staff Rules for the IHA. The Rules govern the conduct of the medical staff in facilities and programs operated by the IHA, and the day-to-day processes by which members of the medical staff provide patient care. The relevant Rules will be discussed later in this decision.

*Physician privileges in a hospital*

[47] Every physician practicing in a hospital must be a member of the medical staff and have a valid permit to practice in a hospital issued by the health authority board: Hospital Act Regulation, section 7(1).

[48] The Medical Staff Bylaws state that the IHA Board of Directors has authority over an appointment and the cancellation, suspension or restriction of an appointment to the medical staff (Article 3.1.4).

[49] For an appointment to the medical staff, an applicant is required to be licensed to practice medicine and a member in good standing of the College of Physicians and Surgeons of British Columbia (the "BCCPS"). Under the Medical Staff Bylaws, the applicant must also:

- demonstrate the ability to provide patient care at an appropriate level of quality and efficiency (Articles 3.2.1 and 3.2.2.1); and
- demonstrate the ability to communicate and work with colleagues and staff in a cooperative and professional manner (Article 3.2.2.4).

[50] Under Article 11.1.1 of the Medical Staff Bylaws, hospital privileges may be cancelled, suspended, restricted or not renewed if a member of the medical staff engages in the following:

> 11.1.1 Unprofessional or unethical conduct or breach of professional ethics codes, or violation of the requirements set out in the legislation, Bylaws, Rules and policies of the Ministry of Health and the Board of Directors, ….

[51] Article 11.2.1.1 allows the CEO or the Senior Medical Administrator to summarily restrict or suspend privileges of a member of the medical staff by notifying the member in writing should either one become aware of a serious problem or potential problem which adversely affects or may adversely affect the care of patients or their safety and security. If this power is exercised, Article 11.2.1.1 then sets out the process to be followed, such as special meeting of the HAMAC and recommendations to the Board of Directors.

*The nature of hospital privileges*

[52] In *Ng v. Richmond* the HAB considered the nature of hospital privileges, and accepted the following:

a) Hospital privileges "are the mechanisms by which hospitals may grant to physicians the opportunity to treat their patients through the use of hospital resources." (page 10)

b) A practitioner is not entitled to treat his patients in a hospital unless the practitioner holds a valid permit, issued by the hospital's board, to practice in the hospital. (page 11)

c) A hospital is entrusted with the responsibility of providing health care to its patients and is responsible for the quality of that care. (page 11)

d) The potential liability of a hospital to patients for negligent treatment necessitates that a hospital administration concern itself with the quality of care within the hospital. (page 14)

e) One of the keys to ensuring quality is the appointment and reappointment of competent, qualified physicians to the medical staff. (page 14)

f) The primary factors considered in granting privileges to a physician are the competence and qualifications of a physician. (page 11)

g) Other factors that can also be considered relate to the prompt completion of medical records, whether the physician has a personality that is disruptive, whether he works well as a part of a patient care team and cooperates with staff and his colleagues. (page 12)

h) The hospital administrators and lay board of trustees rely upon physicians supervising each other and on the professional conduct of each person, and trust department heads to supervise their staff; i.e., they depend upon the medical society (i.e., the medical staff organization) "to function as a disciplinary body and a quality control mechanism over its members." (page 15)

[Emphasis added]

[53] This Panel has been guided by these principles when reviewing the merits of this appeal.

## SUMMARY OF THE EVIDENCE

### A) The Patient Cases

[54] The events leading to the Appellant's suspension arose following the examination and review of the care given to four patients treated by the Appellant in the spring of 2013 in the emergency room of the NVH.

[55] The evidence regarding the four cases from 2013 included statements and complaints received from patients or family of those patients. A general description of the issues raised regarding the Appellant's care, is as follows:

*Case #1*

Issues regarding the Appellant's care that were considered on review were: (1) unprofessional conduct towards the patient and his family; and (2) lack of an appropriate transportation plan, including transport in a private vehicle with the accepting site being unaware of the transfer.

*Case #2*

Issues regarding the Appellant's care that were considered on review were: absence of emergency department documentation; lack of blood cultures or lactate ordered on patient despite elevated white blood cells; antibiotics not ordered until 7 pm the following day and choice of antibiotics not sufficient to cover potential sources of sepsis; no repeat

blood work ordered for the day following admissions despite elevated white blood cell count and abnormal renal and hepatic tests; and allegations that the Appellant yelled at the patient.

*Case #3*

Issues regarding the Appellant's care that were considered on review were: no emergency department documentation; lack of investigation on admissions despite increased heart rate and low blood pressure; continued issues with lack of investigation the following day; despite worsening renal function there was limited intervention or transfer to higher level of care until the patient was seen by his family doctor; limited/no documentation on patient's chart as to condition/management plan; handover of patient from the Appellant to the family doctor occurred but without a handover note.

*Case #4*

Issues regarding the Appellant's care that were considered on review were: no emergency department documentation; no handover documentation signed by the Appellant to colleagues in Merritt (dictated note the following day); the drug Tenecteplase ("TNK") was not given to the patient by nursing staff and the Appellant failed to recognize the error; inadequate ECG testing; very limited transfer and handover of care documentation and instructions; standard of care issue regarding whether an angiogram ought to have been required.

[56] During the appeal hearing, the Panel also heard evidence regarding another case from 2009 (Case #5), which had previously been reviewed by Dr. S, where the patient presented with head and facial injuries and abdominal pain. Dr. S had discussions with the Appellant in 2009 about the case, and found the Appellant to be defensive about his conduct. However, the review was concluded without punitive action, in that it was seen as a "teaching moment".

[57] In addition to the 2009 case, there were two other instances of concerns raised involving the High Acuity Response Team ("HART") in 2011 and 2012. In both cases the outcome was an apology from the Appellant to the HART team. In the second instance, the HART team manager also apologized to the Appellant.

[58] The Respondent submits that it provided evidence regarding these past incidents to demonstrate a trend in both the Appellant's patient care and attitude.

B) The Respondent's experts' review of the cases

*1. Dr. R, Medical Director Emergency Services, IHA*

[59] In July and August 2013, Dr. R conducted the accountability review of the above-noted cases that had come to the attention of Dr. S.

[60] Dr. S asked Dr. R to conduct the review from the perspective of a director of an emergency room, and asked Dr. R to answer a number of specific questions about each case. The report sets out the facts of the cases and identifies concerns. It makes no recommendations. This was the first review of this kind carried out by Dr. R. Dr. is an IHA expert on small hospital emergency rooms and is responsible for patient transfer within the IHA.

[61] Dr. R testified that, prior to doing the review, he had had cases transferred to him at the Royal Inland Hospital from the Appellant that were similar to the four cases that he reviewed. He also testified that no quality assurance reviews were being carried out at the NVH by the medical staff prior to the completion of his report.

[62] Dr. R reviewed the four patients' medical records and interviewed the Appellant for one hour by telephone on August 20, 2013, the day before the report was submitted to the IHA administration.

[63] In his written review, Dr. R noted several general deficiencies in the Appellant's performance. As noted earlier, these included deficiencies in the standard of care in all four of the cases, incomplete emergency room physician documentation in three of the four cases, and no written handover notes. In addition, he noted allegations regarding insensitive conduct and mannerisms toward two of the four patients and/or their families.

[64] Dr. R also identified significant care issues in each of the four cases. These include:

- In case #1, permitting an acutely ill psychiatric patient to be transferred in a private vehicle after administration of medication, and declining the family's request for transfer by ambulance.
- In cases #2 and #3 involving two seriously ill patients, the Appellant did not initiate follow-up investigations on a daily basis and, while he performed emergency investigations, they did not seem comprehensive and thorough.
- In case #3, failure to aggressively care for this patient (investigations, aggressive fluid resuscitation, initiation of the IHA sepsis protocol, transfer for specialist care). Dr. R notes that the Appellant felt that the patient did not want to be transferred from Merritt, but there is no note to this effect in the chart.

  In case #3, the patient's family doctor, upon receiving handover from the Appellant, initiated the IHA sepsis protocol and consulted and transferred the patient to internal medicine in Kamloops. This patient died a few days later due to sepsis and renal failure.
- In case #4, failure to follow up to ensure that the drug TNK was administered by nursing staff, not being present when TNK should have been given, and then not noticing, through regular patient assessment, that the TNK had not been given.

> In case #4, he also failed to consult with cardiology regarding this patient's care, which is the standard of care for a patient presenting with a ST elevation myocardial infarction. While the Appellant's note states that she was not a candidate for angioplasty given her age, Dr. R states that this case should have been discussed with cardiology to assess her appropriateness for angiography.

[65] Regarding case #2, while the patient died, and there were some issues identified regarding the care provided by the Appellant, Dr. R concluded that in his opinion the issues with the Appellant's care did not likely contribute to her death.

*2. Dr. T, Department Head Emergency Medicine, Royal Columbian Hospital*

[66] In 2015, at the request of the Respondent's counsel, Dr. T was engaged to provide an opinion regarding the clinical management of the four cases from 2013, plus case # 5 from 2009. His report, dated August 25, 2015, was entered as an exhibit and Dr. T testified at the hearing to give expert evidence on the standard of care to be provided by physicians in emergency departments.

[67] Dr. T's assessment comprised a retrospective review of the medical records related to the care of the five patients and an opinion based on that information. He did not interview the patients, their relatives, or the Appellant. He testified that he was provided with the Appellant's written responses to the concerns identified that had been provided to HAMAC. Dr. T stated that he looked solely at the care provided and was not asked to make recommendations.

[68] Dr. T was asked to advise whether the clinical management of each of the five cases was "within the standard of care of a reasonable and prudent physician practicing emergency medicine in a rural hospital in British Columbia as at the times they attended". Dr. T noted that this included a consideration of the level and scope of services that are available at a rural emergency facility. Further, Dr. T testified that it is important to understand what is available at NVH because it defines in part the scope of practice that is able to be taken care of in that facility. Accordingly, you need to identify transfer sooner and initiate the process sooner, especially if there are any circumstances that may delay the transfer.

[69] Dr. T concluded that all of the cases demonstrated significant issues in the Appellant's ability to provide safe, quality patient care. In four of the five cases, his opinion was that the care was substandard for an emergency physician practicing in a rural facility. This substandard care led to or contributed to the poor outcomes experienced by the patients.

[70] Issues with the care provided by the Appellant included poor documentation, particularly upon admission, and poor communications with other health care providers leading to delays in care and missed opportunities to provide quality patient care. In his opinion, the Appellant demonstrated substandard clinical knowledge and competence at times, as well as a lack of interpersonal skills, judgment and relationship management. The Appellant underestimated the medical issues before him, and delayed in transferring to higher levels of care and in consulting with other physicians in referral hospitals.

[71] Regarding Case #3, Dr. T also noted that the patient had a Living Will and that the Appellant had stated he had numerous conversations with the patient who was adamant he did not wish to pursue aggressive treatment. However, Dr. T notes in his report that there was "no documentation in the patient's medical record by the Appellant or others that there was knowledge of the Living Will at the time of his presentation and it was discussed with the patient and the patient wanted to continue to invoke its contents." In his view, the Appellant incompletely investigated and treated the patient and by doing so neither followed nor ignored the patient's Living Will.

C) The Respondent's other witnesses

[72] Dr. S testified about his previous interactions with the Appellant in August 2009 in regard to concerns Dr. S had in case #5. He stated that this was meant to be a collegial discussion to improve practice but the Appellant's reaction was defensive and not treated as a learning opportunity. Dr. S also testified in regard to the two complaints from the HART team in regard to disrespectful communication and intimidation.

[73] In regard to the situation in 2013, Dr. S testified regarding the series of four cases that came to his attention. He testified that because of the situation he was faced with - having a cluster of 4 cases in a roughly 2 month period with 2 of the patient's having died- he felt he needed to act quickly and get an expert review that was unbiased. He also testified as to why he recommended revocation of privileges rather than remediation at HAMAC, including that the previous cases, in his view demonstrated a pattern of conduct and attitude, and that the Appellant had not learned from the previous incidents.

[74] Dr. S also testified that, subsequent to the four cases in 2013, the IHA conducted a significant chart review of the medical records of physicians at the NVH. This review found that the standard of records generally at the NVH was better than the records kept for the Appellant's four cases.

[75] The Respondent also called Dr. CM, a full service family practice physician providing on-call services for emergency at the Revelstoke Hospital since 2000. He has been Chief of Staff there since 2007. Revelstoke Hospital is similar in size to NVH and treats a similar mix of patients.

[76] Dr. CM was also the Regional Chief of Staff for the Thompson Cariboo Shuswap region from 2011-2014, where he was partially responsible for addressing issues in Revelstoke, Salmon Arm and Merritt. Dr. CM was also involved in the HART complaints in 2012 as well as the initial discussions with Dr. S regarding the plan for the review of the Appellant's care in the four cases arising in 2013. Dr. CM testified that he was aware of the criticisms of the Appellant's care in regard to the HART complaints and in Dr. R's review. He gave evidence that the standard of care expected of a GP in a rural hospital emergency department was not met by the Appellant in those cases.

[77] The Respondent also called Dr. O, Executive Medical Director, Acute Services for the IHA, as a witness. Dr. O testified regarding historical and current staffing

issues and the community needs in Merritt and his views on what would be required in the way of remediation for IHA to have confidence in the Appellant's use of judgment and his ability to work with teams.

D) The Appellant's evidence

[78] The Appellant did not call any expert witness to testify in support of his management of the care that he provided to the patients in the above-noted cases. The evidence of Dr. R and Dr. T was not significantly challenged by the Appellant. The Appellant did not challenge the underlying factual foundation provided in the reports of either Dr. R or Dr. T, focusing instead on what were characterized as flaws in the reports such as, for example, that:

- Dr. R and Dr. T do not work in the NVH emergency department, both are more qualified than the Appellant and are not rural family physicians;
- the experts did not personally interview the Appellant, other staff at NVH or the other physicians who treated the patients;
- Dr. R had communications with hospital administration while preparing the review and Dr. T was provided a copy of Dr. R's report while conducting his own review;
- the reports do not include recommendations; and
- the scope of the reviews was limited to a small number of cases and were not comprehensive quality assurance reviews of the Appellant's practice in general.

[79] However, the Appellant did testify on his own behalf regarding the cases. In his testimony he noted that he provided continuous and consistent coverage for the NVH ER at least every other weekend, seeing up to 100 patients per shift. He never missed or was late for a shift. He never failed to answer a page. He never received a complaint by medical or nursing staff of NVH. Prior to August 2013 he was never suspended nor have there been any conditions or limits placed on his hospital privileges.

[80] He testified that because of his suspension by IHA, the BC College of Physicians and Surgeons had initiated a review of the records maintained in his practice at Big White. At that time his first priority was to satisfy the college and ensure that he could continue to practice medicine in BC.

[81] In regard to case #1, the Appellant testified that he felt the family likely took his comments the wrong way and that he remembered the incident better than the family who was under a lot of emotional duress that day. He stated that as he felt the aggression was triggered by a new situation the ambulance would have been a lot worse for him. He stated that the psychiatrist was expecting the patient's arrival and the typical standard was that nurses would fax the paperwork to the receiving facility.

[82] Testifying as to case #2, the Appellant stated that he did not yell; he was speaking very loudly to make sure the patient was responsive. In regard to the

delay in transfer, he testified that he wanted to treat her aggressively in hospital and see if she "brightened up" and get her started on antibiotics as quickly as possible. He testified that he wanted to do "serial exams" to assess her to see where she was at in the past and determine what direction she was going in i.e. improving or deteriorating. He said that he gave a trial treatment for 36 hours and she initially perked up and was doing better but she subsequently started deteriorating and then he transferred her when he thought that a CT scan could be part of the workup, which is not available in Merritt.

[83] In regard to the sparse notes in this case the Appellant stated that he was not sure that what was written on the page was necessarily a reflection of what he was thinking or how much. He disagrees with Dr. R that he should have considered initiating the sepsis protocol as the white cell count being high was consistent with a bladder infection and the liver function test indicated a chronic problem of liver failure, particularly in the face of low albumin. He felt the patient did not qualify for the sepsis protocol as he thought the patient had a renal system infection not 'sepsis syndrome' that would have required initiation of that protocol. He does not agree that the patient was likely in septic shock.

[84] In discussing case #3, the Appellant testified he was aware of the Living Will and had a lengthy discussion with the patient about it. The Appellant said the patient felt he was dying and didn't want to do it there. He suggested transfer when the patient first came in but he wasn't agreeable. The Appellant testified that he provided treatment throughout the weekend but the patient was "between a rock and a hard place" in that his heart was failing, he was fluid overloaded and in Atrial Fibrillation. It was difficult trying to find the right balance because he needed fluids to get his kidneys functioning again but if one gave him more fluid it would collect in his lungs and his legs. His kidney function was deteriorating so there were a lot of good reasons to give him fluid and also reasons why he needed diuretics to limit it. The Appellant did not see any indication that the patient had sepsis – no fever or high white cell count suggesting infection. The patient was going up and down and it was his impression that it was more of the same chronic issues and he knew the patient's own doctor was coming in shortly. When he left to head back to Big White he told the nurse to give him a call if there was any problem and he would call when he got there. The Appellant testified that he called the hospital when he got to Big White and they told him the patient had taken a turn for the worse.

[85] In response to a question from the Panel the Appellant admitted it was wrong not to note his discussion with the patient on the chart and stated that in retrospect, while he agreed that he should have put the discussion about his living will on the chart, he didn't want to put 'DNR' because he wasn't the patient's primary physician and didn't know how his feelings might change in consultation with his physician so he didn't want to put anything on the chart that would discourage aggressive treatment if he was transferred.

[86] The Appellant testified that even in retrospect he doesn't agree that he should have started the sepsis protocol as it would be expected that the patient's lactate would be elevated given his heart failure and his was only minimally elevated, certainly not enough to qualify for a septic syndrome. The Appellant

testified that it was unfortunate that the patient was treated for sepsis when he got to the ICU as in his opinion that fluid overload may have contributed to his early demise.

[87] In addition, the Appellant agreed that he was the most responsible physician while he was on the road back to Big White notwithstanding that he was not available by cell phone. However, he testified that the nurse could call the on-call physician if the patient's condition changed before his own physician arrived and she could not reach the Appellant. Dr. T, however, testified that in order for the on-call physician to be an appropriate person for the nurse to contact, there would need to be a transfer.

[88] The Appellant testified regarding case #4 that you don't want to transport heart patients out too soon after giving them TNK because they are more likely to have rhythm complications in the ambulance on route. He testified that the standard is to keep them around for 12 hours, discuss with the cardiologist who is going to do the procedure that day and arrange transfer during the day.

[89] He acknowledged that he missed that the TNK was not given and that the patient did not get a 90 minute post thrombolytic ECG, but he testified that if a patient is pain free, which he states she was, it doesn't matter what the ECG says as it doesn't affect management. In cross examination he agreed that if they had done a 90 minute EKG and he'd checked it in the chart and flipped it open in the order set he might have noticed that it wasn't signed off and realized the TNK hadn't been given. However, he says that they aren't always signed off so he may not necessarily have been able to determine it hadn't been given. He did agree that he shared in the responsibility for failure to give this patient TNK.

[90] Further, the Appellant testified that the discussion about angioplasty is moot as this patient was never a candidate for angioplasty given their location and time to a hospital. In addition, in her case he did not feel she was a candidate for angioplasty as she was pain free. In regard to her age, the Appellant stated that he meant that the benefit of angioplasty for someone younger is more life years with the same or less risk whereas given her age the balance is more in favour of medical treatment.

[91] Finally, in regard to case #5, the Appellant noted minor errors in facts by Dr. T. He also stated that he believes Dr. T doesn't understand the logistics in Merritt, and minimized his diagnostic report. The Appellant disagrees that he didn't take appropriate resuscitative measures or that there were any long delays. He also disputes the interpretation of tachycardia or that the patient's pain was inadequately treated. He felt that the family was mistaken about some concerns and was clearly distraught and perhaps distressed and feeling guilty. He felt that the patient did not have signs of a concussion and assessed that the vomiting and tachycardia was a result of the Ketamine. He admits he missed the pelvic fracture but testified that he didn't feel a pelvic x-ray was necessary as when he pressed on the pelvis it was stable and it's very common to miss a stable pelvic fracture early particularly when there are other bruises and it's hard to tell a displaced stable pelvic fracture from a bad bruise.

[92] The Appellant also testified that it would be hard for Dr. T to understand how Merritt works or what the most appropriate time and way to transfer patients is and the rural philosophy about delaying transfer until stabilization.

[93] In summary the Appellant testified that "I do the best I can with the resources at hand." "I don't believe I overestimate my ability to treat these patients." "I feel I am competent and safe and have proved myself over a period of 20 years." He further testified that he thinks about transfer before the patient hits the hospital if he knows they are coming but that he thought it would have been dangerous to send these patients out sooner when he has a more longitudinal view. He stated that the patients weren't in Merritt that long and were receiving treatment during that time and the treatment received would not have been that different from what they would have received at another facility.

[94] Finally, the Appellant testified that he is going to take a charting course offered through the BCCPS.

E) The Appellant's other witnesses and evidence

[95] The Appellant also called two of his colleagues from NVH: Dr. DM and Dr. B. Dr. DM worked with the Appellant during all of the Appellant's 20 years at the NVH. Dr. DM's evidence was that the Appellant raised the standard of care provided in the emergency room at the NVH. He was not aware of there ever having been a complaint regarding the Appellant's care.

[96] Dr. DM also confirmed that you need to think about transfer very early on because transfer is a laborious process trying to get patients out of the NKH emergency room. Accordingly, one needs to start discussions early and often, but he stated that it is sometimes difficult to predict when a patient is going to crash.

[97] Dr. B, a GP, testified that he considered the Appellant's charting to be average or above average in comparison to the other family physicians at the hospital. He considered the Appellant to have been part of the medical staff who provided a great service to the ER in Merritt. Dr. B testified that he had no concerns with the Appellant caring for his patients nor any concerns about his competence or judgment.

[98] Both Drs. B and DM expressed surprise that the IHA would suspend the Appellant. No one from the IHA Medical Administration ever contacted them to discuss the situation that had come about, or its cause.

[99] Written letters of support for the Appellant were received by the IHA from three of six of the Appellant's Medical Staff colleagues at the NHV, and from six of the nurses who have worked with the Appellant in the hospital. These letters confirmed the writers' opinions that the Appellant is a good physician, his standard of care was appropriate and he dealt with people visiting the ER with respect and good medical management. The letters attest to the Appellant being an integral and reliable part of the community and to the willingness and confidence of those colleagues to work with him.

## DISCUSSION AND ANALYSIS

### 1. Was a summary suspension of the Appellant's privileges (pending a full review of the concerns) warranted in the circumstances?

[100] The Appellant submits that a summary suspension is an extraordinary remedy which ought to be used with great caution and reserved only for the rarest or most serious of cases. The Appellant argues that this was not such a case.

[101] Further, the Appellant submits that the interim suspension power under the Medical Staff Bylaws is similar to the jurisdiction given to regulatory colleges under the *Health Professions Act*. James T. Casey in the Regulation of Professions in Canada refers to interim suspensions in that context as "a draconian power in many senses because the member's ability to practice his or her profession and earn a livelihood has been suspended with the possibility of permanent damage to his or her reputation without there being a finding of any misconduct." (at pg.14-2) Accordingly, the Appellant emphasizes that as an interim suspension may have drastic consequences it ought to be used sparingly.

[102] The Appellant also relies on the BC Court of Appeal case in *Scott v. College of Massage Therapists of British Columbia* 2016 BCCA 180 ("*Scott")* as authority for a number of guidelines appropriate in interim proceedings including that the regulator:

- must be satisfied that there is a real risk of harm to patients, colleagues or other members of the public if an order is not made; it is not enough that an order is merely desirable;
- should consider the seriousness of the risk, including the seriousness of the allegation, the nature of the evidence and likelihood of conduct being repeated if an interim order is not made;
- should take into account the impact of an interim order on the practitioner and balance the need for the order against the consequences to the practitioner; will need to consider the source of the allegation and its potential seriousness and may act if it takes the view that there is a prima facie case that requires the public be protected by an interim order; and
- ought to consider if less onerous conditions would be appropriate.

[103] The Appellant submits that similar considerations should apply to the exercise of the power under the Medical Staff Bylaws to summarily suspend privileges. Further, the Appellant submits that there was insufficient evidence to justify such an extraordinary remedy in this case as it was based solely on Dr. R's report.

[104] The Appellant also submits that the hospital ought not to have relied on Dr. R's report in support of a summary suspension as it was under-developed, "incomplete and, at times, inaccurate", particularly in light of the fact it was used to justify an extraordinary remedy such as suspension. In support of this the Appellant notes that:

- Dr. R had not been to the NVH emergency department,
- Dr. R was not independent in that he engaged in ongoing communications with medical administration,
- Several doctors were away when the review was conducted,
- Dr. R did not meet with the Appellant, speaking only with him by telephone,
- Dr. R did not document whether he discussed any issues with nurses, staff or NVH administrators, nor any physician who treated the patients,
- The review falls short of providing conclusive findings as to the standard of care provided by the Appellant, at best identifying areas and elements of practice that may require further investigation,
- Scope of the review was limited, only a handful of cases were identified as having issues and some of the Appellant's comments regarding his care appear to have been disregarded or given little weight, and
- Dr. R's review contained no recommendations.

[105] In considering the test applicable to the summary suspension of physicians providing care to patients in hospital, the Panel is aware of the ultimate responsibility of the hospital administration for quality of the care provided within the hospital. In exercising this responsibility, the hospital needs to have the ability to take swift preventative action where deemed appropriate. The Medical Staff Bylaws reflect this. It is also important to remember that the ability to treat patients in any given hospital is a privilege, not a right.

[106] The Panel accepts the Respondent's submission that the *Scott* case does not strictly deal with the test applicable to this case which is set out in in Article 11.2.1.1 of the Medical Staff Bylaws. The test to be applied here is a different test than that set out in the *Health Professions Act* to govern a regulatory college, as was the case in *Scott*.

[107] The Medical Staff Bylaws allow for the summary restriction/suspension of members of the medical staff (Article 11.2.1.1). Where the CEO or Senior Medical Administrator (in this case, Dr. Murray, the Acting VP Medicine and Quality) becomes aware of a serious problem or potential problem which adversely affects or may adversely affect the care of patients, or the safety or security of patients or staff, and action is required to protect the safety and best interests of patients or staff, the CEO or Senior Medical Administrator may summarily restrict or suspend the privileges of a member of the medical staff by notifying that member in writing.

[108] The Article refers to a serious problem or <u>potential problems</u>. At this stage, all that is required is a prima facie case, not a strong case, of concerns that <u>may</u> adversely affect the care of patients and a belief that action is required to protect the hospital's patients.

[109] Dr. S testified that he was of the opinion that there was a real risk of harm being done to patients should the Appellant continue to practice. He and Dr. Murray were faced with concerns raised in four separate cases occurring over a

period of roughly only two months in which two patients had died and no one knew if that was related to the Appellant's care. Once they received Dr. R's report identifying a number of serious concerns, they were justified in ordering a summary suspension. The threshold of a serious or potential problem which may adversely affect patient care was met and entitled the Respondent to act summarily to protect the safety and best interests of patients. There just needs to be the potential for harm, not actual harm, to meet the test under Article 11.2.1.1 for suspension.

[110] Regardless of whether Dr. R had actually visited NVH or spoken to all of the players, including the Appellant, and notwithstanding that he did not make definitive findings or recommendations, the Panel finds that, as the Medical Director for Emergency Services in IHA, it was appropriate for him to conduct the accountability review. It was reasonable and prudent for the hospital administration to rely on his review in determining whether there was a serious risk of potential harm should the Appellant continue to exercise his privileges pending a fuller consideration and determination in regard to the action to be taken.

[111] Finally, although the Appellant submits that a summary suspension did not sufficiently consider the needs of the community in terms of having the Appellant's services unavailable on short notice, in the Panel's view patient safety and the community interest in high quality care override that factor where the concerns are in regard to clinical judgment and patient care.

[112] The Panel also notes that Article 11.2.5 provides protection to a member whose privileges have been summarily suspended by providing that any summary suspension must be considered at a special meeting of the HAMAC within fourteen days and that the member must be given an opportunity to be heard.

[113] Further, the Panel notes that the Appellant did not challenge the suspension before the Board of Directors as he testified that at that time, his first priority was to satisfy the BCCPS and to ensure that he could continue to practice medicine in BC, not reinstating his privileges at the hospital.

[114] The Panel finds that the concerns with the Appellant's actions in the four cases as identified in Dr. Rings review, were sufficiently serious as to constitute grounds for the summary suspension, pending a full consideration by HAMAC and the Board of Directors and that such action was justified in order to protect the safety and best interests of the patients in the IHA facilities (Article 11.2.1.1 of the Medical Staff Bylaws).

## 2. What is the appropriate quality of care / standard of care to be applied to the Appellant's conduct in this case?

[115] To establish a benchmark of the standard of care relevant to the issues in this case, the Panel considered a number of sources: the Medical Staff Bylaws; the Medical Staff Rules; the testimony of the two expert reviewers; and the testimony of the Appellant and other general practitioners at the NVH and the Revelstoke Hospital. Testimony in this regard will be discussed in the next section.

[116] The Medical Staff Bylaws for the IHA set out the conditions under which members of the medical staff provide patient care. Some of the relevant sections include:

> 2.1.2 To be accountable for the quality of medical care provided in the programs and facilities of the IHA
>
> 2.1.3 To assist in providing adequate and appropriate documentation for the purpose of maintaining a health record for each patient.
>
> 2.1.5 To promote a high level of professional performance of all practitioners authorized to practice in the IHA.
>
> 3.2.2.1 [An applicant for privileges] must demonstrate the ability to provide patient care at an appropriate level of quality and efficiency…
>
> 3.2.2.4 demonstrate the ability to communicate and work with colleagues and staff in a cooperative and professional manner.
>
> 5.2.3 Members of the medical staff shall ensure the availability of medical care to their patients, and will, once having accepted responsibility for a patient, continue to provide services until they are no longer required, or until arrangements have been made for another suitable practitioner to provide that care.
>
> 5.2.4 Formal transfer of responsibility for the care of a patient must be acknowledge on the patients record by both the referring member of the medical staff and receiving member of the medical staff.

[117] The Medical Staff Rules set out the expected, and acceptable, practices for patient care at IHA facilities. The sections relevant to the Appellant's conduct in this case are as follows:

> 4.2 When, in the opinion of the Most Responsible Practitioner (MRP), clinical resources are not available for the appropriate and safe care of the patient, the practitioner shall initiate a process to transfer the patient to a more suitable facility. The practitioner shall be responsible to identify the patient who requires transfer, the resources needed and provide relevant medical information in keeping with clinical policies and procedures where they apply. ….
>
> 4.9 The transfer of Most Responsible Practitioner (MRP) status (other than "on-call") from one practitioner to another shall be duly recorded on the order sheet. It is the duty of the Most Responsible Practitioner (MRP) to contact and obtain agreement from the practitioner to whom he/she wishes to transfer care. …
>
> 5.1.3.1 When a patient requires admission in emergency circumstances, the physician who initially assesses and determines that the patient requires admission is responsible for documenting clinical findings, the diagnosis and treatment plan. The MRP must ensure full documentation for each emergency patient within 24 hours of admission.
>
> 5.1.6 When a patient is to be transferred to another hospital or facility for medical reasons, the Most Responsible Practitioner (MRP) … shall identify

> the relevant documentation from the patient's clinical record to be sent to the receiving hospital ….
>
> 5.3.5 Locum tenens practitioners are responsible for the completion of the health records of patients they have been caring for. …. Failure of a locum tenens to complete clinical records may result in a review of that locum's privilege by the Department Head.
>
> 6.1.1 All orders for medical treatment shall be legibly written and signed by a practitioner with appropriate Medical Staff privileges. …
>
> 6.2.1 Progress notes for acute patients shall be sufficient to describe changes in the patient's condition, reasons for change of treatment, and outcome of treatment and shall be written as frequently as the patient's condition warrants ….

[118] The Panel finds that the Appellant had a responsibility to be aware of, and to follow, the requirements in the Medical Staff Bylaws and Medical Staff Rules regarding the provision of appropriate and safe care, the circumstances where transfer of a patient is appropriate, and the prompt and thorough completion of medical records and progress notes.

[119] The Panel also finds, that in assessing whether the Appellant met these requirements and provided appropriate clinical management, the Appellant should not be held to the level of care that may be provided by the most experienced and highly qualified physicians in a large urban center. Rather, the appropriate standard of care for which his conduct in treating his patients is to be judged is on the basis of a reasonable and prudent physician practicing emergency medicine in a rural hospital in British Columbia at the relevant time.

### 3. Did the Appellant meet the applicable quality of care standard?

[120] The Appellant submits that his poor communication, while admitted, did not rise to the level of impacting patient safety. He disputes that his care and judgment were inappropriate and submits that the Respondent has not met its burden of proof to justify the Decision. He provided evidence of a significant number of letters of support and two witnesses as evidence of the fact that his colleagues find his care acceptable. Further, the Appellant submits that there is insufficient reliable, objective evidence to support the Decision.

[121] In addition, the Appellant urges the Panel to consider his 20 years of continuing and consistent service in the ER, with no previous suspensions or conditions placed on his privileges.

[122] The testimony from two of the Appellant's colleagues from the NVH supported the Appellant as a competent general practitioner emergency room physician. Dr. B had worked with the Appellant in the NVH for a number of years and had no issues with the Appellant's professional judgment or with the care that he provided to patients. In addition, he never felt that the Appellant did anything inappropriate. Dr. B testified that the quality of the Appellant's documentation was no different than any of the other doctors on staff at the NVH, but he

acknowledged that the Appellant had "a degree of an issue" regarding his communications.

[123] In regard to the letters of support, while these are admissible and have been considered by the Panel, we note that they are not based on any knowledge of the individual cases or the specific concerns and some of those colleagues providing letters or testimony in support had a personal interest in the Appellant continuing to work and thereby being in a position to cover their call. In addition, the concerns in this case were not limited to communication issues. Here there were significant patient care issues.

[124] The Panel heard testimony from five witnesses relating to the care provided by the Appellant in the four subject cases. The testimony of Dr. R and Dr. T focused on review of the patient charts in the four or, alternately, five, cases assessed. Dr. R and Dr. T were accepted by the panel as qualified to give expert evidence in regard to whether the Appellant's care met the standard of care of a family physician practicing emergency medicine in a rural hospital. Although the Appellant's counsel submitted that there were flaws in the expert review process, she accepted that they are both well qualified to speak to the standards of care of emergency physicians and whether those standards were met in the four cases. Dr. CM, who is a rural family physician, echoed the testimony of the experts that the Appellant's conduct did not meet a reasonable standard of care in the four cases.

[125] The reviews of such a small number of charts provide a somewhat limited view of the nature of the care provided generally by the Appellant. We note however that there was no countervailing expert called by the Appellant to suggest that the IHA experts were wrong in their views of the Appellant's clinical judgment in those cases.

[126] The Panel has conducted its review of the particular cases at issue in this appeal, to determine whether the standard of care as required by the Medical Staff Bylaws and Medical Staff Rules was met by the Appellant and finds as follows:

Case #1

The Panel accepts that the case was challenging.

The Panel agrees with some criticisms of care expressed by the Respondent's experts, in that the Appellant did not display good professional conduct in his interactions with the patient and his family.

The Panel also accepts that the transfer of the patient was poorly handled, but that no harm to the patient occurred from these events.

However, the Panel agrees that the lack of hand written contemporary documentation in the patient chart was not acceptable, and was in contravention of good practice regulations and guidelines.

Case #2

The Panel agrees with the Respondent's experts, Dr. R and Dr. T, that the institution of a formal sepsis protocol was unnecessarily delayed. Further, there was an almost complete lack of documentation over a period of more than two days.

In addition, the transfer was, in the Panel's view, unnecessarily delayed. These views notwithstanding, the Panel agrees with Dr. R that the death was not the result of the Appellant's management, nor was his management likely a contributing factor in her demise.

Case #3

There was almost no written contemporary charting by the Appellant in the case, apart from an initial diagnosis and a single follow-up comment. There is no documented discussion between the Appellant and the patient of the Living Will and the patient's wishes concerning treatment in accordance with the Living Will.

The Panel agrees with Dr. T that, while respecting the existence of the Living Will, the Appellant failed to adequately evaluate the patient's problems early in the period at the NVH emergency room and unnecessarily delayed transfer.

In addition, there was valid concern regarding the patient's transfer, and the perception that the Appellant underestimated the potential reversibility of the presenting acute features of illness. It is noteworthy that, when the patient was transferred to his family physician by the Appellant, the family physician immediately implemented the IHA sepsis protocol and arranged for immediate transfer.

Case #4

The Panel finds that, in this case, there was no satisfactory documentation of a full physical examination or other initial findings. Although the initial treatment plan was appropriate, the Panel agrees with the Respondent's experts that the follow-up evaluation was not adequate leading to the patient not being given the drug TNK, and that there was delay in consulting the cardiology department at an appropriate time prior to transfer. The ST elevation myocardial infarction protocol was instituted, though not properly documented. There is no documentation of any discussion with family regarding the wishes of the patient regarding management. Thus, if any such conversation took place, the Panel is unable to evaluate it.

The Panel believes that the patient was likely given less consideration for interventional cardiac care due to her age; the patient was otherwise healthy apart from being overweight. These conclusions are unchallenged by any contemporary hand-written documentation by the Appellant. The outcome for the patient was, in the Panel's view, likely to have been adversely influenced by these deficiencies in the Appellant's approach to her.

> After transfer by the Appellant to the family physician, the family physician assessed the patient and determined that TNK had not been administered. The family physician consulted cardiology and transferred the patient.

[127] We have considered the Appellant's reasons, explanations and at times disagreement in regard to the criticisms of his patient care, as well as the support and testimony of his colleagues. We are not persuaded that evidence contradicts or overcomes the serious concerns in regard to these four cases expressed by the experts.

[128] Where the evidence conflicts between the Appellant or his witnesses and the Respondent's witnesses regarding the appropriate care, we give greater weight to the evidence of the Respondent's experts over that of the Appellant who is self-interested in the outcome of the proceedings. We note that counsel for the Appellant admitted that Dr. T is an expert in emergency medicine, "perhaps the most qualified in BC". We also note the Appellant's criticisms that Dr. T has never been to NVH and is not a rural family physician. Dr. CM who works in a similar sized facility, gave evidence that he agreed with Dr. R's assessment that the Appellant had not met the appropriate standard of care. Further, the Appellant's witnesses Dr. B and Dr. DM acknowledged that they would stay or be nearby for the administration of TNK and would always consider transferring patients early on. Further, in two of the cases reviewed by Dr. R and Dr. T, the Appellant's colleagues who assumed care of the patients from the Appellant took steps, almost immediately upon assuming care, that had been identified by both IHA experts as steps that would have been appropriate for the Appellant to have undertaken himself sooner. In our view, the weight of the evidence clearly establishes that there were deficits in the Appellant's care and that the Appellant did not meet the standard of care applicable to a physician working in an emergency room at a small rural hospital.

[129] In making these findings, the Panel recognizes that a physician's work in a busy small rural emergency room, such as exists at the NVH, is intense and demanding. Maximum organizational skills and clinical expertise are demanded especially at busy hours. Dr. O and Dr. S confirmed that approximately 1,000 patients per year are seen, although a proportion of these could more satisfactorily be handled by adequate primary care service in the community.

[130] The NVH emergency room is typically manned by one nurse, one physician and a clerical employee. Thus, greater reliance is, of necessity, placed on verbal interaction between nurse and doctor, and the confidence each has in the other's skills in highly charged situations.

[131] The Panel also recognizes that the Appellant has served the hospital and community of Merritt well, and reliably, for more than 20-years: he has provided emergency care on weekends as a locum when the local physicians have felt themselves unable to do this work. The IHA administration has accepted this arrangement for many years.

[132] The Panel recognizes that the IHA administration is taking actions to raise the medical staffing and safety standards of their small rural institutions to a level

commensurate with those of a modern, small rural hospital as far as is possible within the available resources.

[133] Notwithstanding these observations, the Panel has concluded that the clinical tendencies - or habits - of the Appellant during his duties in the four cases at issue, were not of an appropriate standard. In particular, his disregard for proper documentation in the patients' charts is of concern. The dictation of a full summary and discharge note was often delayed. In an emergency room situation, such a practice does not adequately fulfill the requirement for patient safety or for the integrity of quality of patient care. This is especially the case where the patient remains under observation and treatment in an emergency room. Even where the unit is small, a minimum of clear case notes is expected. During his testimony, the Appellant acknowledged that he had "communications issues" and that his charting "might be deficient". The Appellant admitted in Case #4 that he had not checked that the nursing staff had administered the TNK nor did he check the patient's ECG.

[134] The Panel notes Dr. S's testimony that, subsequent to the four cases in 2013, the IHA conducted a "significant chart review" of the medical records of physicians at the NVH. This review found that the standard of records generally at the NVH was better than the records kept for the Appellant's four cases. Although it is not clear what the time period of the review was, it may be assumed that some of the Appellant's other cases were included in this chart review and not identified as problematic.

[135] The Panel also finds that, in the cases at issue, the delays in transfer were not appropriate. There is a concern that the delays may reflect reluctance by the Appellant to give up control of the management of the patients. This is not an acceptable practice, particularly in a small rural hospital with limited access to diagnostic equipment, surgical facilities and specialists.

[136] The Panel concludes that the Appellant violated the requirements of the Bylaws and Medical Staff Rules where he failed to meet the accepted standards of care of the IHA with respect to documentation, appropriate clinical decision making, following the IHA-accepted patient care protocols, and providing quality medical care for the patients in the four subject cases.

[137] While recognizing the Appellant's professional interest in this matter, the Panel is satisfied that the evidence before it demonstrates that the Appellant did not meet the quality of care standards applicable in a rural hospital emergency room of the IHA in the four cases.

[138] In making these findings on whether the Appellant met the applicable standard or quality of care, the Panel has not relied upon case #5 or the HART cases. Counsel for the Appellant objected to inclusion of case #5 in the external review by Dr. T and submitted that the Respondent ought not to now raise previous complaints or issues that were not considered by Dr. R when the Appellant was suspended, and which had been dealt with by the hospital without taking any disciplinary action, as justification for the decision to revoke the Appellant's privileges. We agree that case #5 and previous complaints should not be considered in this case in determining the merits of whether the Appellant's

practice fell below the standard of care. However, we agree with Counsel for the Respondent that they are relevant in consideration of whether remediation is appropriate, as discussed in the next section.

### 4. Is remediation appropriate in this case?

[139] The Appellant submits that there is an ethical obligation on the hospital and his professional colleagues to support his efforts at remediation and facilitate his return to the emergency department. Further, the Appellant argues that the Decision ignores the principle of progressive discipline and support of physicians. The Appellant raised concerns about the Respondent raising past issues that had been dealt with (with no disciplinary action) and that were not considered when the suspension was ordered. The Appellant also submits that if there were concerns about his "governability", he ought to have been provided with an opportunity to respond to those allegations and address them on a remedial basis. Further, the Respondent's decision to suspend and revoke his privileges demonstrates a disconcerting lack of support for a long standing member of the medical staff. In effect, the Appellant submits that the hospital "washed its hands" of the Appellant without considering reasonable alternatives such as reinstatement with conditions, further education or remediation, and the concept of progressive discipline, such as other, less drastic punitive sanctions. Given the seriousness of the impact on the Appellant, he submits that the Respondent should have first considered if less onerous conditions were appropriate that would allow him to maintain his privileges.

[140] The Respondent submits that IHA did consider remediation as it is always a consideration in these kinds of cases. However, a review of past incidents demonstrated that remediation had not been successful. Further, the Respondent submits that the nature of the clinical concerns was significant and based on the evidence, it was clear that patients were at risk. It was these findings that the Respondent says formed the basis of the recommendation to suspend and revoke the Appellant's privileges. The Respondent further submits that the Appellant's repeated lack of insight into concerns and the impact of his behavior on others also meant that remediation at the time was reasonably thought not likely to succeed.

[141] The Appellant testified that he is willing to do whatever it takes to get back to work, although he did not acknowledge during his testimony that there may be any issues with his clinical work. Since his suspension, he has taken continuing medical education courses. The Respondent testified that the courses the Appellant has taken do not address his deficiencies. The Appellant noted that there is a charting course which addresses many of the issues raised in the cases presented, but he has not completed the course to date, although he is signed up for its next session in the fall of 2016.

[142] The Panel finds that the concerns about patient safety have not been adequately addressed by the Appellant either in the evidence presented at this hearing or in his assurances that he is willing to accept feedback, learn from the past and modify his practice going forward.

[143] The Respondent's position is that the deficiencies need to be addressed by the Appellant; specifically, he needs to complete a three to six month period working in a large, teaching hospital emergency department under clinical supervision. The quality of his patient care and of his communications can then be assessed. In addition, evidence of continuing medical education focused on remediating his deficiencies is required. The Respondent's position is that the IHA has no role in arranging, or facilitating, any remediation initiatives with the Appellant, and that it is totally the Appellant's responsibility to satisfy the IHA's requirements before he can apply for privileges in any IHA facility.

[144] The Panel finds that, while the Appellant is a skilled, well-educated and trained GP emergency room physician, in the cases discussed above, he failed to fulfill the requirement for sound clinical judgment. Fully developed diagnoses and safe documentation were absent as were proper patient management planning and prompt referral to facilities offering a higher level of care. While it is of serious concern that these four cases arose within a relatively short period of time, in the Panel's view, these deficiencies can be corrected so that the Appellant could be allowed to resume his career within the IHA at some point in the future.

[145] Accordingly, the Panel agrees that there is a place for remediation in this case. However, this must be preceded by a recognition on the part of the Appellant that remediation is necessary. Based on the evidence of the Appellant in discussing the cases considered by the experts, and wherein he continues to defend his deficiencies, we are not satisfied that he has fully acknowledged the problems or learned from these concerns. The Appellant admitted to shared responsibility for the TNK and to significant charting deficiencies, which in and of themselves constitute a breach of the Bylaws and Medical Staff Rules. He has signed up for a charting course to address these. However, there were additional deficiencies in patient care, not admitted by the Appellant but established on the evidence, in regard to his clinical judgment, transfers, assessments, handovers and communications with colleagues. While we find that there is a greater recognition on his part now of some of the deficiencies, it is yet to be tested and we see no evidence of concrete steps to address them.

[146] In *Ng v. Richmond*, the HAB stated at page 40 that, for remediation to be successful, there are six conditions to be met by an applicant for privileges:

1. The applicant is able to accept constructive criticism, and is willing to truly recognize and accept problems.
2. The applicant must be willing to demonstrate, following mentoring, that he can meet the standards of the hospital to which he is applying.
3. The applicant's associates must be willing to obligate themselves to supervise.
4. There must be support for this type of supervisory program.
5. Someone must be responsible for carefully monitoring all aspects of the program.
6. Patients' rights must be completely considered.

[147] Although the Panel has not considered case #5 or the HART cases in determining whether the Appellant met the applicable standard of care in the four cases, these cases are appropriately considered for the purposes of determining what remediation, if any, should be imposed. These cases assist in addressing the above criteria for remediation in this case. For instance, in case #5, the Appellant's documentation, bedside interactions, and degree of evaluation of the patient were not appropriate. The Appellant demonstrated that he underestimated the severity of some of this patient's injuries and displayed a tendency to delay transfer to a higher referral institution. The Panel finds that, while no serious complication occurred as a result of the management of this case and no disciplinary action was taken regarding this matter, it is shows a pattern of conduct. The fact that the same or similar issues arose in 2013, also indicates that the Appellant lacks insight into his deficiencies, or fails to accept them, and has not remedied his behavior, contrary to conditions 1 and 2 (above). This justifies additional remedial measures being imposed before applying for privileges in the IHA.

[148] In addition, the Panel concludes that the position of the IHA makes it challenging for the Appellant to successfully achieve remediation within the IHA, and possibly any other health authority in BC. The Panel notes that the Appellant has provided approximately 20 years of dependable service in the emergency room of the NVH, and locum coverage in other rural hospitals within the IHA's territory. A review of patient records at the NVH by the IHA does not appear to have found other instances of substandard care by the Appellant. Only one other case reflecting poor quality patient care (case #5) was identified in 2009.

[149] The Appellant remains a physician licensed by the BCCPS. Based upon this fact, it appears that the BCCPS is satisfied that the Appellant has the basic competence to practice medicine in BC.

[150] There was testimony that there are currently two family practice vacancies in the Merritt community. Relief for the NVH physicians by temporary staff appointments and itinerant GPs is needed on a continuous basis. The NVH physicians testified that the staffing arrangements are currently less satisfactory than they would wish. Physicians working in rural communities require access to physicians willing to provide temporary coverage during their absences from their practices. They need relief to reduce stress that may lead to "burn out".

[151] Recent changes to the allocation and administration of medical staff categories in the IHA negates the use of the locum staff category for relief emergency room coverage at the NVH. This is the category of privileges that the Appellant has requested be reinstated in this appeal. Temporary staff is now the accepted category for such relief coverage.

[152] The Panel notes that the IHA decision does not preclude the Appellant from now taking steps to address the deficiencies that have been identified and applying for privileges within IHA at some future date on the basis of his remediation, subject, of course to the reviewing medical advisory committee being fully cognizant of the past events. Noting the support of the Appellant by his colleagues and hospital staff, we encourage the Appellant to undertake appropriate

remediation and reapply for appropriate privileges. However, for all the reasons stated above the Panel is not prepared to reinstate his privileges at this time with conditions related to such remediation. The assessment of the adequacy of any remedial efforts and the decision to approve future privileges is best left to the judgment of the relevant decision-makers at the time any such application is made.

[153] The Respondent has expressed an openness to receive, and consider, an application for privileges from the Appellant once he has completed remediation satisfactory to the IHA. It is appropriate that whoever in the IHA reviews any future application for privileges by the Appellant be informed of the Appellant's suspension, the reasons for the suspension, as well as the nature and extent of the Appellant's remediation initiatives.

[154] The Panel is concerned that IHA has expressed no willingness to work with the Appellant during his remediation. The Appellant, for his part, needs to acknowledge his clinical deficiencies. He also needs to undertake initiatives to remediate his deficiencies to the satisfaction of the IHA medical administration if it remains his goal to apply for any privileges within IHA. This will require that the IHA Medical Administration clearly delineates its expectations for his successful remediation.

[155] Further, an appointment would only be considered if the Appellant can satisfy the IHA that he has followed, and completed, a remedial pathway. For this to happen, the IHA first needs to clearly delineate its requirements for the Appellant's remediation and we recommend that it do so. The remediation process could be facilitated by IHA undertaking to enable the Appellant to work under supervision in an IHA hospital emergency department. In addition, the committee considering any future appointment should be provided with evidence that the Appellant has completed a process of remediation acceptable to the Medical Administration of the IHA.

[156] The Panel notes that the Appellant is no longer able to apply for the type of locum privileges he previously enjoyed in the NVH emergency room, as that category staffing arrangement no longer is available. He would therefore be required to apply for privileges in the appropriate staff category.

[157] Finally, as the Panel has determined that the suspension and revocation was justified, we do not need to make any finding in regard to the Respondent's alternative argument that there is no current need for the Appellant's locum tenens privileges to be reinstated.

## DECISION

[158] The Panel has taken into account all of the evidence and argument in this case, whether or not it has been expressly referenced in the decision.

[159] The Panel is aware of the significant impact of the Decision on the Appellant and his ability to practice in his chosen field in the way in which he wishes to. However, the evidence, on balance, satisfies the Panel that the suspension and

revocation of all of the Appellant's privileges was an appropriate sanction and continues to be justified in all the circumstances of this case.

[160] The Panel also agrees with the Board of Directors that any IHA medical advisory committee that reviews any future application for privileges by the Appellant be informed of the reasons for his suspension and the subsequent revocation of his privileges.

[161] Accordingly, the Panel finds that the Respondent has met its burden of proving that the Decision ought to be affirmed and we so order.

[162] The appeal is dismissed.

"Rick Riley"

Charles (Rick) Riley, Panel Chair
Hospital Appeal Board

"Paul Champion"

Dr. Paul Champion, Member
Hospital Appeal Board

"Stacy Robertson"

Stacy Frank Robertson, Vice-Chair
Hospital Appeal Board

January 9, 2017