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DECISION NO. 2015-HA-002(g)

In the matter of an appeal under section 46 of the *Hospital Act*, R.S.B.C. 1996, c. 200

BETWEEN:	Dr. David Kates	**APPELLANT**
AND:	Interior Health Authority	**RESPONDENT**
BEFORE:	Cheryl L. Vickers, Chair's delegate	
DATE:	Conducted by way of written and oral submissions, concluding on March 19, 2018	
APPEARING:	For the Appellant:	Alfred C. Kempf, Counsel
	For the Respondent:	Ryan Berger, Counsel

[1] In the fall of 2016, the Hospital Appeal Board (HAB) heard the appeal of Dr. Kates from the decision of the Board of Directors, Interior Health Authority to revoke or refuse to renew his appointment to practice at Kelowna General Hospital (KGH) or anywhere within the Interior Health Authority (IHA). Prior to the conclusion of the hearing, the parties came to an agreement to resolve the appeal and asked the HAB to make an order under Rule 6(2)(e) of the HAB's Rules including the terms of settlement. The HAB made an Order on December 5, 2016, dismissing the appeal on terms and conditions agreed to by the parties (the Order). The Order provided that the parties may return to the Chair or the HAB for "clarification on implementation of this Order".

[2] The parties have returned to the HAB seeking clarification and direction as they have been unable to agree on the implementation of the Order, and in particular on a gradual return to work schedule in accordance with paragraph 5 of the Order.

[3] The parties agreed to participate in a "mediation/arbitration" process whereby I would endeavor to facilitate agreement respecting implementation of the Order, but if the parties were unable to reach an agreement I would make a decision to provide direction for implementation of the Order. Unfortunately, the parties could not come to an agreement on some key implementation issues including the nature of a graduated return to work schedule and distribution of work. Accordingly, having considered the parties oral and written submissions provided to the HAB on March 19, 2018, I will make a decision.

[4] The purpose of this proceeding was to provide clarification and direction for the implementation of the Order. It was not an opportunity to re-litigate issues raised in the original HAB hearing or to have HAB adjudicate matters not addressed in the Order. Consequently, this decision does not address the issue of whether the *Human Rights Code* applies to the relationship between a hospital authority and physician with hospital privileges. That was a live issue that the HAB did not have the opportunity to resolve and the Order does not address. Similarly, this proceeding was not to determine whether Dr. Kates is ready to return to work. The parties agreed and the HAB ordered that Dr. Kates would return to work. Dr. Kates and his treating physician say he is ready to return to work, and IHA cannot re-litigate Dr. Kates' fitness to return to work.

[5] The parties agreed, and the Board ordered, that Dr. Kates would return to work and that his return would involve "an appropriate gradual return to work schedule" that does not have Dr. Kates doing on-call (inpatient and dialysis coverage) at the same time as doing clinic work or office work, and "does not take a share of Dr. L's current inpatient, dialysis or clinic work". The Order provides that the ultimate schedule is subject to approval by the Director of the KGH Nephrology Division, which is "not to be unreasonably withheld".

[6] There is no question that Dr. Kates must be returned to work, and that return must be in accordance with a gradual return to work schedule (GRTW). The GRTW must be "appropriate" to all of the circumstances of the case. The issue is what GRTW will be "appropriate" in all of the circumstances, and whether the Director's reluctance to approve the GRTW proposed by Dr. Kates on the recommendation of his treating physician is "unreasonable" in the circumstances.

[7] An "appropriate" GRTW will consider the specific circumstances and needs of the physician returning to work as well as the needs of the hospital. The ultimate goal of the Order's provision that there be "an appropriate gradual return to work schedule" is to successfully reintegrate Dr. Kates into the KGH renal program without compromising the program or patient care. It is in all parties' best interest that the GRTW provide the best chance for successful reintegration.

[8] Dr. Kates has not worked in the hospital environment since 2012. He has undergone treatment for physical and mental illness. He has engaged in therapy with a goal to developing better coping strategies, and is confident that he will not repeat the disrespectful and disruptive behavior that ultimately lead to the decision to not renew his privileges and his appeal to HAB. He remains under the care of his treating physician and is required by the College of Physicians and Surgeons to follow her advice.

[9] Dr. Kates completed all of the pre-requisites to return to work required by paragraph 3 of the Order by the summer of 2017, including acknowledging past wrongs and that he engaged in disruptive and disrespectful behavior. He has expressed his desire and willingness to be part of the nephrology team under the leadership of Dr. M. He has accepted the IH Nephrologist Goals and Expectations endorsed by the IH Nephrology Group on March 9, 2015.

[10] IHA granted Dr. Kates provisional privileges in accordance with the Order, but he has not been able to enjoy the benefit of those privileges in the absence of agreement on a GRTW.

[11] The GRTW requested by Dr. Kates requires accommodations that the other nephrologists are unwilling to make. To date, the Director of the Renal Program has not been willing to approve a schedule that causes disruption to the other physicians. The issue of the reasonableness of the Director's refusal to approve Dr. Kates' proposed GRTW schedule must be assessed in light of the Director's role to weigh the relative impacts to all concerned and the program generally, and in light of the Director's obligation to approve an "appropriate" GRTW for Dr. Kates with the goal of successful reintegration.

[12] The nephrologists currently work on a four week rotating schedule with week one for dialysis and on-call, and week 3 for community multi-disciplinary clinics (the Hospital Weeks). Weeks 2 and 4 are allocated for private office clinic or time off. In anticipation of Dr. Kates' return to work, IHA contracted with Dr. B as a locum to assist with Dr. Kates' Hospital Weeks in the four week rotation.

[13] IHA proposes that Dr. Kates return to work on the four week rotating schedule and perform as much or as little as he wants of the duties that go with the Hospital Weeks, with Dr. B covering the remainder. IHA proposes that he gradually increase his workload until he is ready to fully assume responsibility for the Hospital Weeks. The aim would be for Dr. Kates to have completed the graduation within 24 to 30 weeks. To accommodate Dr. Kates' request for more frequent exposure to dialysis responsibilities, two of the nephrologists have agreed that Dr. Kates may

work on their weeks as a resident under their supervision. IHA's proposed schedule would minimize the impact on the other nephrologists.

[14] Dr. Kates proposes a GRTW schedule that allows for a gradual phasing in of both hours and duties by allowing him to introduce specific responsibilities associated with the Hospital Weeks one at a time, and initially more frequently than once every four weeks. He would start with building up dialysis duties (but not do call or clinics) on a two week rotation for about 4 weeks, before transitioning to the one in four rotation at or about the time he takes responsibility for most of the dialysis duties and most of the days in the week. Then he proposes to introduce call, without dialysis, then call with dialysis, again on a two week rotation while gradually increasing the number of days working until transitioning into the full one in four rotation with full duties. He would be fully integrated into the program after about 30 weeks. This proposed schedule will be disruptive and inconvenient to the other nephrologists as it requires each of them to accommodate Dr. Kates' gradual return for some of the days during weeks they would otherwise be responsible for dialysis and call. It is, however, the graduated return to work schedule recommended by his treating physician as having the best chance for his successful reintegration into the hospital environment.

[15] Dr. S is Dr. Kates' treating psychiatrist. She has been involved with return to work plans with other physicians returning to work following medical leave. She says a gradual return to work plan should allow for gradual escalation in hours and scope of practice. She writes:

> As a general guiding principle a GRTW should allow a process of work hardening to the various components of a physician full scope of practice. Usually this involves a shift from part time to full time hours and a gradual reintroduction of the types of patients and clinics that the physician was previously engaged with. Inherent in this process of gradual return is some method of feedback from his healthcare providers to assess his mental status and function as the load is increased both in terms of hours and complexity.
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> …
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> The pace of introducing new clinic types and new venues office/out patient clinic/dialysis/ward/on-call should allow for timely mastery of skills such that over a reasonable period of time the physician is back to full scope of practice.

[16] In Dr. S' opinion, an increase in the scope of work every four weeks is too long an interval and that a two-week pace of expanding scope and hours is needed. She writes:

> While I understand that once Dr. Kates is able to resume a full work load that he would be scheduled into a ¼ schedule, his reintegration to work after such a long time away needs to involve a more frequent exposure to the various types of functions he will perform.

[17] Dr. S suggests the on call aspect of Dr. Kates' work should be the last responsibility added.

[18] IHA urges me not to accept the opinion of Dr. S because, in its view, she has "crossed the line" from an independent expert to an advocate for her patient. However, Dr. S' opinion is the only professional evidence before me of what an "appropriate" GRTW for Dr. Kates should look like. Moreover, the terms of the Order at paragraph 6(e) are that "Dr. Kates will continue treatment in accordance with the instructions of his care team and will have Dr. S…provide written confirmation every six months that Dr. Kates continues to be cleared for work". I accept that Dr. S cannot provide an independent opinion; she is not independent but is Dr. Kates' treating physician. Her opinions ought not to be dismissed out of hand, however, but considered for what they are, namely her recommendations as to what is best for the successful reintegration of her patient into the renal program.

[19] IHA submits that its proposed GRTW provides adequate opportunity to gradually increase scope of work and stamina and to achieve work hardening at the pace suggested by Dr. S. The suggestion that Dr. Kates work with the other nephrologists as a resident under their supervision, while it may provide exposure to dialysis, is not a proper return to work as Dr. Kates would not be remunerated as the treating physician. Moreover, it imports elements of supervision not contemplated by the Order and unnecessary given other provisions of the Order which address monitoring. It is not reasonable to ask Dr. Kates to return, even on a part-time or temporary basis, in a capacity similar to a resident.

[20] IHA expresses concern that changing the existing schedule may affect team morale and patient care. I do not doubt that there is stress and anxiety respecting Dr. Kates' return to work generally, and that changing the existing schedule to accommodate Dr. S' recommendations may contribute to that stress and anxiety. But, generalized fear of the possibility of an outcome is not enough to ground a reasonable decision. The period of disruption will be short and the loss of income to the regular KGH nephrologists will be relatively small. The team is comprised of committed professionals, and I would not expect the short lived inconvenience and disruption that will result in implementing the GRTW recommended by Dr. S to cause significant issues for the continued delivery of high quality care to the program's patients.

[21] I do not doubt that Dr. M has done her best to try and accommodate Dr. S' recommendations while at the same time endeavouring to cause as little disruption as possible to the other nephrologists and the renal program. She has been placed in the difficult situation of trying to balance the needs of all of the physicians and the program in general. She is clearly a committed and passionate physician who provides leadership to the renal program with the best interest of patients in mind and with the unequivocal support of IHA.

[22] However, the Order providing for an appropriate GRTW necessarily anticipates accommodation to assist with successful reintegration over a period of time that while potentially disruptive in the short term, will not compromise patient care or be detrimental to the program in the long term. I do not accept that the GRTW proposed by Dr. Kates on the recommendation of Dr. S will compromise patient care or be detrimental to the renal program. While inconvenient and disruptive, I am of the view the accommodations requested by Dr. Kates to provide the best chance for successful reintegration are reasonable, and the Director's refusal to accept Dr. Kates' proposed GRTW is unreasonable in all the circumstances of this case.

[23] I am also of the view that Dr. Kates' proposal respecting the distribution of work with Dr. B during the GRTW is not unreasonable. I acknowledge IHA's concerns respecting contract issues with Dr. B, but Dr. B should have been advised that the schedule for Dr. Kates' reintegration was not known and would have to be flexible. There should be no expectations on Dr. B's part other than to support Dr. Kates' return by covering the duties as necessary until he is fully reintegrated.

[24] With respect to the provision in the Order that the GRTW "not take a share of Dr. L's current inpatient, dialysis or clinic work", it is my understanding that since the Order was made the nephrologists have moved from a 1 in 3 rotation to a 1 in 4 rotation, so Dr. L's dialysis work will have already been impacted by that move. I further understand that any schedule changes required to accommodate Dr. Kates' requested GRTW impacting Dr. L will result in a relatively small loss of income in the short term and will not take away from Dr. L's current practice in the long term.

[25] All of the nephrologists, including Dr. L, may expect schedule changes during the GRTW, although every effort should be made to minimize schedule changes and to allocate schedule changes as evenly as possible amongst the other nephrologists. I appreciate that the other nephrologists will experience both personal and professional challenges when faced with schedule changes, but I do not accept that they are challenges that cannot be overcome or mitigated, or that outweigh the goal of providing the best chance for successful integration of Dr. Kates into the renal program.

[26] As to other matters for which IHA seeks direction, the Order contemplates internal and external monitoring in paragraph 6. The parties have agreed to an Internal Monitoring Protocol that will provide for effective implementation of the provision for internal monitoring at paragraph 6(c) of the Order. The parties have also agreed to an External Monitoring Program that will provide for effective implementation of the provision for an external monitor at paragraph 6(d) of the Order. The external monitoring program will be conducted at or near the end of the GRTW.

[27] IHA seeks direction as to whether Dr. Kates, prior to returning to practice, ought to agree substantially to the provisions set out in a letter dated March 5, and meet with Dr. M to review it as an orientation to the functions, approach, and workflows of the nephrology department. The Letter of March 5 attempts, in my view, to add terms to the Order beyond those contemplated by the Order and is outside the scope of this process for clarifying implementation of the Order. That being said, however, Dr. Kates has agreed to most of the content of the March 5 letter, and the agreed content, including that he meet with Dr. M to review the program, is not unreasonable. The intent of the Order is that Dr. Kates be successfully reintegrated into the renal program as it exists today under the direction of Dr. M. Dr. Kates should be expected to comply with the expectations for standard of care by nephrologists set out in the March 5 letter including the expectations set out with respect to the sharing of patients.

[28] I trust that this decision provides the parties with sufficient clarity and direction for implementation of the Order. I appreciate that this process has been difficult and that both Dr. Kates and members of the nephrology team are anxious about the pending reintegration. I urge the parties to move beyond the anxiety and concern over past events, and focus on the goal and intent of the Order, which is that Dr. Kates be successfully reintegrated into the renal program.

[29] The parties may return to the HAB, if necessary, for further clarification on implementation of the Order.

"Cheryl Vickers"

Cheryl L. Vickers

March 22, 2018