HOSPITAL APPEAL BOARD

BETWEEN:	Dr. Timothy Ng	APPELLANT
AND:	Richmond Health Services Society	RESPONDENT

Members of the Panel:

Gordon R. Armour, Chair
Lori Messer, Member
Lorraine Grant, Member

Counsel for the Appellant	Mr. Christopher Hinkson, Q.C. Harper, Grey, Easton
Counsel for the Respondent	Ms. Penny A. Washington Bull Housser & Tupper

HEARD at Richmond, British Columbia, on March 25, 26, 27, 28, 2002; and April 24, 25, 26, 2002; and heard at Vancouver, British Columbia on May 21, 22, 2002; and June 17, 18, 19, 20, 2002; and September 8, 9, 10, 11, 2002.

REASONS FOR JUDGMENT

This is an appeal from the December 21, 2001 decision of the Public Administrator for the Richmond Health Services Society, exercising the duties of the Board of Trustees of the Richmond Hospital ("Board of Management"), revoking the Appellant's privileges as a member of the Provisional Active Staff of the Richmond Hospital ("the Hospital").

The Hospital Appeal Board ("the Board") notes that as a result of a December 12, 2001 reorganization of the health regions in the province, the Hospital is presently owned and operated by the Vancouver Coastal Health Authority. Neither party identified these issues of ownership or authority as affecting the decision below or the hearing before this Board.

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Background

The Appellant undertook his education and training in pre-medicine at Memorial University of Newfoundland in the department of Biochemistry from 1977 to 1979. Following this, he undertook further training at Memorial University in the Faculty of Medicine from 1979 to 1983, receiving a Bachelor of Medical Sciences in October 1981, and his M.D. in June 1983. During the years 1983 and 1984, the Appellant completed a Rotating Internship in the Faculty of Medicine at Memorial University of Newfoundland. Subsequently, he entered postgraduate training in the specialty of Community Medicine through the University of Calgary (1986-1987) and the University of British Columbia (1987-1989). In the years 1990 through 1995, the Appellant undertook postgraduate training in the specialty of Obstetrics and Gynecology first at the University of British Columbia (1990-1993) and completed his requirements at the University of Saskatchewan (1993-1995).

The Appellant's experience practicing in the field consists of a Rotating Internship at the Health Sciences Center, Grace Hospital, St. Clare's Hospital, and Janeway Children Hospital in St. Johns Newfoundland from July 1983 to June 1984. During the period from September 1984 to May 1986, he undertook a Canadian Government Postgraduate Foreign Exchange as a Surgery Resident at the Chung Shan Hospital in conjunction with the Medical University of Shanghai (formerly Shanghai First Medical College). For the period of June 1986 through June 1987, the Appellant served on the Community Resident Staff of the University of Calgary working in departments of the Calgary Health Services and the Mountview Health Unit. July 1987 to April 1988 saw the Appellant serving on the Community Medicine Resident Staff of the University of British Columbia, in the departments of Health Care & Epidemiology, UBC, North Shore Health Unit, BC Ministry of Health, and the BC Centre for Disease Control. He was subsequently employed as a Federal Field Epidemiologist in BC with the Health Protection Branch, Health Canada for the years April 1988 through June 1990. For the years July 1990 to November 1993, the Appellant served with the Obstetrics & Gynecology Resident Staff of the University of British Columbia seeing duty in St. Paul's Hospital, Vancouver General Hospital, B.C. Women's Health Center (formerly Grace Hospital) and Prince George Regional Hospital. The Appellant then was a member of the Obstetrics & Gynecology Staff, University of Saskatchewan, serving in the Regina

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General Hospital, Saskatoon City Hospital and the Royal University Hospital from December 1993 to June 1995. Following his time in Saskatchewan, the Appellant was in private practice and a member of the Active Consultant Staff for Obstetrics & Gynecology at both Ridge Meadows Hospital and Surrey Memorial Hospital through the years July 1995 to October 1999.

The Appellant practised at the Richmond Hospital as a long-term temporary locum to cover the absence of another physician from November 1, 1999 to October 2000. The physician ultimately did not return to practice and the locum was extended to February 16, 2001, at which time a vacancy was declared in the Department. The Appellant applied for the position and was appointed as a member of the Provisional Active Medical Staff of the Hospital in the Department of Obstetrics and Gynecology on March 27, 2001 under the authority of Article 3.3.3 of the Hospital Bylaws. The Appellant's Provisional Privileges would in the ordinary course have terminated on March 31, 2002, at which time he would have been at liberty to apply to become a member of the Active Medical Staff.

On October 20, 2001, the Chief of Staff, Joint Department Heads of Obstetrics/Gynecology and the Chief Operating Officer of the Hospital suspended the Appellant's privileges on an emergency basis pursuant to Article 4.3.4 of the Hospital's Medical Staff Bylaws.

On November 8, 2001, The Medical Advisory Committee ("MAC") upheld the emergency suspension and recommended to the Hospital's Board of Management that the suspension continue to allow a more extensive review of the Appellant's cases.

On November 15, 2001, the Board of Management met to consider the recommendations of the MAC. On November 19, 2001, the Board of Management decided to extend the Appellant's suspension pending a further clinical review.

In the course of its investigation the Hospital commissioned two independent chart reviews. The report submitted by the first reviewer was not tendered as evidence by either party. The Hospital engaged a second specialist to undertake the review of the Department of Obstetrics/Gynecology, ("the Department").

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The second reviewer reviewed approximately 120 cases of members of the Department, including approximately 50 cases by the Appellant. The parameters for his review are set out in a letter dated November 29, 2001[1] stating that the reviewer would be acting on behalf of the Richmond Health Services Society as an external reviewer of the care of patients at the Richmond Hospital by the Appellant and other staff obstetricians/gynecologists. The letter further states, "The purpose of the review is to establish whether there are any issues of concern with respect to both the Appellant's clinical practice and the practice of the other staff obstetricians/gynecologists in the Department." The letter provides the parameters of the review as outlined in the Minutes of the MAC meeting of November 22, 2001.[2]

The second report was presented to the MAC on December 13, 2001. The MAC recommended that the Appellant's privileges be revoked.

On December 21, 2001, the appointed Public Administrator, sitting as the Board of Management, released the following decision, which is the subject of this appeal:

> "Having carefully reviewed all the material before me, I find that it demonstrates a pattern of incompetence and unprofessional conduct, contrary to the By-Laws and Rules & Regulations of The Richmond Hospital and, pursuant to Section 4.1 of the Medical Staff By-Laws and, as recommended by the Medical Advisory Committee, I hereby revoke your privileges as a member of the Provisional Active Staff of The Richmond Hospital as of today."

Notice of Appeal

On January 16, 2002, the Board received a Notice of Appeal on behalf of the Appellant seeking an order from the Board that the decision of the Administrator be set aside, and that his privileges be reinstated to Provisional Active Staff Privileges.

The grounds of Appeal were stated as follows

[1] Exhibit # 27
[2] Exhibit # 43

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a) that the Administrator failed to consider, properly or at all, the expert report of [the first reviewer] dated November 4, 2001;

b) that the Administrator failed to give appropriate weight to the basis upon which the Medical Advisory Committee made its recommendation, particularly the opinion submitted by [the second reviewer] dated December 8, 2001, and more specifically:

A. Concerns identified by [the second reviewer] as significant are in fact minor in nature, overwhelmingly concerned with the adequacy of [the Appellant's] charting practices, and did not put patients at risk;

B. [The second reviewer] misinterpreted patient records that were before him;

C. [The second reviewer] based his review on incomplete medical records;

D. [The Appellant's] complication incidence and significance of complications and management are within norm for profession;

E. Complex cases cared for by [the Appellant] are in keeping with standards of obstetrical care;

F. While [the second reviewer] expressed concern with the speed with which [the Appellant] conducts surgery, [the Appellant] is entitled to practice based on his judgement, exercised interoperatively, with respect to the pace of surgery required in the best interests of his patients;

G. While [the second reviewer] purported to review the charts of all members of the Richmond Hospital Department of Obstetrics and Gynecology, he applied a higher standard to [the Appellant] and

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ignored similar errors evident in the charts of other physicians; and that

H. there is no objective evidence which would support any restrictions on [the Appellant's] right to privileges at the Richmond Hospital.

c) that there was no reliable objective statistical or empirical evidence, or in the alternative, insufficient reliable objective evidence, which would justify the Administrator's decision; and

d) that the decision is unreasonable and against the weight of the evidence.

In a response filed on behalf of the Hospital on February 12, 2002, counsel for the respondent seeks an Order from the Board affirming the decision of the Public Administrator made on December 21, 2001, to revoke the Appellant's privileges at the Richmond Hospital.

The Hospital submits that the Public Administrator did consider and give appropriate weight to the first expert report of November 4, 2001. In response to the balance of the Appellant's grounds of appeal, counsel for the respondent states that "the issue of the appropriate standard of obstetrical care and the standards applied by the second reviewer to the Appellant and the other members of the Department will be canvassed before the Hospital Appeal Board as these issues are raised for the first time in these proceedings."

Nature of Appeal to the Board

The British Columbia *Hospital Act* [3] ("the *Act*") requires each hospital to have a board of management, and bylaws or rules to govern the management of the hospital, including appointments to its medical staff. Section 2(1)(c) of the *Act* sets out these requirements as follows:

[3] R.S.B.C 1996, c.200

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Requirements for hospitals,

2 (1) A hospital, except a hospital owned by the government or by Canada, must do the following:

(c) have a properly constituted board of management and bylaws or rules thought necessary by the minister for the administration and management of the hospital's affairs and the provision of a high standard of care and treatment for patients;

The *Medical Staff Rules and Regulations of the Richmond Hospital,* under which medical staff appointments and privileges are granted, state as follows:

Section VIII: Medical Staff Appointments and Privileges

1. Technological advances with new procedures being developed require specific standards of training and assessment of competency as formulated by the departments and sections involved.

2. The determination of privileges at the initial appointment shall be based upon a review of the applicant's training, experience and demonstrated competence.

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6. Suspension of privileges will be considered when:

- utilization variances are identified through Quality Improvement, Utilization and Risk Management system not in conformance with prescribed standards
- there is a failure to provide appropriate medical management to patients.

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The *Act* also provides for the establishment of the Hospital Appeal Board, providing a right of appeal for medical staff who disagree with a decision of a hospital's board of management.

Section 46 of the *Act* states:

> **Hospital appeal boards**
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> 46 (1) For the purpose of providing to practitioners appeals from
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> (a) a decision of a board of management that modifies, refuses, suspends, revokes or fails to renew a practitioner's permit to practise in a hospital, or
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> (b) the failure or refusal of a board of management to consider and decide on an application for a permit,
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> the Lieutenant Governor in Council may, by regulation,
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> (c) establish one or more hospital appeal boards, and
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> (d) specify the powers, duties, functions, practices and procedures, including the quorum
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> (2) A hospital appeal board may affirm, vary, reverse or substitute its own decision that of a board of management on the terms and conditions it considers appropriate.

Pursuant to Section 8(8) of the Hospital Act Regulation[4] ("the Regulation"), "An appeal to the Hospital Appeal Board is a new hearing of the subject matter of the appeal."

In *Jain v. North and West Vancouver Hospital Society*[5], the Board (then known as the Medical Appeal Board) made it clear that:

> "In the opinion of the Appeal Board, the appeal of a physician who is

[4] BC Reg 121/97
[5] unreported July 18, 1974

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> 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.

Further, in *Iqbal v. Mission Memorial Hospital*[6] the Board added:

> "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: *Samson v. Sisters of Charity of the Immaculate Conception* (1984), 52 B.C.L.R. 76 (S.C.); affd (1985), B.C.J. No. 2021 (C.A.); *Hicks v. West Coast General Hospital*, [1993] B.C.J. No. 107 (S.C.); *Cimolai v. Children's and Women's Health Centre of British Columbia*, [2002] B.C.J. No. 490 (S.C.). 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 is a clearly plain language expression of the previous Regulation's reference to a "hearing *de novo*".

In regard to the procedure of the Board of Management in coming to their original decision, counsel for the Appellant argued before this Board that:

> "the process undertaken by … the Board of the Hospital amounted to a hearing in absentia at which no evidence on behalf of the Appellant was presented;"

[6] unreported February 25 1974

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The Board believes that the primary responsibility for presenting evidence on behalf of the Appellant at the original proceedings rested directly with the Appellant and his counsel. We are unaware of the Appellant's reasons for non-attendance, other than the March 25th response of his counsel to the opening remarks by counsel for the Hospital that " we did not appear before the regional body because we preferred to appear before this board". We note that the minutes of the Richmond Health Services Society, Extraordinary Board Meeting of December 21, 2001,[7] state the following:

> "…[the] Public Administrator for Richmond Health Services, noted that [the Appellant] did not choose to appear before him or make a submission, and did not request an adjournment of this meeting today, although he was given the opportunity to do so."

In any event, 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 the Appellant's privileges.

Preliminary Issues

(a) The Nature of Hospital Privileges

Hospital privileges are the mechanism by which hospitals grant to physicians the opportunity to treat their patients through the use of the hospital facilities. This is reflected in section 7 (1)(b) of the Regulation:

> **Attending and treating patients in a hospital**

[7] Exhibit # 58

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> 7 (1) A practitioner is not entitled to attend or treat patients in a hospital or in any way make use of the hospital's facilities for his or her practice unless the practitioner
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> (b) holds a valid permit, issued by the hospital's board, to practise in the hospital.

By the very nature of the *Act* and its Regulation, it is obvious that the permit to practise within a hospital facility is a privilege and not a right. From the perspective of the physician who has been licensed to practice medicine anywhere in the province, it may be difficult to accept that his or her license does not carry with it the automatic right to care for patients in the hospital. A hospital, on the other hand, is entrusted with the responsibility of providing health care for patients. The hospital board is ultimately responsible, both morally and legally, for the quality of the care provided within the hospital. As a result, it will want to choose carefully those who will provide that care.

The primary factors to be considered in determining whether to grant hospital privileges to a physician are the competence and qualifications of the physician. However, as noted in *Roberts v. Grant*[8]:

> ". . . there may be many other qualifications requisite for appointment to a medical staff beyond competence in the professional field."

Lorne Rozovsky stated[9], and as later cited by the Board in *Loewen v. Cariboo Memorial Hospital (No. 1)*[10]

> "Numerous factors may be, and, in fact, in some instances should be, taken into consideration when granting medical staff privileges. Can the physician be relied upon to take his turn in the emergency department? Does he live within a convenient distance? Can he be relied upon to be on call nights and weekends? Will he abide by the

[8] (1962), 34 D.L.R (2nd) 639 at 650 (B.C.S.C.)
[9] Canadian Hospital Law (Toronto: Canadian Hospital Association, 1974) at 58
[10] 7 November 1984, unreported, at 16.

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> hospital bylaws and accept the responsibility required of a member of staff? Does he complete his medical records promptly? Does he have a personality known to disrupt the efficient performance of the hospital team? Qualities of personality, temperament and emotional stability are properly considered when evaluating the criteria necessary for an appointment or for dismissal from medical staff."

In the case of *Board of Governors of the Scarborough General Hospital v. Schiller*[11], Mr. Justice Cromarty said, at p.225:

> "In exercising its undoubted right to select its own staff, that art which arises out of long study and continuous involvement with the practice of medicine in a hospital, the medical advisory committee and the hospital board must look at the whole man, at his personality traits, at all the circumstances surrounding his application before deciding that he is the man who ought to be on the staff of the hospital."
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> "The hospital board must decide if this applicant is one who will fit with and complement the existing staff, and who will co-operate and work well with his fellows."

This approach was affirmed and further explained by the Board in the decision *Hicks v. West Coast General Hospital* [12], at pp. 37 - 38:

> . . . . "a hospital board's duty, in selecting doctors for its medical staff, is to have regard to the whole person, not merely that person's qualifications and skills but the applicant's character and personality as well. Every hospital has a duty imposed on it by the Hospital Act RSBC 1979, ch.176, to provide a high level of patient care. That duty is owed to the community, which, in this country, supplies through taxes, the greater portion of the costs of operating the public hospitals. The onerous task faced by a hospital board is to ensure that the institution

[11] (1974) 4 O.R. (2nd) 201, affirmed on Appeal
[12] unreported May 25, 1991

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> is run competently and efficiently. It is a delicate mechanism. If the total trust, cooperation and general team work of any of its constituent parts breaks down the result can be unfortunate for the hospital and community." [emphasis added]

In his report to George Bryce of the *Royal Commission on Health Care and Costs*, dated June 18, 1991 regarding Hospital Privileges in British Columbia, Bill Veenstra, Law Clerk stated,

> "A hospital may look beyond whether a physician is competent to practise his specialty and consider whether the applicant possesses a desired level of skill, even if that desired level of skill is higher than the general standard for hospitals in the province. There is good reason to look beyond the license to practise medicine."

He goes on to quote author Lorne E. Rozovsky, a frequent contributor of articles and periodicals on *Canadian Hospital Law* in Canadian Hospital Law [13]at page 78:

> "This license is merely recognition that the physician has received a certain basic medical education which the licensing authority recognizes as acceptable to enable him to practise medicine within the scope of his license in the province. It establishes basic medical standards. It does not imply that the physician is of any particular merit nor that he actually practices good medicine. It does not imply that the licensed physician would be suitable as a member of the medical staff of every hospital."

In his report to the Royal Commission, Mr. Veenstra went on to say[14],

> "In recent years the concepts of "quality assurance" and "risk management" have become key focuses of hospitals and the medical profession. In 1983, the Canadian Council on Hospital Accreditation

[13] 1974, Canadian Hospital Association
[14] at page 25-26

(CCHA) determined that by 1986 every hospital must have in place a quality assurance program in order to qualify for accreditation. The CCHA Guidelines for accreditation now require, for example, that:

> The quality assurance program shall include activities related to the entire medical staff, such as: credentialing process of the medical staff; periodic review of privileges; . . . activities such as review of statistics, criteria audits, clinical records review, tissue review, morbidity and mortality review, autopsies, review of complications, investigations of complaints. [Emphasis added]

At the same time, the potential liability of a hospital to patients for negligent treatment has spurred hospital administrations to carefully consider the quality of care within the institution. While quality assurance focuses on planning for the future through the implementation of programs to maintain the quality of care, risk management focuses on protecting the institution against liability claims and losses.

A key element in any quality assurance program is the appointment of highly competent, qualified physicians to the medical staff of a hospital:

> The reappointment process is one of the hospital's prime mechanisms of quality assurance. More than any other single measure, it determines the standard of hospital medical care. The appointment of competent, well-trained, ethical and conscientious physicians is the highest assurance a hospital can give of high quality medical care. The hospital board has the responsibility to establish means of assuring this high quality.[15] [Emphasis added]

[15] J.R. Dillon, Legal Opinion on Disclosure of Ongoing Lawsuits upon Reapplication for Hospital Privileges, September 22, 1989

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An additional element of both quality assurance and risk management programs is the institution of an effective peer review mechanism:

> Hospital administrators and a lay board of trustees cannot directly ensure that all physicians meet an acceptable standard of practice. They must depend on physicians supervising each other and on the professional conduct of each person, and trust department heads to supervise their staff. Thus, the administration and the board depend on the medical society to function as a disciplinary body and a quality control mechanism over its members.[16]"

The Hospital Appeal Board supports and adopts the approach described above in the appointment, reappointment and re-consideration of physician privileges.

In the case currently before the Board, counsel for the Appellant has repeatedly emphasized the significance of this decision for his client's ability to practice his chosen profession.

The Board fully understands the significance of the Appellant's interest, which weighs heavily in our decision-making and which has informed the high degree of procedural fairness he has been granted in this proceeding. At the same, this Board must, on the merits, acknowledge that a hospital also has an interest in ensuring that the highest quality of care is provided within the hospital. This is not a simple contest between the Appellant and the Hospital, and in which the only consideration is the Appellant's professional interests. The issue is more complex and necessarily requires the Board to take into account the interests of patients and patient care. In this regard, we find it useful to reproduce the following exchange between counsel during argument on the admissibility of certain evidence. The Appellant's counsel argued that:

> "... we're talking about [the Appellant's] professional life."

[16] M. Stevens, "Protection of Quality Assurance and Peer Review Data" (1989) 9 Health Law in Canada 79.

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The Board concurs with the statement made in response by counsel on behalf of the Hospital that:

> "... I appreciate that this is[the Appellant's] professional life, but I also appreciate this is a very significant patient care issue for the hospital."

The Board is further reminded that the act of granting a permit to practise within a hospital is a privilege and that, in Canada, a qualified physician has no automatic right to practise in a hospital.

(b) Quality Assurance Reports

Counsel for the Appellant submits that the Hospital asks the Board to place reliance upon the Quality Assurance Reports, without making all the individuals who provided information relied upon by the Quality Assurance Committee available for cross-examination, and despite the fact that there is no written record of much of the evidence relied upon by the Committee in their reports. Counsel further states, "this would be contrary to the Rules of Natural Justice. It would be inappropriate for this Board to rely on the factual assumptions relied on in the quality assurance process."

As stated earlier by the Board, one of the key elements of a quality assurance program is an effective peer review mechanism that includes educational activities for and closer supervision of quality assurance risks, as well as minor disciplinary proceedings not affecting a physician's hospital privileges. A structured peer review system provides both the medical staff and the hospital with important data to use in reviewing applications for reappointment to the medical staff and in the consideration of any restriction or removal of hospital privileges.

It is sufficient for purposes of this Board, that it identifies the Quality Assurance reports as the product of the Quality Assurance review process that was undertaken in

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accordance with the Medical Staff bylaws Articles 2.2 and 2.3. In a ruling on the admissibility of the Quality Assurance reports within the hearing,[17] the Board stated:

> "The quality assurance process has been deemed so important that it has been given special legislative protection. Section 51 of the *Evidence Act* states that such reports cannot be disclosed or used in proceedings against medical practitioners. In *Sinclair v. March*, [2000] B.C.J. No. 1676 (C.A.), the Court of Appeal held that "the Legislature intended to protect this area of hospital activity by preventing access by litigants. Rather than striking a balance of interests, the Legislature made a clear choice in favour of one interest, hospital confidentiality."

The Quality Assurance Reports referred to in this appeal were the result of a properly administered quality review as supported by the bylaws of the Hospital. It was the substance of the external review undertaken by the second reviewer that resulted in the decision of the Hospital to revoke the Appellant's privileges. Further, any findings of fact we make are the result of the review of the testimony of the witnesses heard directly before this Board.

(c) Experience at other institutions

On the issue of the Appellant's experience prior to working at the Richmond Hospital, counsel for the Hospital submitted that the Appellant appears to acknowledge that he suffers from some deficit in his ability to deal with his colleagues. The Hospital states "where that deficit impacts adversely on patient care, it must take the action it has. It is of note that this is not the first time such a problem has arisen for [the Appellant]."

The Appellant gave evidence in cross-examination that during his residency, a group of physicians at Vancouver General Hospital decided "they did not like him" and had "clinical competency concerns" although the Appellant said that was not really what was going on. As a result, he transferred to Saskatchewan in the middle of a year to

[17] preliminary decision dated June 10, 2002

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finish his residency. He also acknowledged that he left his practice at Ridge Meadows Hospital in part because of a "conflict' with an anesthetist, as well as overwork.

Counsel for the Appellant submits that the Hospital's reference to the Appellant's experience at other institutions without any evidentiary basis implies that the Appellant's evidence should in some way be discounted on these issues. It is the further position of counsel for the Appellant that regarding the Appellant's prior experiences, the Board is bound to accept his answers on these collateral issues, especially where the Appellant stated that the suggestions and assertions made by the Hospital were incorrect.

The Board finds that the Appellant's past experience is worthy of note given the issues in this appeal. It is sufficient for the Board to indicate that it has concern with regard to the Appellant's past experiences with colleagues, especially with those in the position of "mentoring" during a period of training, or those in the position of assisting with the provision of patient care as in conflicts with an anesthetist in Maple Ridge. The Appellant in his testimony indicates "there is always tension between people in every place that we worked". We note that the delivery of patient care within the specialty, in which the Appellant practices, requires a great amount of physician cooperation and teamwork, and that no specialist "can be an island unto himself".

(d) Adverse Inference

Counsel for the Appellant raises the question as to the possible drawing of an adverse inference by the Board in regard to the calling of certain witnesses at the hearing of the appeal. In his argument, counsel states that an initial request was made in December 2001 to interview certain nurses, and that the Hospital assured that the interviews were being arranged. Counsel advises that he was informed in March 2002 that in fact the Hospital was refusing to produce the nurses on the grounds of litigation privilege. Counsel further submits that permission was initially sought to interview specific nurses involved in some of the cases in question. This request was ultimately denied. A general request was then made to interview nurses without identifying specific individuals, and again, this request was denied. The Appellant's counsel submits that he should not have been required to identify to the Hospital which nurses they wished

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to interview: "a witness is either available and free to be interviewed by either party, or not." Counsel further suggests,

> "for the Hospital to insist that we identify specific nurses so that they may assess whether they are willing to allow us to interview these witnesses is an untenable position. In so doing, they are in essence denying us the opportunity to call these individuals as witnesses."

Pursuant to the Court of Appeal's decision in *Barker v. McQuahe et* al,[18] counsel for the Appellant submits that, where the party with control over any given witness fails to call such witness or prevents the opposing party from doing so, the opposing party is entitled to an adverse inference being drawn against the controlling party.

Counsel further adds that the letter written in support of the Appellant's application for privileges at Richmond Hospital further supports that an adverse inference should be drawn in this case. The Appellant testified that this letter was unsolicited and was written and signed by 36 nurses who had worked in the obstetrics department with the Appellant during his 16 months as a locum. Counsel for the Appellant submits that there is no evidence indicating that this support from the nurses no longer exists, and in fact, the Hospital's act of denying counsel access to the nurses as a group suggests the contrary. Counsel thereby submits that this Board is entitled to draw the inference that these nurses continue to support the Appellant.

Counsel for the Hospital submits that the law with respect to adverse inference goes no further than to state that an adverse inference may be drawn against a party who fails to call a material witness. Counsel adds that an inference adverse to a litigant may be drawn if, without sufficient explanation, he or she fails to call a witness who might be expected to give important supporting evidence. It is the position of the Hospital that no adverse inference may be drawn where a witness is available equally to both parties.

In regard to the access to nurses for the purpose of interviews, counsel for the Hospital submits that contrary to the assertion made by the Appellant's counsel in his

[18] (1964) 49 W.W.R. 685 (B.C.C.A)

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submissions, no assurances were ever provided that interviews with all of the nurses were being arranged. It is clear from the Appellant's counsel's letter of December 4, 2001 that she would "ascertain whether they [the nurses] wished to agree to such an interview".

In considering this submission of counsel for the appellant, the Board examined a number of issues: What was the nature of the request for access to witnesses? Was there a deliberate attempt to restrict access to the nurses? Was there a failure to call a witness or witnesses, who might be expected to give important supporting evidence? Does *Baker v. McQuahe*[19] apply in this case? And lastly, should any adverse inference be drawn in this instance?

The issue of the Appellant's access to a number of nurses for purposes of pre-appeal interviews arose early in the appeal process, before the commencement of the hearing process. Counsel for the Appellant, during a conference call with Hospital counsel and the Board Chair raised the issue of access to a number of nurses. It is the understanding of the Board that although, upon initial request in December of 2001, counsel for the Hospital in the appeal assured counsel for the Appellant that interviews could be arranged, counsel for the Appellant was subsequently advised in March 2002 that as a result of pending litigation, counsel representing the Hospital in the litigation proceedings had directed the nurses not to voluntarily submit to an interview, but to appear for questioning at the hearing of the appeal should they be summoned to do so. The Chair of the Board informed the Appellant's counsel of the Board's limitation in ordering the nurses to appear before Appellant's counsel for the purpose of an interview, but stated that it would respond to a request to have the nurses appear before the Board through a summons. Counsel for the Appellant did not seek to summon the nurses and did not raise the issue again until late in the hearing as a result of a request of the Board for correspondence addressing another matter connected with this appeal, such correspondence also containing the issue of access to the nurses in question.

[19] supra note 9

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In all of the circumstances before us, the Board finds no deliberate attempt to restrict access to the nurses in question. The Board has received no evidence that any or all of the nurses in question were any or all of the nurses that supported the Appellant's initial application for privileges at Richmond Hospital. Further, the Hospital's request that counsel for the Appellant identify specific nurses to be interviewed is seen by this Board as simply an offer to help process the request and in no way a denial of the opportunity to call these individuals as witnesses. Counsel for the Appellant was free to summon whichever witnesses he felt necessary, and as indicated earlier, was supported in those options by both the Board and the nurses in question, as counsel for the Hospital in the pending litigation had indicated the nurses in question would respond to a summons by the Board.

The Board was advised during the course of the hearing that the nurses involved in a number of the Appellant's cases have either been named in a lawsuit or anticipate being so named, and are represented by independent legal counsel retained by the Hospital's insurer. They received independent legal advice about participating in interviews.

There was evidence before the Board that in at least one case, one nurse that agreed to be interviewed, was interviewed by the Appellant's counsel and was subsequently not called by the Appellant to testify. As well, information was provided to counsel for the Appellant from another nurse, following which it was determined there was no need for an interview.

The Board finds that no adverse inference should be drawn in these circumstances.

(e) The Review Process

The Appellant's counsel submits that the review process undertaken by the second reviewer on behalf of the Hospital was biased and unfair. Counsel for the appellant submits that the second reviewer failed to meet many of the requirements set out by Cresswell J. in *National Justice Compania Naviera S.A. v. Prudential Assurance Co. Ltd. ("The Ikarian Reefer')*[20] case. Counsel argues that the second reviewer improperly

[20] (1993) 2 L.L.R 68 (Q.B.)

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relied on a reporting physician in one case and neglected to look at the Appellant's office chart in another case. In addition, the speed with which the second reviewer performed his purportedly thorough review, the fact that the second reviewer ascribed criticisms to the Appellant in cases with which he had little or no involvement, and which were properly ascribed to other physicians, the fact that he clearly held the Appellant to a higher standard than the other members of the obstetrics department, and that he presented as a strong advocate for the Hospital, puts him in breach of, at minimum, three of the 7 duties listed. Counsel states "[the second reviewer's] failure to meet his obligations was one of the factors that resulted in a biased and unfair review, which cumulated in an inaccurate and misleading report."

Counsel for the Appellant further submits that where an expert fails to meet one or more of his responsibilities, as stated in *Canada (Director of Investigation and Research) v. Southam Inc.*[21] he loses his right to deference.

The Board finds that the involvement of the reporting physician in one case was completely appropriate given the terms of the review decided upon by the MAC at its November 22, 2001 meeting and in particular the request by the MAC that the review also include "[a]ny other case under any obstetrician/gynecologist specially brought forward for review by any physician in that patient's care." As the reporting physician was the admitting physician in this case, bringing this case to the attention of the second reviewer met the guidelines for review. With respect to the "speed" at which the second reviewer performed his review, counsel for the Appellant suggests that given the total time for the review, simple math can deduce that the second reviewer spent less than 25 minutes on each chart reviewed. We conclude that this explanation is far too simplified. As has been observed through extensive testimony regarding a number of the cases in question and the degree of patient concerns (which varied greatly from case to case), it would be inappropriate for the Board to conclude that the second reviewer, given his extensive background in undertaking such reviews, did not provide the appropriate level of review to each and every case reviewed. As to the question of the second reviewer failing to review the office chart of a patient, we note that the initial review undertaken by the second reviewer was to be restricted to those

[21] [1997] 1 S.C.R. 748 at 779-80

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patients' records, as the property of the Hospital, as the review at hand was one of patient care provided within the Hospital.

The Board further notes that in those instances where the second reviewer ascribed criticisms to the Appellant in cases with which he had little or no involvement, when provided with clarification, the second reviewer changed his views and acknowledged such in his subsequent report. The changes acknowledged in the subsequent report are not significant enough to change the overall outcome of the second reviewer's review. We are convinced that the second reviewer did not apply any greater "standard" to a review of the Appellant's cases than he did to all of the cases under review, including those of other members of the Department.

The Appellant's counsel also submitted that the worksheet, provided by the Hospital listing the cases to be reviewed, providing a summary of the procedures performed and in some cases noting a summary of the Hospital's complaints, demonstrates yet another level of procedural flaw and bias in the Hospital's review. We conclude that the worksheet provided nothing more than an "index" of the charts of the cases provided for review.

The Board concludes that the second reviewer met all of his responsibilites as an expert for purposes of this appeal as he was able to fully support the reasons for his conclusions in a coherent and defensible manner. In this regard, we had the great benefit of not only reviewing his report, but also of hearing his evidence with regard to each of the cases, which evidence was subject to extensive cross-examination.

(f) Additional Expert Reports Provided on Appeal

(i) Appellant Expert #1

Expert #1 was qualified as an expert in the area of obstetrics.

Expert #1 was provided with 22 charts of the Appellant's patients identified by the second reviewer, in his review, as being significant, or very significant. Expert #1's

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review was limited to those 22 charts provided to him. Expert #1's March 7, 2002 report[22] states that:

> "It would also be much more scientifically valid if a number of charts of other patients cared for during the same time period, at the same institution, were selected at random for the same type of scrutiny."

In Expert #1's testimony he stated as follows:

> Question: "Okay. So I take it you weren't aware that, in fact, [the second reviewer] had looked at all obstetrical cases for all obstetricians at Richmond Hospital for a certain time period, identified by morbidity of mortality checklist requirements?"
>
> Answer: "That's correct."
>
> Question: "And you weren't aware that he'd looked at all gynae cases for certain complications, again for all obstetricians for Richmond Hospital for the same time period?"
>
> Answer: "Correct"
>
> Question: "Or any case by any obstetrician brought forward by other physicians involved in the care at the same time period? So that was approximately 120 charts in total. And I take it you'd agree that, then you have no basis to actually compare the Appellant's practice, as it could be derived from the 22 charts you looked at, to his colleagues at Richmond Hospital because you haven't seen their charts?"
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> Answer: That's right"

[22] Exhibit # 69

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Question: "And certainly, bearing in mind what you say about a random review, this type of review is not uncommon in a quality assurance process and it – and does it provide a reviewer with some valuable information in terms of looking at how all the obstetricians handle various complications; correct?"

Answer: "Yes"

Expert #1 also testified that his Canadian experience has been essentially at teaching hospitals.

(ii) Appellant Expert #2

Expert #2 was qualified as an expert in the area of obstetrics and gynecology. Expert #2 reviewed the 21 charts of the Appellant's provided to him. In his testimony, Expert #2 stated that he didn't review the charts of any of the other obstetricians at the Richmond Hospital, and that he could not speak to the issue of how the Appellant compares to his peers in the Department of Obstetrics at Richmond Hospital. Expert #2 further testified that he knew the Appellant during his (the Appellant's) residency, and that he was involved in coming down to the University of British Columbia to help the Appellant with regard to an issue during his residency that involved a general practitioner in Prince George who lodged a complaint with regard to personal behaviour by the Appellant.

(iii) Appellant Expert #3

Expert #3 was qualified as an expert in obstetrics and gynecology. Expert #3 was asked to review the same 21 charts that Expert #2 reviewed. In his testimony, Expert #3 stated that before his suspension, the Appellant took call for Expert #3 at Surrey Hospital, and in fact that a large majority of the time, the Appellant took call for him on weekends as Expert #3 was not fond of doing an entire weekend of call. He further added that the Appellant was quite accommodating and didn't complain that he found doing his call onerous.

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(g) Weight to be Given to Expert Reports

(i) The First Review

The report of the first reviewer was not entered into evidence before this Board, following a ruling by the Chair, after being advised that the first reviewer would not be called to give evidence. Accordingly, this Board places no weight on any issues purported to be evidence within his report.

(ii) The Reviews of the Second Reviewer, Expert #1, Expert #2 and Expert #3

The Board concludes that the review undertaken by the second reviewer is superior to those undertaken by the three Appellant experts. The second reviewer's review clearly assessed the standard of care provided by the Department of Obstetrics and Gynecology at Richmond Hospital and more closely followed the original guidelines for a review as set out by the MAC of the Hospital. This position is supported by both the opening remarks in the second reviewer's and Expert #1's reports, together with the testimony of Expert #1 and Expert #2. The second reviewer's review relates far more strongly to the issue of the appeal at hand, that being the Standard of Care within the Department of Obstetrics and Gynecology of Richmond Hospital and the comparison of the individual physicians of that department in the meeting of those standards. Moreover, we find that the second reviewer has more extensive experience in the undertaking of such reviews than the three Appellant experts. The second reviewer's lack of any previous association with the Appellant reinforces our confidence regarding the objectivity of his review.

The Evidence

(a) The Patient Cases

[The full decision summarized and compared in detail the relevant evidence heard and reviewed by the Board regarding the specifics of the 20 individual patient charts examined, which has been omitted in this version.]

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Case Review Summary

The second reviewer

In summary, the second reviewer observes, "[The Appellant] has had a significant number of problems in the same time that his colleagues had very few." On the issue of documentation, the second reviewer observes, "if we were to be generous and to remove some of those cases where my opinion is focused solely on poor documentation or missing records, all his colleagues would have lost any cases appropriate for criticism." On the issue of speed, the second reviewer comments, "A common thread running through this practitioner's practice is one of hurry. Almost all his caesareans, including complicated ones, are completed in under 15 minutes. I do not believe that the Appellant pays enough attention and takes, enough time when cases are particularly at risk."

With regard to the Appellant leaving the operating room in the middle of a serious case, the second reviewer stated in his report, "I have never heard of a surgeon bowing out and absenting himself in the middle of what might have been a life-limiting situation, leaving another colleague alone until an assistant was obtained. This is entirely unprofessional". The second reviewer concludes, "When reviewing all these cases, it becomes obvious that there are multiple deficiencies in [the Appellant's] management of patients and problems."

Appellant Expert #1

In summary, Expert #1 wrote, "In reviewing the 22 charts which follow this letter, I have found examples of what might appear inappropriate care or decision making, which viewed under a more thorough exploration of all the factors involved (including those not on charts) might well be found within normal expectations". He adds, "In a few cases, where intervention was needed, or selected, it appeared that an opinion of a senior colleague might have been helpful, although on most of examples seen, the selected management might well have been the same." Expert #1 notes, "His surgical procedures, mostly caesarean sections were nearly always completed in a shorter interval of time than is usual."

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The panel notes that although Expert #1 suggests he reviewed 22 charts, his report only contains 21 such charts reviewed.

Appellant Expert #2

Expert #2 notes that in at least two cases, the Appellant should have been written or dictated more detailed information with the occurrence of serious problems arising during labour and/or delivery.

In five cases involving caesarian sections, with significant maternal or fetal complications, Expert #2 notes that the common factor appears to be the rapid "skin-to-skin" time. He adds, "In my view, 10 minutes is an insufficient time in which to properly observe the vessels for hemostasis. This would increase the risk of a bleeding problem postoperatively. With a caesarian section of under 15 minutes, the risk of intraoperative or postoperative complications is increased." Expert #2 comments that a caesarean section case is an example of poor leadership, teamwork and communication skills on the Appellant's behalf.

Appellant Expert #3

Expert #3 writes, "It is my opinion that [the Appellant's] diagnostic acumen, surgical skill, clinical judgment and documentation are within the standard of practice of a physician practicing at a community hospital."

Counsel for the Appellant submits, "When presented with clear and irrefutable evidence of errors or inconsistencies in his opinion, [the second reviewer] was belligerent in his demeanour and refused to concede that he could be in error in any respect." Counsel adds, "Throughout his evidence, [the second reviewer] commented extensively on [the Appellant's] lack of leadership, teamwork and communication skills, even though he conceded that his opinions were entirely dependent on the level of detail that was available in the charts. In contrast to [the second reviewer's] strong opinion that [the Appellant's] lack of positive decision-making and failure to make definitive plans was clear from the record, [Expert #2] and [Expert #1] both commented that it is

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extremely difficult to draw accurate conclusions as to one's leadership capabilities, teamwork and communication skills from a chart review. [Expert #3] commented that in his opinion, the charts appeared to indicate that [the Appellant] was a strong team member with good communication skills. However, unlike [the second reviewer], [Expert #3] acknowledged that it was difficult to draw firm conclusions on such skills solely on the basis of a chart review. In addition, [the Appellant's] leadership and communication skills are evidenced by the spontaneous letters of support from many of the general practitioners and nurses who worked in a team with him at Richmond Hospital."

Counsel for the Hospital argues, "While [the second reviewer] was firm in some of his views, it is not fair to characterize him as belligerent. Where a new fact or document changed his opinion, he said so. [Expert #1] was even more decided in his views and unreasonably irritable with the suggestion that not everything was "in the charts", and he flat out refused to comment on such evidence in some instances."

The panel does not agree that the second reviewer was belligerent. We find that he was professional, clear and very helpful in his evidence. In contrast to the evidence of the three Appellant experts, his conclusions were not successfully attacked or qualified on cross-examination. The conclusions he reached in his reviews were, with the exceptions listed above, fully supported based on the fulsome and tested evidence before us, and were more helpful and in accord with that evidence than the reviews of Expert #1, Expert #2, and Expert #3.

Of the 20 cases that are the referenced in this review, there exist at least 11 cases where the Appellant's quality of care was below the institution's reasonable expectations for its staff; 6 cases where the Appellant's communication skills with either patients, family or colleagues were inadequate; at least 4 cases in which the Appellant demonstrated a complete absence of clinical leadership; and at least 10 cases in which the documentation is inadequate or completely lacking. The panel finds that in many of the cases the poor or missing documentation seriously impacts communication, leadership and the meeting of an acceptable standard or quality of care. The panel also finds that in too many instances, the Appellant was too anxious to shift responsibility and blame to other medical staff involved and did not acknowledge

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responsibility for his actions or inactions. Evidence regarding a number of these points is further outlined below.

(b) Communication and Interpersonal Relationships

(i) Written Communication / Documentation

In correspondence directed to the second reviewer, the guidelines for the review provided a list of specific questions for his consideration. In the area of documentation, it outlined "adequacy, comprehensiveness of operative reports, admission history and physicals (when appropriate)" as indicators to be considered. Section 4.1 of the Medical Staff Rules and Regulations[23], states:

> "1. The physician responsible shall maintain an adequate clinical record for every person admitted as an inpatient, outpatient or emergency patient, who received any patient care or treatment service from the hospital. The clinical record shall be accurate, timely, complete, comprehensive and legible as it is the sole legal documentation of a patient's life in hospital."

The second reviewer was critical of the Appellant and others in the Department for documentation that he believed was inadequate. The second reviewer was concerned with the lack of adequate documentation in 10 of the charts with respect to the Appellant.

Expert #1 notes in his report, "His documentation was adequate, although the tradition of only requiring prompt legible, or dictated reports, in circumstances related to surgical events, which persists in most institutions, unfortunately mitigates against the ideal practice of dictating a report promptly in any medical care event, of an unusual nature or of undue complexity and gravity, regardless if surgery is involved or not."

[23] Exhibit # 59

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Expert #2 indicates in his report that the Appellant's documentation is adequate with few exceptions.

Expert #3 concludes that the Appellant's documentation is within the standard of practice of a physician practicing at a community hospital.

The Appellant on numerous occasions explained the issue of "lack of documentation" as a result of written or dictated notes by him that had somehow gone missing from the charts. This panel heard evidence that there were photocopying problems with some of the charts; however once the error was discovered, those missing pages were provided to the second reviewer for review allowing him to provide further views in light of the additional information. As a result, the second reviewer withdrew his criticism in one case. The Appellant continued to make the assertion that there were further notes missing from the original charts and while he was provided with the opportunity of reviewing the originals, none of those notes were located.

(ii) Verbal Communication and Leadership

On questioning from the panel, the experts each testified that it was hard to assess leadership, teamwork and verbal communication skills from a chart review. The second reviewer testified that his ability to answer the question was entirely dependent on the detail of the notes in the chart but felt he could get "a good feel, though, from a lot of charts as to whether an individual is capable of making appropriate organized decisions and having done so, acting upon those decisions." He described a good leader as one who came out with a definite opinion, made a plan and executed that plan without hesitation using others as resources. Expert #1 testified that a good team player was someone who "agrees with what's the majority feeling of the department – how to handle things." The panel heard testimony from other witnesses who had direct experience working with the Appellant.

It appeared that the Appellant's communication style adversely effected how many of his colleagues perceived his leadership as it related to patient care and clinical judgment. Four anesthetists all testified that in several instances they were not satisfied that the Appellant provided full communication and an honest representation

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of the patient's condition. Some examples include one anesthetist, in testifying on an unexpected breach case, who said that it was an uncommon and rare occurrence that an incision would be extended and that he wouldn't be told. Another anesthetist felt that the Appellant was "in denial" about the seriousness of the patient's condition, in a case that involved labour with the spontaneous rupture of membranes. A third anesthetist testified that he was surprised that the Appellant communicated to him that he needed help with the same case. The fourth anesthetist said with regards to two patients, that the lack of action on the part of the Appellant to communicate adequate and timely information to the anesthesiologists compromised their ability to give good and effective care. The fourth anesthetist said an anesthesiologist is at a real disadvantage because they have not followed the patient for a long time—they depend on colleagues to alert them to the concerns that they understand through their more intimate knowledge of their patient.

In addition to the anesthetists, other members of the patient care team testified they had concerns about communication and leadership. Many of these concerns came to a head in the case of labour with the spontaneous rupture of membranes.. A nurse testified that the Appellant told her he was not taking this patient back to the OR because he had done that before and had to attend a lot of meetings because the patient hadn't needed to go. She was shocked and upset because she thought the patient was "bleeding out". Another nurse was told to "calm down, you're getting too excited" by the Appellant. One doctor testified "a good clinician would have recognized that the watery blood was from prolonged bleeding and would have told me". She also testified that as the most responsible physician he should have stayed with his patient and not left her to introduce herself to the family and explain the situation afterwards. The doctor described him as a "by-stander" who was "panic-stricken" and unable to take the initiative and make decisions about the patient's care. Another doctor testified that the Appellant was not participating in conversations about doing a hysterectomy. A nurse, who was present in the OR as the circulating nurse, observed that the Appellant seemed tense and uncommunicative with the other doctors and needed to be prompted to contribute.

(iii) Personal judgment and responsibility

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Another theme that arose in the testimony was the Appellant blaming others for poor outcomes. This was evident in several cases including when the Appellant blamed another doctor for taking the patient back to OR; another case where he alluded that a doctor or someone else other than himself could be responsible for the baby's broken arm, and with another case where a nurse testified that he blamed the nurses for not being on top of things.

In two cases, the Appellant demonstrated passivity through his willingness to go along with the patient, rather than follow his own judgment. Four doctors testified that the Appellant abrogated responsibility for the patient's care through his reluctance to seek help from his colleagues. Getting help is also an SOGC guideline.

(c) Trust

The panel heard an overwhelming amount of testimony about the lack of trust in the Appellant.

One doctor commented on a lack of trust and concerns with judgment in the Appellant's care of patients. "We are a small group, not a teaching centre and need to be able to trust each other." "Trust between the group is extremely important and we have to be able to rely on each other" and "be flexible in our willingness to be involved with each other in problem cases." She described this as an issue of trust and judgment that "would put us [the Hospital] at a risk of further incidents" and that within their setting as a small group of obstetricians without back-up that quick judgements are necessary.

Another doctor, an anesthetist, in his testimony said "I don't want to have to deal with someone who operates in this fashion" [misrepresents patient's condition].

One doctor, the other joint department head, initially welcomed the Appellant and had no reasons to be concerned. He testified he would have a great deal of trouble trusting the Appellant now with the care of his patients.

Another doctor said that relatives of patients might ask her why she would sign out to the Appellant knowing that there could be complications — "I don't have that trust any more."

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One doctor said that “in the operating room we work as a team”. “You have to have comfort with each other’s ability. You have to trust each other. You have to commmunicate with each other . . . he has broken our trust — I still get emotional about this case.”

Conclusions

(a) Competence

It has long been established by this Board that in consideration of the issue of physician competency, consistent with the Act and Regulations, and in concert with a hospital’s Medical Staff Bylaws, the Board will rely on the licensing body to decide overall competency of a physician. The Board is not in the position to decide whether or not the Appellant is fully competent in his field of practice. That is the mandate of the College of Physicians and Surgeons of British Columbia (“the College”), a statutory body whose function it is to evaluate the competence and conduct necessary to maintain registration and licensure.

It also has long been established that physicians wishing to apply for privileges within a hospital must, in accordance with section 7 (1) of the Regulations, be a member or registrant in good standing of the College. As previously stated, it is the role of the Board to put itself in the position of the hospital board of management in its determination of an appeal regarding the granting of privileges to physicians and in doing so, we must take into account the quality of care standards provided by the Hospital and its Medical Staff. A hospital may look beyond whether a physician is competent to practise his specialty to the standards set out by the hospital even if that desired level of skill is higher than the general standard set for the purpose of licensure. In hearing appeals before it, the Board will consider physician competency only as it relates to the standard of care as set out by the hospital’s Medical Staff Bylaws, together with department Policies and Procedures. In the case at hand, the Board has had the opportunity to examine and cross-examine evidence brought before it as it relates to the quality of care standards of Richmond Hospital.

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(b) Quality of care standards

In order to establish a benchmark for the care standards relevant to the issues in this case, the Board looked to four major sources: the Medical Staff Rules and Regulations, the testimony of the expert reviewers, the testimony of the other four obstetricians and gynecologists who are members of the Department of Obstetrics and Gynecology at Richmond Hospital and the Chief of Staff. The Panel's view was also informed by the Society of Gynecology Clinicians (SOGC) Clinical Practice Guidelines, particularly as they relate to the treatment of postpartum hemorrhage, the transfer of responsibility from one physician to another, and informed patient consent.

The Board accepts that:

1. The SOGC guidelines are a reasonable expectation and benchmark against which to measure the care of obstetrical patients at Richmond Hospital.
   All of the experts and staff obstetricians endorsed the SOGC Guidelines as appropriate guidelines by which to measure and follow in the treatment of PPH. Under cross-examination the Appellant testified that they are only guidelines and not rules that must be followed every time.
2. The accepted standard at Richmond Hospital describing the conditions under which the department chief may require a physician to obtain a consultation is described in Section V (1) of the Medical Staff Rules and Regulations for Richmond Hospital[24] which states that a consultation is indicated when:
   i) The diagnosis of the patient is in doubt after reasonable investigation.
   ii) The patient does not appear to be responding to the prescribed treatment.
   iii) The patient's condition is serious enough to be considered life threatening.
   iv) There are other circumstances which, in the opinion of the department chief or section head that require consultation.

   It is noted that the SOGC guidelines also refer to asking for consultation and help from others.
3. The accepted standard at Richmond Hospital for the transfer of responsibility is as articulated in Section V (2) of the Medical Staff Rules and Regulations for Richmond Hospital[25] which states:
   "2. Transfer of Responsibility
   a) Each member of the medical staff shall provide assurance of

[24] Exhibit #59
[25] Exhibit #59

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continuity of adequate professional care for his/her patients in hospital by being available or having available an alternate member of medical staff with whom prior arrangements have been made.

b) When a patient's care is to be transferred to another physician on the medical staff, the transferring physician must call the receiving physician, speak to him/her directly, and will remain in charge of the patient until the receiving physician accepts the patient. He will then make an appropriate notation on the patient's chart designating the receiving physician as the Most Responsible Physician."

4. The definition of informed consent, as put forth by the Chief of Staff in her testimony on June 17th, 2002, reflects the accepted standard at this hospital; namely describing the situation and the clinical findings to the patient and the risk and benefit of having and not having the procedure. This is the general requirement at law as reflected in s. 6(e) of the *Health Care (Consent) and Care Facility (Admission) Act.*[26]

Under these definitions and in these areas, the panel found the Appellant's quality of care to be lacking in the following cases:

i) SOGC Guidelines (5 cases)
ii) Consultation (6 cases total): [1 Pathology]; [2 Radiology]; [1 Cardiology]; [2 Another Obstetrician]
iii) Transfer of Responsibility (1 case)
iv) Informed Consent (1 case)

The Medical Staff Bylaws of Richmond Hospital make reference to the fact that with technological advances and new procedures being developed, specific standards of training and assessment of competency as formulated by the department and section involved is required. This panel has heard evidence from members of the Department of Obstetrics and Gynecology with regard to the adherence to National Guidelines.

Section IX of the Bylaws of the Richmond Hospital provides:

[26] R.S.B.C. 1996, c. 181

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> "Each new physician on staff will be oriented to the hospital. This orientation may vary depending on the physician's prior association with and knowledge of this hospital. Specifically the orientation must include:
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> i) By-Laws and Rules and Regulations
>
> ii) Health Records, including:
>
> a) clinical record documentation requirement;
>
> b) dictation system;
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> c) incomplete records and notification procedures;
>
> d) requests for statistics and clinical studies.

It was the Appellant's testimony that he was never given any orientation to the hospital, either when he began locum privileges or when he was appointed to active staff. Exhibit # 76 provides the Appellant with formal notice of Active (Provisional) privileges having been granted to him, along with notice to arrange formal orientation in two areas. The Appellant testified that he attempted to arrange the required orientation, was able to receive direction from Health Records, but that staff was on holidays when he sought orientation to the Maternity, Labour and Delivery suites. The Appellant also acknowledged that although he left a message for the staff member, he did not follow up upon her return.

The Bylaws provide extensive direction with regard to the completion of medical records, rules regarding the most responsible physician together with direction on the transfer of care to another physician and direction in the area of surgical operations. The Appellant acknowledged in his testimony that he had indicated that he had read the bylaws by his signature.

The Appellant testified, "When I say the orientation is more important thing is in the clinical ward what is to be done. The department didn't give me any orientation about this." The Appellant was asked by the panel, "would it not be important for you to make sure that you were fully oriented as to the requirements for all things at Richmond?" His reply was, "Yes".

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This panel concludes that the Appellant had a responsibility to take appropriate initiative to fully orient himself to the hospital, including the expected standards to be followed. He was remiss in not doing so.

This panel has had the opportunity to hear testimony from an extensive number of witnesses relating to the care provided by the Appellant. The observations of other physicians and nurses within the department, together with the external "chart" reviews of a number of experts within the field of Obstetrics/Gynecology has provided us with an extensive overview of the Appellant's care. The panel acknowledges the rather limited view that can be provided by a simple chart review of a number of cases as attested to by those undertaking the reviews. As noted above, our conclusions also take into account the evidence provided by the other witnesses called to testify and which either reinforced and added context to the charts, or provided information that was not evident in the patient charts. In particular, while the charts can provide a limited insight into the provision of care as documented, issues such as communication, leadership and trust are better provided by the direct observations of those that work in close contact with the Appellant.

This panel finds valid the concerns raised in the evidence regarding the speed at which the Appellant performs many of his clinical functions. The panel further finds that the Appellant has not met expectations in key cases when confronted with issues of extreme urgency, or those that arise during crisis situations.

The Board concludes that the Appellant failed to meet the accepted care standards for Richmond Hospital with respect to documentation, appropriate clinical decision-making, the following of accepted clinical guidelines, and the provision of quality medical care for his patients.

(c) Remediation

Expert #2 wrote in his report that "His surgical skills could, however, benefit from a one month supervisory period at a training hospital,…"

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This panel agrees there is a need for remediation, but this must be preceded by recognition on the part of the Appellant that remediation is required. It has been stated by others that the Appellant has not accepted previous counsel in changing his method of practise. Counsel for the Hospital submits that in order for remedial work to be effective, an individual must be prepared to accept that it is required, and that the Appellant does not. Counsel further submits that in nearly every instance, the Appellant has provided some reason as to why the poor outcomes are not his fault. The Appellant remained adamant throughout his testimony that his actions in the cases were the correct ones, and that what others testified was incorrect. It wasn't until questioning by the panel that he changed his response. It was suggested to him that during his testimony he had "stuck with your original thoughts in terms of the decisions that you made. You were confident that the decisions you made were the right ones". He then began to suggest that, in fact, he could meet the challenges outlined in the recommendations of the Quality Assurance Ad Hoc Committee report, the substance of which was discussed with the Appellant on October 10, 2001. In this final testimony he indicated to the panel, "there won't be any challenge. I can meet them all".

This panel concludes that the Appellant only recanted his previous position in the presence of the substantial amount of evidence presented in the course of hearing this appeal.

For remediation to be effective, there also must be willingness from the rest of the department to provide mentoring. Based on the evidence on lack of trust, it is clear that this willingness does not exist at Richmond Hospital.

One witness gave evidence that " clinical judgment is developed over time and cannot be taught, in this respect I feel remediation was not appropriate." Another testified in chief, "He does not learn from his mistakes."

In his report, the second reviewer writes, "I am at substantial loss to suggest any appropriate remedial training . . . particularly as he has now been in practice for several years." The second reviewer testified, "I believe that [the Appellant] has been offered mentoring by his colleagues at the Richmond Hospital, and I'm not in a position to advise you about that." The second reviewer adds, "But if you say in your wisdom that

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you believe that this individual should have mentoring, you have to persuade a university department to take him, and there are pragmatic problems."

The Board concludes that for remediation to occur, there exist a number of conditions for success. These conditions would include:

1. The applicant is able to accept constructive criticism, and is willing to truly recognize and face 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 willing to be responsible for carefully monitoring all aspects of the program.
6. Patients' rights must be completely considered.

The second reviewer testified, "I hesitated to suggest that the Richmond Hospital would be able to offer remedial help, because I see that at Richmond the anesthesia service and the gynecologists are apprehensive about this practitioner's practice, and you can't refer somebody on to the hospital because you've got to have other colleagues and the nursing staff and everybody else working collegially with them."

As noted above, there was no acknowledgement by the Appellant until the very end of his testimony that he thought there was anything he should fix; he even argued the SOGC guidelines. The panel further notes that within the setting of Richmond Hospital there exists a small group of obstetricians operating without back up where quick judgments are necessary.

The Board concludes that there does not exist any opportunity for the Appellant to undertake any form of remediation at Richmond Hospital, and that given the issues of care reviewed in this appeal, the most appropriate place for any remediation to occur would be within a teaching facility. We have no evidence before us regarding the possibilities at any such facility, let alone his success in such a program.

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Decision

Having fully taken into account the Appellant's professional interests in this matter, and recognizing that the onus of justifying the Hospital's decision fell on the Respondent to this appeal, the Panel is satisfied that evidence before us amply demonstrates that the Appellant did not, according to the various dimensions discussed above, meet the quality of care standards applicable to the Department of Obstetrics and Gynecology at the Richmond General Hospital. Further, we conclude in the circumstances of this case that this is not an appropriate case to direct or order remediation to be undertaken at Richmond Hospital.

The Appellant does not accept nor meet the standard set by Richmond Hospital, and has by his own evidence argued a different interpretation of widely accepted National Guidelines of practice within his own specialty.

We make no comment regarding what might transpire should the Appellant engage in remediation and re-apply to Richmond or any other Hospital for privileges. We consider that matter best left to the good judgment of relevant decision-makers, taking all relevant factors into account, at the time any such application is made.

The appeal is dismissed.

Dated at Victoria British Columbia, this 6th day of February 2003.

Gordon R Armour

Lori Messer

Lorraine Grant