Hospital Appeal Board

Fourth Floor 747 Fort Street
Victoria British Columbia
Telephone: (250) 387-3464
Facsimile: (250) 356-9923
Mailing Address:
PO Box 9425 Stn Prov Govt
Victoria BC V8W 9V1
Website: www.hab.gov.ca
E-mail: hab@gov.bc.ca

DECISION NO. 2018-HA-002(f)

In the matter of an appeal under section 46 of the *Hospital Act*, RSBC 1996, c 200

BETWEEN:	Dr. Andrew Campbell	**APPELLANT**
AND:	Provincial Health Services Authority	**RESPONDENT**
BEFORE:	A Panel of the Hospital Appeal Board: Stacy F. Robertson, Panel Chair Cheryl Vickers, Member Dr. Paul Champion, Member	
DATE:	Conducted by way of oral hearing and written submissions concluding on October 18, 2019	
APPEARING:	For the Appellant: Susan Precious, Counsel Nevin Fishman, Counsel Amelia Boultbee, Counsel	
	For the Respondent: Penny Washington, Counsel Kieran Siddall, Counsel Kayla Strong, Counsel	

Decision on the Merits of the Appeal

OVERVIEW

[1] The Appellant, Dr. Andrew Campbell, is a pediatric cardiothoracic surgeon. He alleges his privileges at BC Children's Hospital (BCCH) have been modified by BCCH and the Respondent Provincial Health Services Association (PHSA), to the point of being constructively revoked. The Respondent terminated Dr. Campbell's contract without cause, but says his privileges have not been modified, refused suspended or revoked, and that the Hospital Appeal Board (HAB), therefore, has no jurisdiction and should dismiss the appeal.

[2] This appeal raises novel and significant issues respecting the nature and scope of privileges as well as the purpose and jurisdiction of the Hospital Appeal

Board. These issues can be more precisely articulated following some understanding of the factual context of the appeal.

BACKGROUND

[3] Dr. Campbell joined BCCH as a pediatric cardiothoracic surgeon in September 2004. He was approved for provisional privileges in February 2005 and was promoted to full active privileges in March 2006. Every year since 2004, Dr. Campbell's application for re-appointment has been approved.

[4] Dr. Campbell was a member of the Division of Pediatric Cardiovascular and Thoracic Surgery at BCCH (the "Division"). The Division is part of the Department of Surgery at BCCH. BCCH is the only facility in British Columbia that performs pediatric cardiac surgeries, and is only one of two hospitals east of Ontario, including Stollery Children's Hospital in Edmonton, Alberta, that performs these surgeries. When Dr. Campbell started at BCCH, there were two members of the Division, Dr. L, who was Head of the Division, and Dr. Campbell. Prior to his arrival there were also two members of the Division, with Dr. Campbell replacing one of the members.

[5] Treatment of patients requiring cardiac surgery requires the coordination of many professionals and hospital staff at BCCH. Typically, a patient will first be seen by a pediatric cardiologist. On Monday afternoons there is a "CATH" or surgical conference with the cardiologists and the cardiac surgeons where the cases are discussed and a treatment plan including surgery, if necessary, is agreed upon. As part of the surgical care of the patients, a pediatric anesthetist will be involved along with a perfusionist, who operates a machine to maintain the functions of the heart and lungs during surgery. After surgery there is specialized care in the pediatric intensive care unit involving physicians and many nursing staff. The entire team comprises the Cardiac Sciences Program at BCCH. Many of the Cardiac Sciences team members attend the Monday CATH conferences.

[6] When Dr. Campbell initially became part of the Cardiac Sciences Program at BCCH, he and Dr. L shared surgeries on a more or less equal basis both as to volume and complexity of cases. While Dr. L was Division Head, Dr. Campbell performed a range of surgical procedures including complex neonatal surgeries.

[7] Around January 2008, Dr. L announced his retirement but stayed on for some procedures and in a consulting capacity. Dr. L stopped operating altogether in July 2009. From January 2008 to July 2010, Dr. Campbell was the acting Head of the Division and performed all neonatal surgical procedures at BCCH. From approximately February 2009 to July 2010, a locum, Dr. NR, worked under Dr. Campbell's guidance for a number of months.

[8] In July 2010, Dr. G joined the Division of Cardiac Surgery at BCCH as the Division Head.

[9] Following Dr. G's appointment as Division Head, more of the surgeries were allocated to Dr. G than to Dr. Campbell. In the ensuing years, the number of surgeries performed by Dr. G continued to rise and the number performed by Dr. Campbell continued to fall.

[10] In December 2016, Drs. Campbell and G signed a new Clinical Services Contract (effective April 1, 2016) (the "Contract"). The Contract included a clause for termination without cause on 12 months written notice. The Contract replaced a Clinical Services Contract signed by Drs. Campbell and G in 2012.

[11] On March 8, 2017, Drs. Campbell and G entered into a MOCAP[1] Agreement with the Respondent to provide on call services to the Division for the term April 1, 2017 to March 31, 2018.

[12] On March 14, 2017, BCCH gave Dr. Campbell written notice of the without cause termination of the Contract, with termination scheduled to take effect 12 months later on March 14, 2018. Neither Dr. Campbell nor other members of the Cardiac Sciences Program were given any reasons for the termination of the Contract. During this 12 month notice period, Dr. Campbell continued to provide services under the Contract, although in a more reduced capacity due to a gradual lessening of his caseload.

[13] In August 2017, Dr. Campbell, through his counsel, sought a hearing before the Medical Advisory Committee (MAC) into BCCH's action to "modify, restrict, or otherwise terminate Dr. Campbell's privileges." BCCH took the position there was no issue for review by the MAC. In November 2017, Dr. Campbell through his counsel, requested the PHSA Board convene a hearing to consider whether or not the administration's actions had or would result in a modification, suspension, revocation, or failure to renew Dr. Campbell's permit to practice at BCCH. The letter alleged the hospital had taken unilateral action materially and negatively impacting Dr. Campbell's privileges. By letter dated December 18, 2017, the PHSA Board declined Dr. Campbell's request for a hearing taking the position that termination of contracts was an operational decision delegated to management and that Dr. Campbell's privileges had not been modified, revoked or suspended.

[14] After March 14, 2018, Dr. Campbell was not allocated any new patients or operating room time, was required to vacate his office at BCCH, and no longer actively participated in the on call rotation, rounds or any other functions, meetings or CATH conferences in the Cardiac Sciences Program.

[15] Dr. Campbell's MOCAP Agreement was not renewed after March 31, 2018.

[16] On March 16, 2018, Dr. Campbell commenced this appeal.

JURISDICTION OVER APPEAL

[17] The Respondent has maintained that the HAB does not have jurisdiction to hear this appeal as Dr. Campbell's privileges are still intact and have not been modified, refused suspended or revoked. The Respondent brought a preliminary application to dismiss the appeal. It argued that the termination of the Appellant's Contract had no effect on his privileges, and that the application could be dealt with as a matter of pure law. The Appellant disagreed and characterized the issue as one of mixed fact and law. The Chair of the Hospital Appeal Board delivered a decision on September 21, 2018 dismissing the Respondent's application to dismiss the

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[1] Medical On Call Availability Program.

appeal with leave for the Respondent to maintain the objection at the full hearing. The Chair stated that he was not convinced that the issue was one of pure law that could be determined in the absence of a full evidentiary record, particularly as the Appellant was arguing that his privileges were constructively revoked or changed. He said (at para 16):

> A proper understanding of whether and how the Appellant's privileges have been affected both prior and subsequent to termination of the contract requires not only analysis of the terms of the contract, but also analysis of the surrounding factual context.

[18] The HAB's jurisdiction to hear appeals is contained in sections 46(1) – (3.1) of the *Hospital Act*[2] as follows:

> 46 (1) The Hospital Appeal Board, consisting of members appointed under subsection (4), is continued for the purpose of providing 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 practice 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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> (2) The Hospital Appeal Board may affirm, vary, reverse or substitute its own decision for that of a board of management on the terms and conditions it considers appropriate.
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> (2.1) A practitioner may appeal to the Hospital Appeal Board if
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> > (a) the practitioner is dissatisfied with the decision of a hospital's board, or
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> > (b) a hospital's board fails to notify the practitioner of its decision within the prescribed time.
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> (2.2) A practitioner who wishes to appeal under subsection (2.1) is not required to first proceed by way of an application to the hospital's board.
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> (2.3) An appeal to the Hospital Appeal Board is a new hearing.
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> (3) The Hospital Appeal Board has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law and discretion arising or required to be determined in an appeal under this section and to make any order permitted to be made.
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> (3.1) A decision or order of the Hospital Appeal Board under this Act on a matter in respect of which the Hospital Appeal Board has exclusive jurisdiction is final and conclusive and is not open to question or review in any court.

[19] As will be discussed in more detail below, whether there has been a modification, suspension or revocation of Dr. Campbell's privileges is an issue in

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[2] *Hospital Act*, RSBC 1996, c 200 [*Hospital Act*].

this appeal. The Board's jurisdiction to hear the appeal arises from the December 18, 2017 decision of the Board to not give Dr. Campbell a hearing respecting his allegations that his privileges had been materially and negatively impacted, and Dr. Campbell's allegations that the conduct of the Respondent has resulted in the modification of his privileges. If the Panel determines, following full consideration and analysis of the evidence and law, that Dr. Campbell's privileges have not been modified, then we must conclude we have no jurisdiction to deal further with the appeal. The HAB has the jurisdiction, however, to consider the threshold question of whether in fact and in law Dr. Campbell's privileges have been modified, suspended or revoked. Indeed, the Respondent does not take issue that the HAB can determine this threshold question, and an even more fundamental threshold question respecting the content of those privileges.

ISSUES

[20] Dr. Campbell alleges that from the time of Dr. G's arrival in mid-2010 until present, his privileges at BCCH have been modified by the Respondent through the:

1. decrease in, and ultimately elimination of patient cases allocated to him;
2. elimination of his operating (OR) time;
3. elimination of his on call time;
4. elimination of his clinic time; and
5. elimination of access to hospital resources such as patient charts, diagnostic equipment, and an office site at BCCH.

[21] He seeks the following remedies:

1. Dr. Campbell receive a fair and equitable allocation of surgical cases within the Division;
2. Dr. Campbell be allocated a minimum of 2.0 operating room days per week;
3. Dr. Campbell be restored to the Division "call" schedule;
4. The Respondent provides Dr. Campbell with an office at BCCH; and
5. Dr. G and Dr. Campbell engage in a facilitation process conducted by an external expert to be mutually agreed upon by both parties for the purposes of reintegrating the Appellant into the Division.

Issues as Framed by the Parties

[22] The Appellant states the issues as follows:

I. Were Dr. Campbell's privileges modified?

II. If so, what is the appropriate remedy?

[23] The Respondent says Dr. Campbell's privileges have not been modified, refused, suspended or revoked. The Respondent says Dr. Campbell's privileges

remain intact and unchanged and he remains a member of the active medical staff at BCCH, although he is currently on a leave of absence. The Respondent does not dispute that since March 14, 2018, Dr. Campbell has not been allocated patients. It says, however, that some of the other entitlements Dr. Campbell relies on as forming part of his privileges, such as operating room time, clinic time, and access to patient charts, flow from having patients. The Respondent says these other entitlements remain available to Dr. Campbell if he has a patient requiring an operation or use of any of the other entitlements. It says other entitlements Dr. Campbell relies on as forming part of his privileges, such as the call schedule and the office, are dealt with through the Contract which has been terminated.

[24] While agreeing in broad terms with the issues as stated by the Appellant, the Respondent identifies the following threshold question:

> Does a permit to practice in a hospital carry with it a right of a physician to be given patients by the health authority creating a corresponding obligation on behalf of the health authority to provide patients to the physician?

[25] The Respondent submits the answer to this question is "no", that a grant of privileges affords a physician with access to resources and facilities needed to perform the procedures in relation to which the physician has been granted privileges, and that patients are not "resources" or "facilities".

[26] The Respondent concedes that if the Panel answers the question above in the affirmative, a finding that the Appellant's privileges have been modified, refused suspended or revoked would follow because the Division Head has not allocated any patients to Dr. Campbell since the Contract was terminated.

[27] The Respondent then submits the HAB does not have jurisdiction to grant the relief sought by the Appellant, and if it does have jurisdiction to grant the relief sought, that it would not be appropriate or in the public interest to do so.

[28] At this point the Panel pauses to highlight an anomaly in the presentation of this appeal. In a typical appeal involving an issue of modification and/or revocation of privileges, an issue would arise as to whether the alleged modification/revocation was justified. In this appeal, the Respondent did not plead justification, nor did it rely on evidence in support of a defense of justification. The Respondent did lead evidence relating to whether a remedy should be ordered if the HAB found a modification had taken place, but because justification was not plead nor fleshed out through evidence, the Panel has not addressed a formal justification argument, though, as will be discussed later in these reasons, the Panel has found that the evidence led on the issue of remedy is insufficient to support a justification defense for the revocation of Dr. Campbell's privileges.

Issues as Framed by the Panel

[29] Broadly speaking, the first issue in this appeal is whether Dr. Campbell's privileges have been modified, refused, suspended or revoked. Determining that issue, however, involves determining, in the circumstances of this case, the content of privileges; including whether Dr. Campbell's privileges include the entitlement to equitable patient allocation, OR time, on call and clinic work, and access to other

resources such as patient charts, diagnostic equipment, and office space. If the Panel determines Dr. Campbell's privileges have been modified, refused, suspended or revoked, we must determine whether a remedy should be granted and the nature of any remedy. The Panel will need to determine if it has the jurisdiction to grant the specific remedies sought by the Appellant, and if so, whether any or all of those remedies are appropriate.

Issue #1 - Have Dr. Campbell's privileges been modified, refused, suspended, or revoked?

What are privileges?

[30] The terms "privileges" and "permit to practice in a hospital" are not defined in the *Hospital Act*. The Medical Staff Bylaws for Children's and Women's Health Centre of British Columbia (the Bylaws) define "privileges" as:

> A permit granted by Children's & Women's Health centre of British Columbia to a member of the Medical Staff to practice medicine, dentistry or midwifery in the Facilities and Programs operated by the Health Authority and granted by the Health Authority to a Member of the Medical Staff as set forth in the *Hospital Act* and *Regulations*. Privileges describe and define the scope and limits of each practitioner's permit to practice in the Facilities and Programs of the Health Authority.

[31] Privileges, therefore, are the "permit to practice in a hospital". They allow the practitioner to practice in the hospital and define the scope of that practice.

[32] Privileges go hand in hand with an appointment to the Medical Staff. Practitioners seeking appointment to the Medical Staff must apply in accordance with the procedures set out in the Bylaws and Medical Staff Rules for the Provincial Health Services Authority (the Rules) and meet specified criteria. The application for appointment must contain a list of the privileges requested. After a process set out in the Bylaws, appointments are ultimately made by the Board of Directors, which is the governing body of the Children's and Women's Health Centre. If the Board of Directors appoints an applicant to the Medical Staff, it must specify the membership category and the Privileges granted to the applicant[3]. Practitioners appointed to the Active Medical Staff are assigned to a primary department and may admit, attend, investigate, diagnose and treat patients within the limits of their privileges[4].

[33] Appointments and Privileges are reviewed at least annually[5]. The Bylaws set out the process for review.

[34] The appointment and privileging of physicians, dentists and midwives ensures that the hospital has sufficient qualitied practitioners of medicine, dentistry and midwifery to meet its needs and ensure that every patient admitted to the hospital will be under the care of a qualified member of the Medical Staff such that

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[3] See Bylaws at Article 4.3.6.
[4] See Bylaws at Article 6.3.2.
[5] See Bylaws at Article 4.4.1.

responsibilities for patient care are met. Appointments to Medical Staff and Privileges carry with them the duties and responsibilities of physicians for patient care in the hospital[6]. But they are also dependent on the resources of the hospital and the needs of the population it serves[7].

[35] Privileges are clearly important to a physician. They are the means by which physicians, particularly specialists, can practice in their field, earn income, continue to develop skills and stay current with acquired skills and knowledge. The loss of privileges can be devastating for physicians.

[36] The importance of a permit to practice in a hospital has been described by James T. Casey in the Regulation of Professions in Canada[8] as follows:

> For most physicians, the ability to practice medicine fully and effectively required extensive use of hospital services, and the consequences for a doctor who fails to obtain adequate hospital privileges are frequently serious, and sometimes calamitous. Specialists have the most to gain or lose through access to staff privileges. Most of them spend the bulk of their practice in the hospital environment and depend on the regular use of sophisticated services and equipment, assistance of other health professionals, and consultation with other doctors – all of which are available only in the hospital.
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> For any doctor, the inability to acquire privileges, the loss of such privileges, or even undue restrictions placed on his ability to practice medicine in a hospital, may mean the loss of some or all of his practice or income. Once lost, privileges will be harder to acquire elsewhere. A doctor without privileges may suffer deterioration in his professional standing and will be deprived of the experience and continuing education that is an informal but vital by-product of close association with other doctors in the hospital.

[37] In a stay application before the Ontario Superior Court of Justice, the Court characterized a decision to revoke a physician's privileges as "a professional death sentence" and that his "reputation as a practicing surgeon will be ruined"[9].

[38] The Respondent says that privileges deal with resources or facilities, and patients are neither of those. In the Panel's view, this position oversimplifies the privileging regime.

[39] The privileging regime ensures that the hospital has fully competent physicians practicing in its facilities to fulfill the needs of the population served by BCCH. The hospital also has control over the review process and any discipline which may affect any privileging decision[10]. The Hospital also has authority over the number of qualified physicians it grants privileges to, balancing the human resource requirements of the Facilities and Programs and the needs of the population served

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[6] See Bylaws at Article 5.
[7] See Bylaws at Article 3.1.5.
[8] James T. Casey, *The Regulation of Professions in Canada*, Chapter 18:18-1, Carswell (Scarborough, Ontario), 1994.
[9] *Harrison v Orillia Soldiers Memorial Hospital*, 2006 CanLII 33670 (ON SCDC), at para. 37.
[10] See Bylaws at Article 3.1.4.

by BCCH[11]. These are key features of the privileging regime. It is precisely because the hospital has control over these features which can have a dramatic impact on physicians with or seeking privileges, that independent *de novo* hearings are statutorily mandated in the *Hospital Act* to the Hospital Appeal Board.

Content of Privileges

[40] At the centre of this case is a dispute about what constitutes privileges and whether a permit to practice in a hospital carries with it a right, in the circumstances of this case, to be given reasonable access to and a fair allocation of patients amongst physicians in the Division of Pediatric Cardiovascular and Thoracic Surgery at BCCH.

[41] Previous decisions of this Board and other similar boards in Canada have found that privileges include reasonable access to the resources to meet the needs of the community for which the privileges were granted by the hospital. The HAB has ordered the inclusion of a physician on the on call rota and OR schedule[12]. Further, a hospital has been ordered by a New Brunswick Court to restore operating room time for a urologist even though he could not participate in the on call rota due to health reasons[13].

[42] In addition, hospitals have been ordered to take steps beyond the typical issues of on call rota and OR time, and have been ordered to provide a physician the supervision and review required under their by-laws[14], and to reintegrate a surgeon into his practice by monitoring his practice which may include scrubbing-in with the surgeon to regain any skills lost by the modification of his privileges[15].

[43] The Panel is not aware of, nor was it presented with, a case where a hospital was ordered to allocate patients to a physician with privileges. However, the HAB has considered this in an indirect way in the case of *Butler v Vancouver Coastal Health Authority* (*Butler#1*)[16], where it refused an application for privileges from an ophthalmologist who argued that the long waitlist of one of the other ophthalmologists and the lack of alleged patient confidence in another ophthalmologist warranted the need for a third ophthalmologist. By refusing this application, the HAB acknowledged that there were two ophthalmologists with privileges and the patients would either have to choose the long waitlist of the one or choose the other. While the hospital was not ordered to directly allocate patients, the effect of the HAB's decision was to state that patient choice is only relevant to the physicians with privileges and as long as the need could be met with two physicians then a third physician would not be granted privileges which would just

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[11] See Bylaws at Article 3.1.5.
[12] See *Walker v Fraser Health Authority*, Decision No. 2013-HA-003(a), and *Behn v Vancouver Island Health Authority*, HAB Decision Issued May 19, 2010.
[13] See *Bryniak v Regional Health Authority B*, 2013 NBQB 395 (*Bryniak*).
[14] See *Dr. Wahid Mardenli v Regional Health Authority*, 2017 NBQB 232.
[15] *Munro v St. Paul's Hospital*, HAB Decision Issued December 22, 2000 (*Munro*).
[16] *Butler v Vancouver Coastal Health Authority,* 2015-HA-003(b) and 2016-HA-001(a) (*Butler #1*).

undercut the patients seeking one of the other two physicians with existing privileges.

[44] In addition, there is the recent case of *Nordal v Alberta Health Services*[17], where the Hospital Privileges Appeal Board (HPAB) found that the without cause termination of Dr. Nordal's contract had the effect of terminating his privileges and ordered Dr. Nordal's privileges to be reinstated to the pre-contract termination status. The exact mechanics of that reinstatement was left to the parties to determine with further direction from the panel if necessary. The *Nordal* case did not deal with the allocation issue specifically, but it involved a facility that specialized in cancer treatment which contained many of the same team assessment and treatment issues as the Cardiac Sciences Program at BCCH.

[45] The content of any particular physician's privileges will be informed not only by reference to the legislative framework and other legal instruments such as hospital bylaws and rules under which they are granted, but also by the nature of the specialty and the typical and historic practice of that specialty in the facility in issue. These factors were articulated by the Ontario Hospital Appeal Board in *Dittmer v Board of Directors of Parkwood Hospital*[18], in the following description of privileges (at p 8):

> …In broad terms, hospital privileges comprise a bundle of rights of a physician to carry out professional practice in the hospital. Those rights include some degree of access to the material and human resources of the hospital including hospital beds for the physician's patients (if the privileges include the right to admit patients), operating rooms, (if the physician is a surgeon), diagnostic equipment, examining rooms, interns, residents, lab technicians and nursing staff. To the extent that the hospital's by-laws or the documents setting out a physician's privileges do not specify the resources attaching to the grant of privileges, a particular physician's privileges must be taken to include access to those resources which are typically employed in the type of practice in which that physician is engaged. Further, and again to the extent to which access to resources is not, and has not previously been, specified in the by-laws or the documents setting out the particular physician's privileges, the resources to which the physician has historically had access in his or her practice in the hospital must be considered in determining what access to resources attaches to the privileges in question.

[46] The content of any particular physician's privileges, and consequently any consideration of whether they have been modified or revoked, will be highly contextual.

[47] Further, privileges do not necessarily carry with them an entitlement to specific allocation of hospital resources. Consequently, not every change to resource allocation will constitute a modification, suspension or revocation of

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[17] *Nordal v Alberta Health Services*, Alberta Hospital Privileges Appeal Board, Decision Issued September 10, 2019 (*Nordal*).

[18] *Dittmer v Board of Directors of Parkwood Hospital*, Ontario Hospital Appeal Board, Decision Issued August 6, 1998 (*Dittmer*).

privileges, as was discussed in *Prairie North Regional Health Authority v Kutzner*[19]. As said in *Prairie North*, however, for there to be any point to granting privileges in the first place, subject to factors like availability of resources and patient demand, privileges suggest a physician "will have *some* access to resources and facilities"[20].

[48] In summary, the content of privileges may be different for different specialties and different hospital settings, and the determination is very fact-specific. To assess the content of privileges in a particular factual circumstance the following must be considered:

1. The privileging documents;
2. The hospital bylaws and the effect of any contractual provisions;
3. The resources typically employed in the specific type of practice under consideration;
4. The historical practice of the physician and the hospital under consideration.

Dr. Campbell's Appointment and Reappointment for Privileges

[49] Dr. Campbell was appointed to the BCCH Medical Staff in 2004. The justification given for his appointment was "We need 2 cardiac surgeons. Dr. Campbell's skills are necessary".

[50] Every year since 2004, Dr. Campbell's application for re-appointment has been approved. Dr. Campbell submits that the fact the Respondent has continued to re-appoint him to the Active Medical Staff every year means there are ongoing "needs of the population" for him to serve as required by the Bylaws for an appointment. Indeed, it is not disputed that the Respondent is actively recruiting a second pediatric cardiac surgeon to have under contract to replace Dr. Campbell's contractual obligations.

[51] When Dr. Campbell joined BCCH in 2004, he received a Letter of Understanding from Dr. B, the then Head of Surgery. The letter states that it serves as a letter of understanding between Dr. Campbell, the Division of Pediatric and Cardiovascular Surgery, Children's and Women's Hospital (C&W), UBC and the Section of Surgery C&W, to clarify relationships with respect to Dr. Campbell's appointment as a 1.0 FTE Pediatric Cardiovascular and Thoracic Surgeon at BC Children's and Women's Health Centre of British Columbia. The letter contains appendices that outline expectations of Dr. Campbell. The expectations include the following:

> As a member of the Pediatric Division of Cardiovascular and Thoracic Surgery and a team player, you will share patient care, patient assessment, patient follow-up, and database information. As such, all cases referred to the Pediatric Division of Cardiovascular and Thoracic Surgery are shared by both surgeons.

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[19] *Prairie North Regional Health Authority v Kutzner*, 2010 SKCA 132 (*Prairie North*).
[20] *Prairie North*, *supra* fn 19, at para 59, emphasis in original.

[52] As Division Head, Dr. G approved Dr. Campbell's privileging appointments from 2011 to 2017. It appears that Dr. S, the Head of Surgery, approved Dr. Campbell's privileges in 2018. The Respondent notified this hearing Panel at the end of this hearing that Dr. Campbell's 2019 privileges were approved by the Board of Directors.

[53] Dr. Campbell's privileges were approved without any qualifications, conditions or restrictions. After 2015, the privileging documents included a detailed list of procedures as part of a privileging dictionary. Dr. G, and subsequently the Board of Directors, approved Dr. Campbell for the full set of procedures set out in the privileging dictionary.

Bylaws of BCCH

[54] The preamble to the Medical Staff Bylaws for the Respondents states that:

> The Board of Directors is ultimately accountable for the quality of medical care, and the provision of appropriate resources within available funding, in the Facilities and Programs operated by Children's & Women's Health Centre of British Columbia.

[55] The preamble also states that the Bylaws "are a description of the relationship and the responsibilities between the Board of Directors and individual members of the Medical Staff acting collectively as the medical staff organization."

[56] A board of management is the same as the board of directors and ultimately has the authority surrounding privileges even if that authority is delegated or exercised upon the advice and recommendations of others. The key jurisdiction over privileging of physicians for BCCH is found in Article 3 of the Medical Staff Bylaws including:

> 3.1.1 The Board of Directors **shall** appoint the Medical Staff.
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> 3.1.2 The Board, on the advice of the Medical Advisory Committee, shall from time to time establish criteria for the Appointment to the Medical Staff and for review of that Appointment on a regular basis. Such criteria are detailed in the Medical Staff Rules.
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> 3.1.3 The Board of Directors may make allowances for Privileges specific to:
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> (a) Facilities and Programs; and
>
> (b) medical or dental procedures.
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> 3.1.4 The Board of Directors **has authority** over an Appointment and the cancellations, suspension, termination, modification or restriction of an Appointment to the Medical Staff and may terminate such Appointment for any reason whatsoever.
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> ...
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> 3.1.8 The **members of the Medical Staff are responsible** to the Head of the Department or Program to which they are assigned and **to the Board of Directors for the quality of Medical Care** in the Facilities and Programs. [emphasis added]

[57] A question which arises in this case is whether the Board of BCCH has the authority to provide procedures for the allocation of surgical cases between the two surgeons in the Cardiac Sciences Program at BCCH. The Panel finds that the Bylaws provide that the Board of Directors may make allowances for privileges specific to a Program, which could include allowances for case allocation in the Cardiac Sciences Program.

[58] The Respondent argues that the termination of the Appellant's Contract and corresponding absence of case referrals/allocation by the Division Head is an operational decision delegated to administration of BCCH by the PHSA Board, and, therefore, is not subject to review by the HAB as it is not a decision to modify, revoke or suspend a physician's privileges.

[59] First, the characterization of issues by the Respondent as operational does not advance the analysis of whether the HAB has jurisdiction over patient allocation or the remedy requested by the Appellant in this matter. We were not taken to the term "operational" anywhere in the *Hospital Act*, the Medical Staff Bylaws or the Medical Staff Rules. This Panel accepts the comments in *Bhargava v Lakeridge*[21] that (at para 41):

> [a]ttempting to categorize an issue as one of resource allocation as opposed to one of privileges seems to be a rather facile exercise. Arguably, everything a hospital provides a physician is a hospital resource.

[60] In *Bhargava*, the Ontario Health Professions Appeal and Review Board found that on call provisions were part of privileges and therefore the hospital board had the ultimate authority over them and thus they were subject to review.

[61] This logic has been applied in BC in the case of *Butler v Vancouver Coastal Health Authority* (*Butler #2*).[22] In *Butler #2*, which dealt with a preliminary application to dismiss the appeal as being outside of the jurisdiction of the HAB, the Chair noted the following(at para 28):

> It appears to be an open question that needs to be determined after a full hearing of the evidence whether or not the failure to renew locum tenens privileges is an operational decision outside of the ambit of the HAB or is a decision ultimately made by the Board of Management and accordingly, subject to appeal.

[62] The HAB Chair noted in *Butler #2* that the issue before him was not whether the decision was operational or not, but whether it was a decision that was within the authority of the Board of Directors even if it was delegated to others. The Chair noted the preamble to the Medical Staff Bylaws which states that the Board of Directors is ultimately accountable for the quality of medical care and provisions for appropriate resources in the hospital. The Chair further noted the policy document for physician selection noted that the process is conducted on behalf of the VCH Board.

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[21] *Bhargava v Lakeridge Health Corporation*, 2011 CanLii 33743 (ON HPARB).
[22] *Butler v Vancouver Coastal Health Authority,* Decision No. 2015-HA-003(a) (*Butler #2*).

[63] Again, the focus of the analysis is not whether a decision is operational or not, but whether the Board of Management, ultimately, has the authority to make the decision affecting privileges, including case allocation, if it is found to be part of Dr. Campbell's privileges in this case. If the answer to that analysis is yes, then the HAB has jurisdiction to review that decision and, if necessary, substitute its decision for that of the Board of Management.

[64] The Respondents cite *Bryniak*[23], for the proposition that a court should not intervene in the operational workings of a specialized and complex public authority which faces high demands and scarce resources. However, this comment had to do with the second request for relief by Dr. Bryniak to enjoin further decisions of the hospital affecting his operating room time. The Court was not prepared to make such an order about future decisions, which distinguishes it from what is at issue in this case. Dr. Bryniak's first request for relief was for his operating room time to be restored to the level it was before the decision of the department head. With respect to that relief, the Court had no problem entering into the operational decisions of the hospital, because they affected privileges and the decision of the department head was not properly made.

[65] In *Bryniak,* the Court quashed a decision of a department head which reduced the operating room time for a physician in his department. The Court found that the reduction and elimination of operating room time was an adjustment to Dr. Bryniak's privileges. The Court went through the relevant legislative provisions and the hospital's Bylaws and found, based on the clear wording of those provisions (including many similar provisions contained in the Medical Staff Bylaws in this case), that privileges must both be granted and adjusted by the Board. The Court therefore held that the decision of the department head regarding operating room time, an element of privileges, was outside of his authority to make, and the Court accordingly quashed the decision.

[66] The HAB also dealt with delegated authority and decision-making in *Munro*[24]. The Panel stated (at p 11):

> This panel is also concerned with the apparent belief by the Program Medical Director that department heads can arbitrarily make decisions when it involves the granting of privileges. We understand that it was his delegated duty to "plan for future needs of the department", however in the carrying out of those plans, there is an expected and required process with regard to establishment of privileges within the department. This panel must remind all involved that it is the legal duty of the Hospital Board, having received a recommendation from a delegated authority, to examine and weigh all facts before it in the determination of its decisions that are in the public interest. Due process must be followed.

[67] The fact that a Board of Directors has delegated an aspect of the privileging regime to others, such as a department head, does not absolve the Board from the responsibility for those delegated decisions or compliance with the procedures in the bylaws which must be followed to modify or terminate privileges.

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[23] *Bryniak, supra* fn 13.
[24] *Munro*, *supra* fn 15.

The Effect of the Contract on the Bylaws and Case Allocation

[68] Much of this case involved the interplay between the Appellant's contractual relationship with BCCH and his privileges with BCCH. Disputes respecting the contractual relationship are not within the jurisdiction of the HAB except insofar as the disputes relate to the issue of privileges; in particular, the modification, revocation, suspension or refusal of privileges. This overlap of jurisdiction raises the issue of whether BCCH can contract out of the privileging regime in its contractual relations with a physician. This Panel doubts whether a hospital can contract out of its obligations under the bylaws and legislation regarding privileging issues but finds that it does not need to make a final determination on that issue as a review of the contract does not show that BCCH contracted out of the Bylaws dealing with privileging. In fact, Article 7.1 of the Contract specifically provides that the physician will provide the defined services under the contract in accordance with the policies, bylaws, rules and regulations of BCCH. If the BCCH had intended to contract out of any of the provisions of the Bylaws it was required to specifically state so and it has, in fact, stated the opposite, that the contract services are in accordance with the Bylaws.

[69] Further confirmation that the Contract was not intended or designed to exempt the physicians from any of their obligations in the Medical Staff Bylaws and instead that the services had to be performed in accordance with the Medical Staff Bylaws can be found in paragraph (C)3 of Appendix 1 of the Contract. This provision provides a list of clinical performance standards that the physicians will endeavour to achieve and includes the following[25]:

> The parties recognize that the foregoing objectives are intended to supplement (not replace or limit) the standards of high quality medical practices by the Physicians and compliance by the Physicians with policies and procedures and Medical Staff by-laws in effect from time-to-time within the Agency [BCCH] or as are determined to be appropriate by the Division Head or Chief of Surgery.

[70] This Panel finds that pursuant to the contractual provisions between Dr. Campbell and BCCH, where there is a conflict between the Contract and the Bylaws, rules and regulations of BCCH, the Bylaws, rules and regulations of the BCCH govern.

[71] The Respondent states that Dr. Campbell's Contract specifically exempted both surgeons from the on call obligations under the Bylaws and that those obligations are dealt with in the Contract. However, the Respondent did not identify any provision of the Contract which specifically exempted the on call obligations in the Medical Staff Bylaws and did not identify any provision of the Contract dealing with on call obligations. The Respondent notes a provision of the Contract which states: "The Physicians will provide all emergency and non-emergency clinical services required when on call." This only deals with the services provided while on call but not the obligation to be on call in the first place. The Contract specifically exempts time spent while on call from the calculation of hours

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[25] Clinical Services Contract, Appendix 1 at para 3(C), JBOD Tab 51.

of service required under the Contract and also exempts the MOCAP contracts which provide compensation to physicians for the time spent on call waiting to provide services. The provision of services while on call are compensated separately under a fee for service MSP model or under the Contract in this case.

[72] The Contract essentially deals with defining the employment relationship between the two surgeons and BCCH regarding employment status for liability, tax, WorkSafe BC and payment and billing issues. There is nothing in the Contract which exempts the application of the Medical Staff Bylaws to the two surgeons.

[73] The Respondent notes the evidence of Dr. SC, who agreed that his privileges and contract with PHSA were separate, and only linked in the sense that his contact allowed him to "monetize" his privileges. Physicians under contract with BCCH are paid a fixed fee and assign all of their fee for service billings under the Medical Services Plan to BCCH. Dr. Campbell is not seeking reinstatement of his Contract and presumably would simply bill for his services under the Medical Services Plan of BC.

[74] One of the clinical performance standards in Appendix 1 of the Contract provides that 90% of operative notes will be dictated with 48 hours of the procedure with the remainder to be dictated within 72 hours of the procedure. The obligation under Article 3.3.3(e) of the Medical Staff Rules provides that all operations shall be described fully by the operating surgeon or delegate within 24 hours. The contract does not override the more stringent obligations of the physician in the Rules regarding operative notes. The Respondent took issue with Dr. Campbell's late operative notes but did not take the Panel to the applicable provisions of the contract. Instead, the Respondent took the panel to the applicable provisions of the Rules.

[75] The Panel finds that the contract between BCCH and Dr. Campbell simply provided an alternative billing arrangement. It dealt with all the issues around billing and certain other liabilities relevant to employment relationships, and did not specifically exempt the operation of any of the provisions in the Medical Staff Bylaws and Medical Staff Rules. On the contrary, the contract confirmed that all services must be provided in accordance with them. The Respondent, in oral submissions, agreed that BCCH could not contract out of the privileging regime in the Bylaws. They agreed that if the Panel found that case allocation was part of privileges, then the issue should be determined in accordance with the privileging regime in the Bylaws and not the private contractual regime. This regime would include the provisions dealing with the process for modification or revocation of privileges set out in Article 11 of the Bylaws and Article 9 of the Medical Staff Rules. These Bylaws and Rules set out a review process for disciplinary matters that is in accordance with the principles of procedural fairness.

[76] On the issue of whether it is possible to contract out of the Bylaws with clear language, the Panel questions whether this would be effective. The Medical Staff Bylaws only become effective when they are adopted by the Board of Directors and then approved by the Minister of Health of British Columbia. (see Article 14 of Medical Staff Bylaws) Section 2(1)(c) of the *Hospital Act* requires all hospitals to have bylaws and 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 Minister assures that a hospital has complied with this provision by requiring the approval of all bylaws and rules of a hospital including medical staff bylaws (see section 2). If the Minister must approve all bylaws and rules of a hospital, then any contract purporting to amend any of those bylaws or rules must also need to be approved by the Minister.

[77] It is well accepted law that delegated authority cannot be greater than the original grant of authority. Therefore, regardless of what is in the contract, its terms cannot modify or alter the provisions and obligations of the Medical Staff Bylaws and Medical Staff Rules of BCCH; which Bylaws must be approved by the Minister of Health of British Columbia[26], and which Rules must be compliant with the *Hospital Act*, *Regulations* and the Bylaws[27]. The contract is simply an alternative payment arrangement, which Dr. K, the Vice President of Medical Affairs at BCCH, stated was a program where the Ministry of Health transfers funding to PHSA. The legislative specifics allowing such arrangements were not provided, however, all parties accepted that such alternative payment arrangements are allowed. However, it is key that it is referred to as an alternative payment arrangement which is very different than an unfettered right to contract, including the right to contract out of the any of the Medical Staff Bylaws or Medical Staff Rules.

[78] This Panel finds that even if it were permissible for them to do so, which this Panel has already expressed doubt on, the Respondent did not contract out of any of the provisions of the Medical Staff Bylaws or Medical Staff Rules regarding any of the privileging issues including case allocation or provision of on call services.

Nature of Pediatric Cardiac Surgical Practice

[79] We heard evidence about Dr. Campbell's practice as a pediatric cardiothoracic surgeon at BCCH as well as evidence respecting the practice of pediatric cardiothoracic surgeons and, in particular, the allocation of patients to pediatric cardiothoracic surgeons with privileges at other facilities in Canada.

[80] A pediatric cardiothoracic surgeon performs surgery on newborns and children to correct both congenital and acquired heart lesions. The different surgical procedures vary in complexity and risk depending on the nature of the procedure itself and other underlying health issues that may be present in the patient. Although there is always some degree of risk and complexity involved with pediatric cardiac surgery, procedures are classified within 5 "STAT" categories ranging from STAT 1, being those cases with relatively speaking the lowest complexity and risk, to STAT 5, being those cases with the highest complexity and risk. Seventy-five percent of pediatric cardiac surgical procedures are within the lower risk/complexity STAT 1-3 categories. Surgeries include both open and closed chest procedures. They include emergency and pre-scheduled procedures and urgent and elective procedures. The Cardiac Sciences Program operates in a team environment, with members from several areas of practice including cardiology, cardiac surgery,

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[26] See Article 14 of the Bylaws.

[27] See Article 12 of the Bylaws.

intensivists, imaging and radiology, anesthesiologists, perfusionists, OR nurses and intensive care nurses.

[81] Prior to Dr. G's arrival in 2010, pediatric heart transplants were referred out to Sick Kids Hospital in Toronto. Dr. G had experience with this procedure, and it appears this procedure was done at BCCH after his arrival. In addition, there was evidence of a rare condition referred to as MPAC cases which were referred to a hospital in San Francisco which had experience with that type of procedure. There was no evidence that this procedure was done at BCCH before or after Dr. G's arrival.

[82] There was also much evidence about Norwood procedures, which are undertaken to correct a rare condition involving hypoplastic left heart syndrome. Prior to Dr. G's arrival, these cases were referred to Stollery Children's Hospital in Edmonton, and after his arrival, Dr. G performed these procedures.

[83] The Panel heard evidence that there were certain index cases which provide a standard by which pediatric cardiac surgeons are judged. An arterial switch is an example of such a procedure. The procedure is only a STAT 3, but involves lots of delicate stitching which is a skill required for many procedures. The evidence was that after Dr. G's arrival, Dr. Campbell was gradually assigned fewer and fewer index cases.

[84] The pediatric surgical practice at BCCH is part of the Cardiac Sciences Program, which is a multidisciplinary team to treat patients' heart conditions. The team works best when all team members work together; including in the diagnosis phase, the surgical phase and the post-surgical care and treatment phase. Everyone needs to work together, which is why the Cardiac Sciences Program was created and why every pediatric surgical practice in Canada operates as part of a close team similar to the Cardiac Sciences Program.

[85] Dr. R, a pediatric cardiac surgeon practicing at Stollery Children's Hospital in Edmonton, gave evidence of his experience at three major facilities in Canada. Dr. R has actively practiced pediatric cardiac surgery since 1989, and was the Head of Pediatric Cardiac Surgery at Stollery from September 1996 to November 2018.

[86] At Stollery, all surgical referrals are discussed in a conference setting and virtually all pediatric and cardiac surgery cases are allocated on the basis of the patient's birth date. Patients born on days 1-10 of a month are allocated to Surgeon "A", those born from the 11th to 20th are allocated to Surgeon "B", and those born from the 21st to 31st are allocated to Surgeon "C". This allocation practice has been in place at Stollery since 2001. Dr. R's evidence was that the practice was adopted to achieve fair and equitable distribution of case volume among surgeons such that operating room time is equally divided, and the number of procedures performed is approximately equal. Occasionally, surgeon experience dictates that an uncommon procedure is allocated to a specific surgeon, but these cases would represent a small percentage of overall volume. As well, the more experienced surgeon may assist the less experienced surgeon in a complex case to broaden surgical experience and expertise in such cases.

[87] At the Hospital for Sick Children in Toronto, all surgical referrals are discussed in a conference group setting and assigned by the senior surgeon to the

entire surgical group depending on case complexity, but a senior surgeon is assigned as the "2nd" surgeon in the more complex cases to provide backup experience and assistance if required. Dr. R's evidence was that patients are essentially allocated on an equitable basis by the surgical head of the program, but considering such factors as surgeon experience and OR availability.

[88] The Children's Hospital in Halifax has two pediatric cardiac surgeons. Dr. R's evidence was that both surgeons participate and assist each other on the majority of the more challenging surgical cases. This practice is primarily to deal with the lower volume of complex cases and is a method to try to ensure that both surgeons maintain their skill-sets regarding those complex cases. Less complex cases performed by one surgeon are essentially divided equally on an alternating basis.

[89] We heard evidence from numerous witnesses as well as Dr. R that it is beneficial for the Cardiac Services Program to have two surgeons that are capable of performing a wide range of procedures. Dr. G agreed that having two surgeons capable of a wide range of procedures was the optimal goal of the Division.

[90] Dr. R's evidence was that in order to retain broad experience and to remain competent with necessary skills a surgeon should have at least 125 cases per year, with 75% of those (approximately 94 cases) being open heart cases. That is why at some of the programs with lower volumes of cases, the two surgeons work together. Dr. G's evidence was that a surgeon needed approximately 200 cases with around 100-130 open heart cases to keep current.

[91] All of the pediatric cardiac surgical programs about which we heard evidence have a system in place to make sure all surgeons get a relatively even number of cases and have procedures in place to provide experience to the less experienced surgeons in the group.

[92] Dr. R was not aware of any pediatric cardiac surgeon in Canada with a stand-alone referral-based practice. His evidence was that the nature of pediatric cardiac surgery is such that risk and complexity dictates that a simple doctor to doctor referral system (as occurs with adult heart patients) is not feasible. Patients should be reviewed in a conference setting, involving both pediatric cardiology, radiology and imaging experts and surgical members, which is the practice in all of the facilities that Dr. R has worked in. Dr. R said that such review is essential for planning the operation.

Historical Practice at BCCH

[93] As indicated earlier, when Dr. Campbell first joined the Cardiac Sciences Team at BCCH, he and Dr. L shared surgeries on a more or less equal basis; both as to volume and complexity of cases. They discussed the cases at the Monday afternoon CATH conferences and approached allocation jointly. They alternated dictating the summary care plan for each patient at the end of the Monday conferences. They split operating room time approximately 50/50. They would occasionally operate together, particularly if an uncommon case was presented.

[94] Dr. L and Dr. Campbell followed a regular call schedule of one week on, one week off. Whoever was "on call" would be contacted by the cardiologists or intensivists for emergencies or new cases.

[95] Between 2004 and 2009, when Dr. L was Division Head, Dr. Campbell performed the full spectrum of surgical procedures in the Division including complex neonatal surgeries.

[96] From January 2008 to July 2010, Dr. Campbell performed the preponderance of complex neonatal surgical procedures at BCCH. A locum, Dr. NR, worked under Dr. Campbell's guidance for part of that time. For the first three months, Dr. Campbell scrubbed in with Dr. NR on every case. Dr. Campbell would generally do the more complex cases.

[97] In 2005, Dr. Campbell performed 115 surgeries, including 4 STAT 5's; in 2006, 106 surgeries; in 2007, 130 surgeries; in 2008 110 surgeries; and in 2009, 137 surgeries.

[98] Following his appointment as Division Head, Dr. G allocated more surgeries to himself than to Dr. Campbell. In 2010, following his appointment in August as Division Head, Dr. G performed 110 surgeries. Dr. Campbell performed 101 surgeries in 2010.

[99] Initially, Dr. Campbell thought an increased allocation to Dr. G was reasonable so that Dr. G could demonstrate his skill and ability as the new Division Head. Dr. Campbell's evidence was the allocation became progressively more inequitable. From 2011 to 2016, Dr. Campbell performed between 80 and 100 surgeries per year (average of 88.66 per year over 6 years) while Dr. G performed between 148 and 214 surgeries per year (average of 181.33 per year over 6 years). During that time, Dr. Campbell did 3 STAT 5 surgeries and Dr. G did 19. In 2017, Dr. Campbell did 39 surgeries and Dr. G did 182. Dr. Campbell's evidence was that since he received his notice of termination in March 2017, he was assigned 22 open-heart cases whereas Dr. G assigned himself 129 open-heart cases.

[100] Dr. Campbell raised his concerns about case allocation with Dr. G in 2011 and 2013. Dr. G, as Division Head responsible for case allocation, was not willing to allocate more cases to Dr. Campbell. Although Dr. G knew Dr. Campbell had been doing surgery on neonates before his arrival, his evidence was that he did not think Dr. Campbell's results were optimal. He said he had concerns with Dr. Campbell's commitment, level of engagement, and record keeping.

[101] Dr. Campbell also had an in-depth review in 2013 as part of his annual privileging approval process and he noted problems with case allocation in his comment section of this report which was signed off on by senior management of BCCH including Dr. G, Dr. S, the Head of Surgery, and Dr. K, VP Medical Affairs. There was no action taken to address the allocation issues raised by Dr. Campbell in his Division meetings with Dr. G or in his in-depth review. Dr. K admitted that he never read the in-depth review when he signed off on it as the VP Medical Affairs and relied on others to bring any issues to his attention.

[102] By letter to Dr. G dated September 19, 2017, Dr. Campbell made a formal complaint about the allocation of surgical cases. Dr. Campbell copied Dr. K, the

Vice President of Medical Affairs at BCCH, with his complaint and Dr. G also forwarded the complaint to Dr. K. In response to inquiries from Dr. K respecting the allocation of surgical cases, Dr. G advised that complex neonates were assigned to himself and articulated four other considerations for allocation including, previous discussions between a cardiologist and a surgeon respecting a particular patient, parental preference, and whether a particular surgeon had previously operated on the patient.

[103] Dr. G's evidence was that for a variety of reasons, including morbidity and length of hospital stay, given the volume of complex neonates he thought their outcome would be better in his hands. His evidence was that often cardiologists would call him in advance to talk about a case and that out of province referrals came directly to him. He did all of the antenatal consults with parents and said Dr. Campbell had never done antenatal consults before and did not express an interest in doing them. Dr. Campbell disputes that he did not express an interest in attending antenatal consults.

[104] As set out above, since March 14, 2018 no cases or operating room time have been allocated to Dr. Campbell and Dr. Campbell was removed from the call schedule. In the week following his termination, Dr. Campbell performed a vascular surgery on which he had been consulted in January 2018 and which had been pre-scheduled. He has not done any surgery at BCCH since.

[105] On two occasions after March 14, 2018, Dr. Campbell received vascular referrals, one with a recurrent malignancy that he requested to see in clinic. When his assistant called to book the clinic time, she was told Dr. Campbell could not book patients because he no longer worked there. Dr. K's evidence was that the advice that Dr. Campbell was not able to book clinic time was incorrect and that he was unaware this advice had been provided. After being told he could not book clinic time, Dr. Campbell did not make further efforts to do so.

[106] From Dr. Campbell's perspective, he has not been able to treat patients at BCCH since March 14, 2018 and has been denied access to all resources and, primarily, any allocation of patients. From Dr. K's perspective, Dr. Campbell is able to access the hospital's resources if he has his own patients. He is simply no longer part of the Cardiac Sciences Team at BCCH and will not be allocated patients by that team.

Cases on Modification and Revocation of Privileges

[107] *Prairie North*[28] set out a test for the modification of privileges that has been considered and adopted by courts and appeal tribunals in other Canadian jurisdictions. It involves considering the combined effect of all relevant factors including the significance, duration, and reach of any change to a physician's access to facilities or resources. The test, as articulated in the context of a change to operating room allocations, was set out by the Court as follows (at paras 62-65):

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[28] *Prairie North, supra*, fn 19.

> [62]...In considering whether a change in operating room allocations amounts to a constructive amendment, suspension or revocation of privileges, the Tribunal will want to consider the combined effect of all relevant factors, One of these factors will certainly be the significance of the change in question. For example, a reduction in operating room time from six days a month to five-and-a-half days a month is presumably something materially different than a reduction from six days a month to one day a year. The closer a change comes to wholly denying a physician the right to perform a specific procedure or specific procedures, the more it will tend to assume the character of an amendment, suspension or revocation of his or her privileges.
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> [63] A second factor the Tribunal will want to consider is the duration of the change. For instance, a reduction in operating room times which is in place for a week is not the same thing as a reduction which is permanent. The longer a change extends, the easier it will be to see it as involving a *de facto* amendment, suspension or revocation of privileges.
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> [64] A third factor to consider might be the reach of the change in issue. A reduction in access to facilities or services that reflects a broad attempt on the part of a health district to reduce expenditures will generally tend to have less of the flavour of a suspension, revocation or amendment of privileges than will a changed targeted at a particular physician. By way of a concrete illustration of this idea, a decision that cuts global operating room time by a specific percentage, and which affects all surgeons in the same way, typically will have less of the character of amendment, suspension or revocation of privileges than will a decision which cuts only one physician's operating room allocation.
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> [65] There might be other factors that should inform the Tribunal's decision making on issues of this sort. The considerations noted above are merely indicators of whether the actions of a health district have, in effect, amended, changed or modified a physician's privileges given the reality that the term "privileges" does not involve any specific allocation of facilities or services but that it does contemplate, subject to the normal realities of matters like resource availability and patient demand, the allocation of some services and facilities. The three factors discussed here are not intended to represent a closed list and, obviously, they might be subject to qualification in some cases.

[108] *Prairie North* goes on to caution that it is not possible to draw a "bright line" between changes that will amount to a modification or revocation of privileges and those that do not, and that each case must be considered in the context of its own facts. It cautions further that appeals alleging modification or revocation of privileges "should not become something that draws [the Board] into the ongoing detail of the ordinary day-to-day administration of hospitals or health districts"[29].

[109] The Appellant says that the elimination of operating room time, clinic time, access to patient charts and on-site office are all modifications to Dr. Campbell's privileges that clearly meet the test in *Prairie North* as to significance, duration and reach. The complete elimination of these aspects of Dr. Campbell's privileges is a clear modification of his privileges. However, the Respondent argues that all of

[29] *Prairie North, supra* fn 19 at para 66.

these aspects of privileges flow from Dr. Campbell having patients. The Respondent argues that Dr. Campbell has no need for operating room time if he has no patients. The Respondent says it is not preventing Dr. Campbell from access to the facilities and resources of BCCH if he has patients, but with no patients there is no need to access the other facilities and resources that the Appellant says were denied by the Respondent. The Panel agrees with the Respondent in that all of the modifications of Dr. Campbell's privileges flow from the allocation of patients. In addition, the Respondent accepts that if case allocation is part of privileges then it agrees there has been a modification or termination in that regard. Therefore, it is only necessary to determine if case allocation is part of privileges in the context of this case and then either dismiss the appeal or proceed to consider the issue of remedy.

[110] While there is no specific case on whether a physician under contract with a hospital has an entitlement to a reasonable allocation of patients as part of the grant of privileges, there are several cases dealing with the interplay of contract and privileges.

[111] The Respondent relies on *Ready v Saskatoon Regional Health Authority*[30], to argue that the HAB does not have the power to grant a remedy that interferes with contractual termination. In *Ready*, the Saskatchewan Court of Appeal set aside a decision of the Practitioner Staff Appeals Tribunal, which had set aside a decision of the Board of Saskatoon Regional Health Authority terminating Dr. Ready's employment. Dr. Campbell does not seek reinstatement of his Contract with the Respondent and therefore *Ready* is distinguishable from this case. It is also worth noting that the *Ready* decision was a court of Appeal decision with three separate sets of reasons. Ottenbreit, J.A. dismissed the appeal and upheld overturning the Tribunal's decision on the basis of jurisdiction. Ryan-Froslie, J.A. found jurisdiction but said the decision of the Tribunal was unreasonable because it omitted to properly consider key evidence. Jackson, J.A. in dissent found jurisdiction and also found that the Tribunal's decision was reasonable. There is no concept of *stare decisis* in administrative law and further it is difficult to find a strong policy rationale to apply legal principles from a case with three different sets of reasons.

[112] The Respondent cites the reasons of Ryan-Froslie, J.A. at paragraph 388 that:

> [e]ven if the underlying motive for dismissal without cause relates to a physician's conduct, it does not in my view circumvent the Bylaws.

[113] However, at paragraphs 342 and 343, Jackson, J.A. noted the problem with that statement as it would allow the health authority to terminate without cause any physician that it has an issue with the privileges of and this would effectively eliminate the review jurisdiction of the Tribunal. Jackson, J.A. agreed that "the role of the Tribunal is to ensure that physicians, however they are remunerated, are

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[30] *Ready v Saskatoon Regional Health Authority* , 2017 SKCA 20 (*Ready*).

treated consistently and fairly"[31] for the public generally and to ensure quality of care.

[114] If the statements of Ryan-Froslie, J.A. were to be followed, then the HAB would be devoid of jurisdiction over any privileging matter for any physicians under contract with a hospital. It is this Panel's view that the freedom of contract cannot override a hospital's obligations under the Bylaws regarding privileging, and cannot avoid the jurisdiction of the HAB found in the *Hospital Act*. The whole rationale for the creation of the HAB was to provide an impartial review of decisions of hospital boards that were determined to be in a potential conflict of interest with the physicians involved in the administration of hospitals. Following *Ready* in this manner would be a significant step backwards in BC and something with which this Panel does not agree.

[115] The *Ready* decision is also distinguishable on factual grounds as Ryan-Froslie, J.A. based her decision on evidence which she said was uncontroverted and inconsistent with the Tribunal's conclusion of constructive dismissal. The Justice noted that the Tribunal disregarded material evidence leading to an unjustified decision based on its finding that Dr. Ready could not practice pathology in Saskatchewan without being under contract with the health authority[32].

[116] However, in the face of this strong condemnation by Ryan-Froslie, J.A., Jackson, J.A. found that the Tribunal's finding that there was an effective revocation of Dr. Ready's privileges rested on a factual finding that pathologists are not practitioners who are able to carry out an independent practice outside of their contract with the authority. Jackson, J.A. noted the Tribunal's expertise underpins this conclusion. Jackson, J.A. noted (at para 282):

> After making that finding, the Tribunal found that being unable to use one's privileges means they had been effectively amended or revoked. For my part, and with all due respect for the contrary view, there is no basis to question the reasonableness of this finding. The Tribunal found functional equivalency between not being able to use one's privileges and revocation of one's privileges. I would go further and say that if one cannot use privileges it would be extremely difficult to say they have not been "effectively" amended or revoked, to use the Tribunal's adverb.

[117] The pivotal factual issue in *Ready* was whether it was possible for Dr. Ready to practice as a pathologist in Saskatchewan without a contract with the hospital authority. This is not an issue in this case as it was the uncontroverted evidence that Dr. Campbell cannot have a viable stand-alone referral practice outside of BCCH in BC or anywhere in Canada. This was the evidence of Dr. R who had experience at many of the 8 hospitals who have pediatric cardiac surgery programs in Canada. This evidence was not seriously challenged by the Respondent. This distinct factual difference further distinguishes this case from the decision in *Ready*.

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[31] *Ready, supra* fn 30, at para 343.
[32] *Ready, supra* fn 30, at para 358.

[118] This Panel finds the reasoning of Jackson, J.A. to be persuasive given the facts in this case.

[119] The Appellant cites *Mardenli v Vitalite Health Network*[33] for the proposition that where a physician has both privileges and a clinical services contract, the termination of the clinical services contract does not impair any of the procedural safeguards affecting their privileges that are contained in the Bylaws. In *Mardenli,* he Court judicially reviewed the decision of the hospital to revoke Dr. Mardenli's privileges on the basis of a lack of procedural fairness in the termination of his privileges. The hospital claimed it did not terminate Dr. Mardenli's privileges but terminated his employment contract. As with most of these cases the facts and issues are not straightforward and require a more detailed review to understand any principles to be taken from the case.

[120] Dr. Mardenli was a pediatrician from Syria who was hired at the Edmundston Regional Hospital in N.B. under a contract of employment. Given Dr. Mardenli's lack of full qualifications, one of the conditions of his employment contract was that he obtain a special license by the College of Physicians and Surgeons of N.B. This special license required ongoing supervision by a designated supervisor. In order to have privileges at the hospital, Dr. Mardenli needed to have the special license to practice. Dr. Mardenli obtained associate member privileges which contained a mandatory one year probationary status in the bylaws. The bylaws also provided that associate members had to practice under supervision and set out a process for review of those associate privileges including two formal evaluations of the associate member's performance and competency at specific times. Any termination could not occur until there was review of the two review reports and a recommendation to the Board through the appropriate committees. Dr. Mardenli did not benefit from the mandatory one year probationary period or the two formal evaluations and the process was not followed in the credentials committee prior to his termination.

[121] Several months into his practice at the hospital Dr. Mardenli was told to stop his clinical activities as a review of his practice would be carried out. Dr. Mardenli was placed into a supervised work placement at another hospital for about a month followed by another six month supervised placement at another hospital. Before the end of the one year probationary period, the hospital withdrew its supervision as it stated that it could no longer offer adequate supervision that was adapted to his needs. This decision by the hospital set in motion several other cascading consequences for Dr. Mardenli. The hospital notified the College that it was no longer providing supervision for Dr. Mardenli and therefore, the College revoked his special license. Without the special license, which was a requirement for both his contract for services and privileges, both his contract and privileges were effectively terminated. The hospital argued that it did not terminate his privileges but due to the revoking of his special license, Dr. Mardenli no longer met the requirements to maintain his privileges. The Court found that all of these consequences flowed from the hospital's decision to remove supervision of Dr. Mardenli, which was required of associate members in the bylaws. The Court found that the hospital told Dr.

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[33] *Mardenli v Vitalite Health Network*, 2017 NBQB 232 (*Mardenli*).

Mardenli that his privileges were terminated. However, the Court found that even if it had not found a direct termination of privileges, it would have found that the withdrawal of supervision amounted to an indirect withdrawal of privileges.

[122] The Court found that there was nothing in the contract which overrode the bylaws and, in the circumstances, the hospital could not terminate Dr. Mardenli's associate member privileges without following the procedural requirements of the bylaws. In fact, the Court found that the employment contract made reference to the bylaws in relation to the two evaluations which could lead to the termination of privileges[34]. The hospital could not ignore the bylaws and simply rely on contractual termination. The Court noted the purpose of the procedural protections in the bylaws as follows(at paras 63-65):

> 63. The By-laws require a division of functions that offers guarantees to the public and to the staff member whose rights could be affected by a decision. The achievement of procedural equity is essential to the concept of fair exercise of power.
>
> 64. The revocation of the Applicant's appointment and privileges had a negative impact on his professional reputation and continues to cause him significant stress and anxiety.
>
> 65. The Applicant was entitled to the safeguards provided by the By-laws. No one's rights, interests or privileges should be affected by an unfavourable decision at the end of an unfair procedure.

[123] The hospital argued that its decision to terminate Dr. Mardenli was justified by a concern for maintaining care and ensuring the safety of patients. The Court found that there was no evidence of any emergency situation and even if such a situation existed, there are bylaws to deal with emergent situations[35]. The Court also noted that it was not the Court's role to rule on the merits of any decision to terminate Dr. Mardenli's privileges, as that decision ultimately belonged to the hospital after it following the procedures set out in the bylaws.

[124] The Court found that there was nothing which authorized the hospital to bypass the process in the bylaws and the bylaws were not followed in the termination of Dr. Mardenli's associate member privileges. The Court quashed the decision of the hospital to revoke Dr. Mardenli's privileges. The effect of that decision was that the hospital had to provide Dr. Mardenli with the supervision required under its bylaws and all of the procedural protections under the bylaws if it wanted to terminate those privileges after the one year mandatory probation.

[125] In this case, the Respondent has not followed any of the procedures in the bylaws to justify any modification of Dr. Campbell's privileges, nor did it plead or make any justification argument in relation to any modification of. Dr. Campbell's privileges in these proceedings. In fairness, the Respondent says there has been no modification so there is no need to establish any justification for the modification.

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[34] *Mardenli, supra* fn 33 at para 57.
[35] *Mardenli, supra* fn 33 at para 67.

The Respondent did raise some conduct and competency issues which are dealt with later in these reasons as part of its argument on remedy.

[126] As referenced briefly above, the Panel was informed of the decision of the Hospital Privileges Appeal Board in *Nordal*[36], which was released after the close of argument in this case. Given the potential applicability of this case the Panel sought supplemental written submissions from the parties.

[127] In *Nordal*, the HPAB had to squarely decide whether a contract termination was a constructive termination of a physician's privileges. In setting out the relevant considerations the HPAB stated (at paras 198-198.3):

> 198. To assess whether a termination of a contract between a physician and AHS [hospital authority] amounts to a termination or variation of privileges, the Appeal Board must consider the following factors:
>
> > 198.1 Was the termination of the ISA part of a colourable attempt to terminate the physician's privileges to evade the obligations imposed on AHS by the AHS Medical Staff Bylaws in circumstances where those Bylaws are designed to apply?
> >
> > 198.2 Was there an "inextricable link" between contract and the privileges such that the physician's privileges are meaningless if the physician is not contracted to AHS?
> >
> > 198.3 The Kutzner [Prairie North] Factors: …"

[128] The HPAB further described a colourable decision as (at para 199):

> A decision is colourable where it is purportedly made for one purpose but, in reality, it is made for another purpose. If AHS uses a termination without cause process to evade the procedures set out in the AHS Medical Staff Bylaws, that is a factor that the Board will consider in determining whether, in effect, the decision was a decision to vary or terminate privileges.

[129] On the issue of the existence of an "inextricable link" the HPAB found as follows (at para 212):

> The Appeal Board finds there is, in the case of Dr. Nordal, an "inextricable link" between Dr. Nordal's ISA and his ability to exercise his privileges. His privileges as a radiation oncologist are meaningless without access to an AHS facility within which to exercise them. This is a further factor supporting the view that Dr. Nordal's privileges were terminated.

[130] The HPAB concluded that AHS termination of Dr. Nordal's contract was a colourable attempt to terminate his privileges in circumstances where the contract was inextricably linked to the exercise of privileges. The HPAB also found that the *Prairie North* factors had been met in finding that there was a termination of Dr. Nordal's privileges which was not done in accordance with the procedures in the Bylaws.

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[36] *Nordal, supra* fn 17.

Findings on Modification and Revocation of Privileges

[131] The Respondent submits that privileges do not carry with them any right to receive patients; that patients are not "resources" or "facilities" to which access is afforded with a grant of privileges. In the context of this case, however, patient allocation is the only way that Dr. Campbell is able to access the hospital's facilities and resources and thereby exercise his privileges. We accept the evidence of Dr. R that pediatric cardiac surgery is not a specialty that can be practiced outside of a facility and that it is not viable to have a stand-alone referral-based practice outside of a facility. Dr. R knew of no pediatric cardiac surgeons in Canada with a stand-alone practice. The Respondent did not provide any evidence to refute Dr. R's evidence on this point.

[132] BCCH is the only facility in BC where pediatric cardiac surgery is performed. The only pediatric cardiac surgeons working in BC are those that are part of the BCCH Cardiac Sciences Team. While it is possible that Dr. Campbell could receive some referrals for vascular surgery required for pediatric patients under the care of other specialists, we find there is no likelihood that Dr. Campbell or any other pediatric cardiac surgeon not associated with the Cardiac Sciences team at BCCH would receive referrals for cardiac surgery. The only way Dr. Campbell can gainfully work as a pediatric cardiac surgeon is through an association with BCCH as part of the Cardiac Sciences Team.

[133] Dr. Campbell's initial appointment contemplates his patients will be those referred to the Division. In addition, if BCCH were to enter into a contract with another surgeon to replace the responsibilities and obligations that were performed under Dr. Campbell's former Contract, then BCCH would have to grant that physician privileges. This grant of privileges would have to consider the needs of the community being served and the resources of the Respondent, and the evidence was clear that the Respondent did not conduct an impact assessment for a third pediatric cardiac surgeon as there was not a need for three pediatric cardiac surgeons with privileges at BCCH. Granting privileges simply to satisfy a perceived patient choice would be exactly what the HAB implicitly rejected in the *Butler* case. Granting privileges to a third pediatric cardiac surgeon without a demonstrated need would be a modification of the privileges of the existing two pediatric cardiac surgeons.

[134] Citing *Sanghera v Vancouver Coastal Health Authority*[37], the Respondent argued that if a third pediatric surgeon were hired and granted privileges, that physician could not be displaced. The circumstances of *Sanghera* involved a competitive hiring decision which is completely different than the circumstances in this case where the hospital has admitted that there is only a need for two pediatric cardiac surgeons with privileges and also admits that there are currently two pediatric cardiac surgeons with privileges. Attempting to grant privileges to a third pediatric cardiac surgeon in these circumstances is not only completely distinguishable from *Sanghera*, it may well be an abuse of process.

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[37] *Sanghera v Vancouver Coastal Health Authority*, HAB Decision No. 2017-HA-002(a) (*Sanghera*).

[135] While Dr. Campbell's Privileges and Appointment to the Medical Staff have been renewed following the termination of his Contract for services, he cannot effectively use those privileges. Although Dr. K testified that if Dr. Campbell had patients requiring surgery he could make arrangements to book the operating room, we find that that in the absence of being associated with the Cardiac Sciences Team at BCCH, there is no likelihood that Dr. Campbell would be referred pediatric patients requiring cardiac surgery. Dr. K's evidence that Dr. Campbell could book clinic time to assess patients is also contrary to Dr. Campbell's actual experience in trying to book clinic time.

[136] Dr. K's evidence is also contrary to the team concept of the Cardiac Sciences Program which requires a close and consistent working relationship between team members. In this regard there was no communication regarding Dr. Campbell's continued privileges, and the effect was that members of the Cardiac Sciences Program did not consider Dr. Campbell a member of the team anymore. This led to confusion and turmoil amongst some team members which the management of BCCH did nothing to resolve.

[137] It was obvious to the Panel that BCCH was aware that Dr. Campbell could not practice his privileges for pediatric cardiac surgery without patients being allocated to him by BCCH, and that the intended effect of terminating his Contract without cause was to terminate his privileges.

[138] The termination of Dr. Campbell's Contract for Services effectively terminated Dr. Campbell's ability to exercise his Privileges and both his Privileges and his Appointment to the Medical Staff became meaningless.

[139] Termination of the Contract constructively revoked Dr. Campbell's "permit to practice in the hospital" and it is disingenuous of the Respondent to say otherwise. As of March 14, 2018, Dr. Campbell effectively could not "practice in the hospital". The modification of Dr. Campbell's privileges started before that on a somewhat gradual basis starting when Dr. G arrived at BCCH. However, it is not critical for the purposes of this hearing to determine any specific date, other than to find that his privileges were modified.

[140] The Panel in *Nordal* dealt with whether the termination of a physician's contract constructively terminated his privileges. The factual circumstances in *Nordal* are similar to this case and the Panel finds that the Appellant's Contract was inextricably linked to the exercise of his privileges at BCCH as a pediatric cardiac surgeon. Much the same as Dr. Nordal, Dr. Campbell cannot practice his specialty without access to the Cardiac Sciences Program team at BCCH.

[141] While the Panel finds the Respondent's termination of Dr. Campbell's Contract was a colourable attempt to revoke his privileges, the Panel does not find this to be a necessary or determining factor in its finding that there was a modification or revocation of Dr. Campbell's privileges. We do not think the Appellant needs to establish any element of intent to establish a modification or revocation of his privileges. The Panel also agrees with Jackson, J.A. in *Ready*[38],

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[38] *Ready, supra* fn 30, at para 282.

that "if one cannot use privileges it would be extremely difficult to say they have not been "effectively 'amended or revoked'"". The evidence that the termination of the Contract was not made for the stated purpose includes:

1. As described later in this decision, Dr. G did not have any issues with Dr. Campbell's surgical skills but had issues with his conduct and lack of drive and attention to detail in the practice. Any conduct or competency issues are required to be dealt with through the privileging regime and not through contract termination.
2. The general lack of any stated reason for the termination of Dr. Campbell's Contract.
3. The incongruity of the Respondent's evolving rationale that Dr. Campbell could not do surgeries on neonates when he had been the sole surgeon at BCCH doing these same surgeries for years prior to Dr. G's arrival.
4. There was no change in the needs of the population and no impact assessment done by the Respondent as Dr. Campbell's Contract termination had nothing to do with a reassessment of needs or the resources of Respondent.
5. The admission of the Respondent that they needed two pediatric cardiac surgeons and were attempting to retain one after Dr. Campbell's Contract termination to replace Dr. Campbell's service obligations under the Contract.
6. The repeated statements by the Respondent after termination of Dr. Campbell's Contract that he left or departed BCCH or was no longer part of the Cardiac Sciences team and there needed to be a transfer of patient care.

[142] All of the above facts are consistent with a termination of Dr. Campbell's privileges and not with some unrelated reorganization in the Division.

[143] The Panel finds that a fair and equitable allocation of patients in the specific context of this particular specialty in BC is part of the privileges of a pediatric cardiac surgeon at BCCH. The Panel finds that fair and equitable means that each surgeon in the Division has the same opportunity to develop and maintain their skills. This generally means a relatively equal division of open and closed cases and a sharing of complex cases including neonates.

[144] The evidence that a pediatric cardiac surgeon cannot practice without patients being allocated by BCCH can be seen from the post termination evidence of Dr. Campbell. He did not get any patients and was required to take a temporary position out of the country while he brought this appeal. He was not invited to attend CATH conferences or any other meetings at BCCH which he was entitled to attend by virtue of his continuing privileges. However, it would have been meaningless to attend any of these meetings or conferences if he was not going to be allocated any patients or surgeries because without patients, he could receive no compensation apart from any contract with BCCH.

[145] The Respondent argues that this conclusion would lead to calamity for hospitals if they have to provide some sort of guarantee of patients for every physician with privileges. This concern is unfounded. For most physicians, the hospital does not have any role in assigning patients. However, where the hospital controls the allocation of cases to encourage a particular specialty, as is the case with the Cardiac Sciences Program, then granting privileges to a physician to practice that specialty would require a reasonable allocation of patients to effectively practice that specialty. If the hospital controls the allocation of patients and allocation is not part of privileges then the hospital could terminate a physician's contract without cause and the physician would have no recourse to appeal any adverse treatment, absent a Human Rights complaint. The HAB was established to provide some protection against unfair treatment by hospitals and if the Respondent's argument is successful then there would be no protections against such actions by a hospital for specialties where the intake and allocation of patients is controlled by the hospital. These types of specialists are rare and highly trained, and are exactly the types of physicians that are in need of the protections of the Bylaws and review by the HAB.

[146] We find that a fair and equitable allocation of patients in the specific context of this particular specialty in BC is part and parcel of privileges and therefore, the Panel's broad remedial powers in section 46(2) are invoked. The fact that the Board of Management never exercised their powers is immaterial to the jurisdiction of the HAB to exercise it on the terms and conditions it considers appropriate.

[147] As set out earlier, the Respondent accepts that if the Panel finds that case allocation is part of privileges then a finding that the Appellant's privileges have been modified, refused, suspended or revoked follows because the Head of the Division has not allocated any patients to the Appellant post termination of the Appellant's Contract. The Respondent acknowledges that the Panel would then have to consider what, if any, remedy it considers appropriate.

Conclusion on Privilege Modification/Revocation

[148] For the above reasons, the Panel finds that the allocation decisions made by Dr. G concerning case assignment to Dr. Campbell resulted in a modification of Dr. Campbell's privileges over time. Further, the Panel finds that the decision of the Respondent not to allocate any cases to Dr. Campbell after the termination of the Contract amounted to a constructive revocation of his privileges.

[149] Having determined that in the context of this appeal case allocation is part and parcel of privileges, this Panel has the broad remedial jurisdiction to provide a remedy. Any remedy must be meaningful and measured. The remedy should not put the parties in a position where failure or further conflict is highly likely. For the good of the public interest and the needs of the patients served, the remedy must as far as possible address all the issues in a meaningful way for the division to move forward to meet its goals while still protecting all the rights and privileges over which the HAB has jurisdiction.

Issue #2 - Can and should the HAB grant a remedy?

[150] As set out earlier in this decision, the Appellant says the HAB has the jurisdiction to and should grant the following remedies in these proceedings:

1. The Appellant receive a fair and equitable allocation of surgical cases within the Division;
2. The Appellant be allocated a minimum of 2.0 operating room days per week;
3. The Appellant be restored to the Division "call" schedule;
4. The Respondent provide the Appellant with an office at BCCH; and
5. Dr. G and Dr. Campbell will engage in a facilitation process conducted by an external expert to be mutually agreed upon by both parties for the purposes of reintegrating the Appellant into the Division.

[151] The Respondent argues that the HAB does not have jurisdiction to grant the remedies sought by the Appellant; particularly the fair and equitable allocation of surgical cases. However, even if there is jurisdiction to grant the remedies sought, the Respondent argues that it would be inappropriate and not in the public interest to do so in this case.

[152] The Appellant says that there is no defense of justification in these circumstances and if the Panel finds that Dr. Campbell's privileges were modified or revoked, then the Panel must consider remedy. The remedy the Appellant seeks is essentially a meaningful reinstatement of his privileges as a pediatric cardiovascular and thoracic surgeon at BCCH.

[153] In the usual course in appeals before the HAB, the Respondent argues that any modification of privileges was justified and that the HAB should therefore uphold its discipline which may include a suspension or revocation of privileges. In this case the Respondent argued that there was no modification and therefore no need for it to address the issue of justification. However, the Respondent's arguments on remedy focused on Dr. Campbell's conduct and competency issues, which would generally form the basis of any justification argument.

[154] The problem with the Respondent proceeding to argue the appeal in this fashion is that the Appellant was not afforded the opportunity to address the justification argument head on. Instead, the Appellant had to attempt to address the issues of competency and conduct in the context of the Respondent's argument that a remedy could or should not be granted because of the dysfunction caused by Dr. Campbell and other general ethical and patient safety issues. The Panel addresses these competency and conduct issues later in these reasons but finds that the Respondent has not established any justification for the decreasing and ultimate discontinuance of case allocations that resulted in the modification and ultimate revocation of Dr. Campbell's privileges.

[155] The Respondent was clear that it was not alleging any conduct or competency issues regarding the termination of Dr. Campbell's Contract or in relation to his privileges. However, the Respondent raised these issues in relation to

remedy which the Panel finds was an inappropriate attempt to raise justification issues while still maintaining that there was no modification. The Panel has struggled trying to reconcile the Respondent's two conflicting positions but is satisfied that justification issues were not properly plead nor addressed in the evidence.

Does the HAB Have Jurisdiction to Grant the Remedy Sought?

[156] Both parties agree that the HAB's jurisdiction to grant a remedy is found in section 46(2) of the *Hospital Act*:

> The Hospital Appeal Board may affirm, vary, reverse or substitute its own decision for that of a board of management on the terms and conditions it considers appropriate.

[157] Considering this broad remedial authority within the context of the jurisdiction found in section 46(1) of the *Hospital Act*, it can be stated that the HAB has jurisdiction to substitute its own decision for any decision that the board of management has the authority to make regarding privileges.

Board of Directors' Authority in the Medical Staff Bylaws and Medical Staff Rules

[158] The Board of Directors' authority over privileges in the Bylaws and this Panel's finding that case allocation is part of privileges in the specific circumstances of this case, is sufficient to find that the HAB has jurisdiction to grant a remedy regarding case allocation in this case.

[159] A review of the Medical Staff Bylaws and Medical Staff Rules demonstrates that the Board of Management has the ultimate authority over any decision affecting privileges. The Bylaws and Rules provide some delegation of that authority to others, but final decisions are still the responsibility of the Board of Directors, either upon the recommendation of, or in consultation with, others.

[160] The Panel finds that the Bylaws provide the Board of Directors with the authority to deal with the allocation of surgical cases and must do so in a way that takes into account their ultimate responsibility for the quality of medical care including supporting the Medical Staff through the provision of adequate and appropriate resources as stated in the preamble to the Medical Staff Bylaws. Providing zero patients and resources to one of two pediatric cardiac surgeons does not provide adequate and appropriate resources to that one surgeon to meet the needs of the community for which he was granted privileges.

Delegation of Authority over Case Allocation

[161] Prior to this dispute, the Board of Directors effectively delegated the responsibility regarding case allocation to the Division Head. This process worked at BCCH under the previous Division Head. There was evidence that at some point after Dr. Campbell arrived at BCCH, Dr. L, the then Division Head, decided not to do as many surgeries on neonates and at some further time stopped doing them

altogether. Dr. Campbell performed the majority of these surgeries before Dr. G arrived as the new Division Head in 2010.

[162] As discussed earlier respecting the issue of modification of privileges, we heard evidence about case allocation at several other hospitals in Canada, particularly Stollery Children's Hospital in Edmonton and IWK Children's Hospital in Halifax. In all other pediatric cardiac programs, cases were allocated equitably to ensure surgeons were able to maintain and improve skill and competency levels. This equitable allocation included having less experienced surgeons operate with more experienced surgeons.

[163] There was no evidence that any surgeon was starved of complex cases at any other hospital, and, in fact, inexperience was dealt with in every example to attempt to ensure that all surgeons were capable of performing the full array of complex surgeries required of a pediatric cardiac surgeon.

[164] The Panel heard evidence from numerous witnesses that there was a distinct benefit to the Cardiac Sciences Program to have two surgeons capable of performing a wide range of procedures. This was also the evidence of Dr. R, whom both Drs. Campbell and G respect as a surgeon in the practice area. Even Dr. G admitted in cross examination that having two surgeons capable of performing a wide range of procedures was the optimal goal of the Division. This does not mean that every surgeon needs to perform every procedure. There was evidence of index procedures, which are specific procedures that pediatric cardiac surgeons are measured against and need to perform to keep their skills current and viable. Every other pediatric cardiac surgical program for which we heard evidence had a system in place to make sure that all surgeons got a relatively even number of index cases and had procedures in place to provide experience to the less experienced surgeons in the group. BCCH had a procedure to deal with allocation issues, but that changed when Dr. G arrived as Head of the Division at BCCH.

[165] There was much evidence about Norwood procedures. Hypoplastic left heart syndrome is a rare and complicated condition requiring three separate operations over a number of years with a relatively high mortality rate. Approximately 50% of patients do not survive to the third operation. Dr. Campbell had not performed many Norwood procedures and was not comfortable performing them whereas Dr. G had more experience with them. Dr. G experienced some difficulties with several of these procedures and recognized that the Division needed to be more selective in which patients they performed this complicated procedure on. The fact that Dr. Campbell was not comfortable with the Norwood procedure is a testament to his awareness of his limitations and is not evidence of his general substandard skills compared to Dr. G. Rather than being a source of contention amongst the surgeons, the apparent solution would be for both surgeons to participate in the surgery as was the practice in several other hospitals in Canada.

[166] As Division Head, Dr. G proceeded under the belief that he had complete control over case allocation decisions and that those decisions were beyond the review of anyone, even the Board of Directors. The Board of Directors was well aware, or ought to have been aware, of issues concerning case allocation in the Division, yet turned a blind eye under the belief that they could not intervene. Any steps BCCH took regarding the dysfunction in the Division, including meetings with

Dr. C, a physician facilitator brought in by BCCH to assist communication in the Cardiac Sciences Program (which we will discuss in more detail later), were completely ineffectual in addressing the underlying alleged conduct issues of Dr. Campbell and the alleged case allocation issues raised by Dr. Campbell.

[167] The Board of Directors neglected to deal with any of Dr. Campbell's conduct issues or the allocation issues until it determined that the best available course was to terminate Dr. Campbell's Contract without cause with 12 months working notice. Working notice is a difficult concept for a person being terminated. The evidence was that Dr. Campbell's conduct issues escalated during the 12 month notice period. While the Panel understands why working notice presented a difficult situation for the Appellant, we must state that some aspects of Dr. Campbell's conduct during the notice period was inappropriate and he should have known better. However, even the misconduct during the notice period went without any disciplinary measures by BCCH.

[168] The Respondent argues that it would be unethical for the Board of Directors to force some form of allocation to both pediatric cardiac surgeons. Some of the Respondent's witnesses[39] stated that they have to have the ability to advocate for the surgeon of their choice; one who they trust.

[169] The Respondent argues that ordering a fair and equitable allocation of surgical cases would be problematic because it would inappropriately interfere with the exercise of professional judgement by cardiologists and the Division Head, and it would generally be unworkable given the current status of the relationship between Dr. G and Dr. Campbell, and the relationship between the cardiologists and Dr. Campbell.

[170] Regarding the Respondent's first concern, we note that PHSA has agreed, pursuant to the Contract with both surgeons, that BCCH will ensure that there is sufficient clinical work to occupy the Physicians during the Term of the Contract[40]. Clinical work is defined to include surgeries. The Respondent notes that by operation of the Contract, Dr. Campbell was entitled to receive sufficient clinical and other work to occupy him during the term of the Contract, but once the Contract was terminated that obligation ceased. The mere existence of this contractual obligation on BCCH suggests that they have the authority to allocate cases to ensure both surgeons receive sufficient clinical work including surgeries. BCCH's Contract obligation is in conflict with their argument that they do not have the authority to deal with surgical case allocation. The Respondent also argued that it was a policy decision of BCCH not to allocate outside of a contractual relationship with a physician. This position further cements that BCCH has control over allocation which they chose to delegate to the Division Head.

[171] There was also evidence of a Letter of Understanding from Dr. B, the then Head of Surgery at BCCH, to Dr. Campbell when he joined BCCH in 2004. This Letter of Understanding also contained a statement that "all cases referred to the Pediatric Division of Cardiovascular and Thoracic Surgery are shared by both

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[39] In particular, Drs. G, H, SA and K.

[40] Tab 51 of the JBOD, Appendix 1(B)(c)-(d) and (C).

surgeons"[41]. There was no evidence of a similar provision in Dr. G's contractual documents when he joined BCCH in 2010. However, the fact that BCCH provided such a term in a contractual document to Dr. Campbell is evidence that they had the authority over case allocation or at least the outcome of case allocation in the Division between the two surgeons. This evidence rebuts the position now taken by the Respondent that it does not have any authority over case allocation.

[172] The Respondent relies on evidence from Drs. G, K, and H. that mandating case allocation would not be ethical, but presented no argument or authorities to support this contention. What is clear from their evidence is that Drs. G, H and S do not want to work with Dr. Campbell due to a myriad of issues which we will discuss later. Dr. K stated that he did not think he had the skills to make allocation decisions and we agree with him on that point. There are many aspects involving privileges where the Board of Directors delegate recommendation or execution of their authority to others with the particular expertise, however, that does not mean that the Board of Directors can abrogate their supervisory and ultimate authority over any aspect of the privileging regime at BCCH.

[173] Dr. K testified that if the if the Panel were to make an order requiring that cases be allocated to Dr. Campbell it would be "disastrous for all patients and families" and "unethical and untenable". This is an example of exaggeration by Dr. K in his testimony. As VP Medical Affairs he did not pursue any disciplinary measures or commence any review process on any of Dr. Campbell's behaviour or conduct issues. The above statement appears to have been made to support the decision to terminate Dr. Campbell with no formal disciplinary issues raised about actual competency or conduct issues. All physicians should be wary of this type of unchecked exercise of power by hospital administration.

[174] Dr. K stated that under the Medical Staff Rules a surgeon could be required to scrub in or take other steps to learn a certain procedure such as a Norwood procedure. BCCH never enforced such a rule for Dr. Campbell, even though they now say they had issues with his diminishing skills. Dr. K stated that it was open to BCCH to specify a certain number of procedures, but that was not the way it worked and doing so was not practical with children so the decisions were left to the Department and Division Heads to deal with. This statement effectively acknowledges the authority BCCH has to allocate cases while choosing to delegate that authority to the Division Head.

[175] Dr. K was taken to Article 2.2.3(i) of the Medical Staff Rules which states:

> Where specific procedural privileges have been granted, the Board of Directors in consultation with the Medical Staff, and/or the Department Head/Program Medical Director/Professional Practice Leader, may specify the frequency at which such a procedure should be performed for this privilege to be retained by the physician or dentist.

[176] After being taken to this article, Dr. K disagreed that the Board of Directors could specify the frequency of procedures such as Norwoods, Arterial Switches,

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[41] Tab 31 of the JBOD.

Berlins, etc. He did not explain the conflict between his statement and the plain wording of article 2.2.3.

[177] The argument that it would be unethical to force allocation to a surgeon not of the treating physician's choosing does not universally apply in a hospital setting. Hospitals are responsible for ensuring that there are emergency room physicians and any number of specialists on call 24 hours a day. When a patient or physician needs emergent services, they get the physician on call, not the particular physician of their or their referring physician's choosing. Furthermore, there is no ability to dictate who the anesthetists or perfusionists or surgical nurses or radiologists or ICU physicians and staff are in a particular case. This is why hospitals set up specialists centres like the Cardiac Sciences Program at BCCH, which is the only such program in BC, ensuring all the necessary specialties are in one place to meet the needs of patients in BC.

[178] The whole Cardiac Sciences Program works as a team. We heard evidence from the head perfusionist and anesthesiologist that to promote the best outcomes for the patients, their staff need to have experience with both surgeons performing a wide array of procedures and be comfortable with their respective styles. If the cardiologists or cardiac surgical Division Head could dictate all case allocation decisions, it could lead to a decrease in skill set for a particular physician or supporting staff and a weakening of the Cardiac Sciences Program.

[179] In addition, as indicated by Dr. R's evidence, when a patient is referred to Stollery's there is no specific surgeon to whom the case is referred.

[180] Of course, hospitals have a check and balance in this system that those working outside of the hospital system do not have. Hospitals have authority over the review of physicians and the appointment and reappointment of their privileges in the hospital so that only competent physicians have privileges to perform the surgeries and other services to meet the needs of the population. Hospitals have the authority in their Bylaws to set any standard of conduct and competence, including a higher standard than any professional standard set by the College of Physicians and Surgeons of BC.

[181] The Board of Directors of PHSA have the authority in their Bylaws to direct case allocation to specific physicians. From a practical perspective, this authority would usually be exercised under the advice and recommendation of others, including the Division Head, within specified parameters set by the Board of Directors.

Conclusion on Jurisdiction to Grant Remedy

[182] As discussed earlier in this section, in accordance with the broad remedial authority set out in section 46(1) of the *Hospital Act*, the HAB has jurisdiction to substitute its own decision for any decision that the Board of Directors has the authority to make regarding privileges. For all of the above reasons, the Panel finds that the Board of Directors has the authority to direct case allocation amongst the surgeons in the Pediatric Cardiac Team. As such, the Panel finds the HAB has the jurisdiction to grant the remedy of fair and equitable case-allocation sought in this appeal.

Is it Appropriate and in the Public Interest to Grant the Remedy Sought?

[183] The Respondent argues that if there was a modification or revocation of Dr. Campbell's privileges arising from a lack of cases being allocated to him, then the HAB should refuse to grant the relief sought because of the dysfunctional environment caused by Dr. Campbell. In its closing submissions, the Respondent refined this dysfunction argument to include patient safety, health and well-being of staff, ill-feelings, and mistrust of team members.

[184] In response to the Respondent's claim that there was a dysfunctional relationship, the Appellant led evidence that any dysfunctional relationship was caused by Dr. G and his "my way or the highway" style of operating the Cardiac Sciences Program.

[185] The Respondent's position on remedy created confusion during the hearing and gave rise to issues relating to relevance in light of its position in its pleadings that Dr. Campbell's Contract was terminated without cause.

[186] The Respondent was abundantly clear that it was not alleging any competency or conduct issues relating to Dr. Campbell's privileges. In its Amended Response to the Notice of Appeal, the Respondent admitted that BCCH "did not allege cause" and "did not raise any issues about Dr. Campbell's credentialing, skill or performance when it terminated the Contract"[42].

[187] Credentialing is synonymous with privileges, and the Respondent also admitted that "[t]ermination of the Contract did not suspend, revoke or modify Dr. Campbell's permit to practice at BCCH. His privileges remain intact and unchanged"[43]. The Respondent also admitted that "[t]here has been no modification of Dr. Campbell's privileges"[44].

[188] Given the Respondent's admissions, there should have been no issue with Dr. Campbell's competency or conduct, and yet the majority of the evidence at the hearing surrounded these issues. This was confusing to the Panel and resulted in the case proceeding in a very disorganized and disjointed fashion. The Panel was forced to make repeated rulings on the admissibility of evidence that the Respondent argued was not relevant, yet the Respondent wanted to rely on evidence of dysfunction caused by Dr. Campbell as the reason why he should not be reinstated and have cases allocated to him if the Panel found a modification of his privileges.

[189] In our interim ruling on document production and relevance we noted this appeal was unusual and had not proceeded in a typical way. Regarding relevance we stated: "The allegations respecting dysfunctional relationships, the Appellant's role in creating the dysfunction, and the appropriateness of the remedies sought by the Appellant have developed during the course of the hearing."[45]

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[42] Respondent Amended Response to Notice of Appeal at para 40.
[43] Respondent Amended Response to Notice of Appeal at para 6.
[44] Respondent Amended Response to Notice of Appeal at para 7.
[45] HAB Decision No. 2018-HA-002(c), at para 47.

[190] The Respondent plead in its Amended Response that if the HAB were to determine that there had been a modification of privileges, then it remained open to the BCCH Board to make a decision at first instance and consider whether there was justification for any modification of Dr. Campbell's privileges. The Respondent also argued that as a result of there having been no BCCH Board decision on privileges, there was an insufficient record before the HAB in respect of issues raised by the Appellant. The Respondent argued that it "reserves its right" to bring evidence forward on those issues and submitted the HAB should remit the matter back to the BCCH Board for a determination on those issues if it found jurisdiction[46].

[191] In its opening statement at this hearing, the Respondent advised the Panel it had changed its position and submitted that if the Panel found that there was a modification of Dr. Campbell's privileges it was not requesting the Panel remit the matter to the BCCH Board for a determination of whether there was any justification for the modification of privileges. The Respondent specifically requested that the Panel consider the issue of remedy, and whether any remedy was appropriate in the circumstances. The issues regarding remedy were fully argued before the Panel.

[192] This case proceeded in a disorganized fashion because the Respondent argued that there were no conduct or competency issues affecting Dr. Campbell's privileges while it also argued that Dr. Campbell should not be granted a remedy because of the dysfunction in the Cardiac Sciences Program which resulted in members of the Cardiac Sciences team not wanted to work with him. The Respondent effectively agreed that Dr. Campbell's conduct and competency issues were part of the reason for the allocation decisions of Dr. G, which it argued it had no control over.

[193] The Respondent alleges Dr. Campbell was the source of any dysfunction while the Appellant alleges any dysfunction was caused by Dr. G. In the middle of the two surgeons, each claiming the other to be the source of any dysfunction, is the management of BCCH which, in our view, abrogated any responsibility for the dysfunction and took almost no steps to resolve the dysfunctional issues. As we discussed earlier and will discuss later in greater detail, the minimal steps they did take were completely ineffectual.

[194] The evidence regarding dysfunction submitted at this hearing can be broken down into three basic categories:

1. the decrease and eventual elimination of any cases being allocated to Dr. Campbell despite his continuous holding of privileges at BCCH without any conditions or qualifications;
2. Dr. Campbell's misconduct including lateness, late and deficient completion of operative notes, absences and lack of attentiveness at rounds or CATH conferences, failure to respond to calls whether on call or

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[46] Respondent Amended Response to Notice of Appeal at paras 85-86.

just for a treating physician to discuss a patient, and general lack of engagement; and

3. the general inaction and missteps by the administration of BCCH to clearly identify and address the above two issues creating dysfunction in the Cardiac Sciences Program.

[195] To fully understand the dysfunction and whether it is possible to reintegrate Dr. Campbell into the Cardiac Sciences team, one needs to understand the three different sources of the dysfunction.

Role of Dr. G's Allocation Decisions

[196] In summary, Dr. Campbell had experience being the only surgeon in the Division for almost a year prior to Dr. G's arrival and had performed almost all of the surgeries on complex neonates for several years prior to that. When Dr. G arrived as the Division Head, Dr. G allocated almost all of the complex neonate cases to himself without any real explanation to Dr. Campbell under the belief that as Division Head he could make whatever allocation decisions he wanted to without any review or oversight. Over time, the allocation of cases worsened, which understandably caused Dr. Campbell significant concern as his skills would only decline over time without any allocation of the complex or index cases which essentially define a pediatric cardiac surgeon's skills. Dr. Campbell never obtained any reasonable answers to his concerns and the management of BCCH turned a blind eye to his concerns about case allocation and its effect on his skills as a pediatric cardiac surgeon.

[197] To fully understand Dr. Campbell's frustration with Dr. G's case allocation after he arrived at BCCH in 2010, it is important to review the history of Dr. Campbell's practice before Dr. G's arrival.

[198] As previously noted, between 2004 and 2009, Dr. Campbell performed the full spectrum of surgical services in the Division. A couple of years prior to Dr. L's retirement in 2009, Dr. L stated his intention to only operate on neonates in emergency situations and let Dr. Campbell perform all the neonate (newborn) surgeries. From June 2009 to July 2010, Dr. Campbell performed almost all of the surgeries. During this time Dr. Campbell brought in Dr. NR as a locum to assist with the simpler cases. For the first three months of Dr. NR's locum, Dr. Campbell scrubbed in for every case and after that he would scrub in for new procedures. This procedure ensured that Dr. Campbell, as acting Division Head at the time, could monitor the standards of patient care and assist in developing Dr. NR's skills.

[199] The Cardiac Sciences Program created a "Heart's Vision" document to advocate for some more program funding in 2009, and for the recruitment of another pediatric cardiac surgeon. The document noted the pediatric cardiac surgery success rate had consistently and dramatically improved and surgical outcomes of newborns, infants, and children with a wide range of congenital heart defects were on par with other leading cardiac surgical centres across North America. The document noted that in 2008 there were 139 open cases, 85 closed cases, 7 pectus repairs, 27 pacemaker implantations, and 125 other thoracic

surgeries. It noted that if there were no ICU bed shortages then the open cases performed would have been around 170.

[200] Dr. G acknowledged that the preponderance of complex neonates were done by Dr. Campbell prior to his arrival.

[201] The issue of case allocation, and particularly the allocation of complex cases, was identified as an issue between Dr G and Dr. Campbell before Dr. G arrived at BCCH. The issue was never appropriately dealt with by either Dr. G or the administration of BCCH. Prior to arriving at BCCH, Dr. G emailed Dr. Campbell in late 2008 outlining some programmatic issues. He noted that outcomes can be correlated to volume of cases and it is important for each surgeon to get a critical mass of cases to remain proficient. However, Dr. G admitted in these emails that given the historical case volume there are not enough cases for two surgeons to maintain a certain skill set and ensure excellent outcomes. He noted that "the allocation of cases should be determined by the head of the division, ensuring an equitable distribution based on complexity, with, of course, the best interests of the patients in mind." Dr. G testified that equitable essentially means what he thinks is in the best interests of the patients, so the concept of ensuring an equitable distribution meant Dr. G allocated most of those cases to himself.

[202] In response to this email Dr. Campbell wrote that they needed to address the question of case allocation very matter-of-factly. He noted Dr. G's desire to do 100-125 open cases a year which was not feasible given the current case volume. He noted that "if your plan would be to pick and choose all the cases, I'm sure you can see that won't work either – it will be necessary for both surgeons to be competent at essentially the full range of neonatal cases since when one is away the other will need to safely perform those operations." Dr. Campbell properly recognized the problem that eventually arose before Dr. G even started at BCCH. He noted one solution would be to operate together. Dr. G responded assuring Dr. Campbell that the cases would be distributed equitably and intelligently and that he would not be operating as much as he had in the past 8 years. He noted it was not his preference to double scrub on cases.

[203] Dr. G's evidence was that he was drawn to BCCH because there was a moderate number of cases and he didn't want to and still doesn't want to do it all by himself .

[204] When asked why he did not allocate cases to Dr. Campbell, Dr. G stated that before he arrived at BCCH he identified that there was higher morbidity with neonates and that there needed to be an improvement in that area. Given the improvements he wanted to make, he allocated the neonates and index cases to himself because there was only about 20-25 index neonates per year. He also stated that Dr. Campbell did not express an interest in doing neonates but resiled from this statement in cross examination and blamed Dr. Campbell's conduct on rounds and other conduct issues as the reason he did not allocate cases. It appears that even before he started at BCCH, Dr. G had decided to do almost all of the neonates and index cases and, therefore, his statements to Dr. Campbell in the 2008 emails turned out to be very misleading. Dr. Campbell was frustrated because he wanted to do the complex cases and neonate cases and did not understand why

he was not getting allocated any of those cases which he had done before. He felt he had experience and good outcomes with these cases before Dr. G arrived.

[205] The issue of why cases were allocated to one of the two surgeons was raised by the Appellant in pre-hearing management in this case. The Appellant argued that he could not refute or respond to the reason for the allocation decision if he did not know the reason for each decision. During pre-hearing management of this matter, the Respondent contended that there were very good reasons for each allocation decision. Therefore, the Panel chair ordered the Respondent to produce a package of documents with the reason and justification for each allocation decision for each patient in the Division from March 2015 to March 14, 2018. During this period, Dr. Campbell had approximately 152 patients and Dr. G had approximately 490 patients.

[206] Pursuant to the Chair's case management order, the Respondent prepared a chart listing the patients, the procedure, the date of the procedure, and the allocation reason[47]. It is unclear exactly who prepared the chart on behalf of the Respondent, but Dr. G testified that he filled out the reason for allocation. However, when questioned about the allocation reason "AC out of town", which appeared on multiple places in the chart, Dr. G stated he did not fill in that reason but that counsel filled that in. The Respondent did not present any evidence to counter or clarify Dr. G's evidence on this point and the Panel was not taken to any of Dr. Campbell's calendars and diaries which were voluminously produced in the matter to establish how the Respondent arrived at that evidence. Dr. Campbell testified in relation to several of these notations that he was in town on the date of the procedure, and in some instances was in the clinic adjacent to the OR. The Panel finds that any additions by counsel for the Respondent with respect to Dr. Campbell's availability are not reliable as no evidence was tendered to establish that fact and Dr. Campbell was not cross examined on any of his availability as shown on the chart.

[207] In addition, there were many times where the reason for allocation was stated as "SG does not recall, however, his operating 2.5 days/week while AC only operated 1.5 days/week (which was AC's request) likely played a role". This reason is not really a reason and was just used where a more defensible reason could not be provided. In addition, Dr. Campbell testified that he did not have enough cases to fill his 1.5 OR days so this reason does not appear to be genuine and is just a catchall reason for Dr. G's stated intention not to allocate complex cases or neonate cases to Dr. Campbell.

[208] There were also several patients where the allocation reason was family request but there were no notes or supporting documents in the case files to substantiate this reason.

[209] Dr. Campbell was taken to many of the patient cases in the summary chart and he gave evidence that he had experience with similar cases that Dr. G indicated were complex and had assigned to himself. The two surgeons did not agree on what was a complex case or procedure even when referring to standardized rating scales

[47] Tabs 367 and 367B of the JBOD.

such as the STAT level 1-5 which is based on mortality frequency and the Aristotle rating which was based more on skill difficulty involved in the procedure. Dr. G viewed every case where the heart was stopped as being complex. This characterization only serves to support his desire to do all complex cases and does nothing to assist in determining the case allocation issue or why Dr. Campbell was not getting allocated the same complex cases and neonate cases that he was doing before Dr. G arrived.

[210] In the end, the Panel found the allocation reasons provided by Dr. G as somewhat self-serving and of questionable validity. However, it is not particularly helpful or necessary to go through each allocation decision to determine its validity as Dr. G has admitted to not allocating Dr. Campbell complex neonates and allocating almost all of them to himself. Therefore, the reasons in the allocation chart are essentially meaningless and are not helpful in determining the issues in these proceedings. The evidence was clear that the complex cases and neonate cases allocated to Dr. Campbell significantly declined after Dr. G arrived and without any complex or index cases, it was just a matter of time before Dr. Campbell's skills would not be current and the ability to exercise his privileges at BCCH would be effectively meaningless.

[211] Dr. G admitted that a surgeon needed approximately 200 total cases with around 100 to 130 open cases to keep current and he agreed that he has had that many cases but that he did not allocate Dr. Campbell that number of cases.

[212] Dr. R noted that a surgeon should have 125 cases per year with 75% of those being open heart cases (approximately 94 cases) which would give a broad array to remain competent with the necessary skills. If there were less than that in a program, then the two surgeons need to work together by scrubbing in together in more cases, particularly the complex ones.

[213] Dr. G acknowledged that he assigned himself enough cases to keep his skills current on the full array of procedures but that he did not allocate Dr. Campbell enough cases to keep his skills current, especially with neonates and index surgeries.

[214] In cross examination, Dr. G stated that he did not think you needed two surgeons with a full skill set and yet in answer to a similar question from the Panel chair he admitted that it was the optimal situation for two surgeons at BCCH to have a full array of skill sets.

[215] Dr. G's evidence about Dr. Campbell's skills and allocation issues was not consistent. In direct examination he stated that Dr. Campbell never expressed an interest in doing neonates and index cases. However, in cross examination he stated that he knew that Dr. Campbell had expressed concern about not getting complex cases and expressed an interest in doing them which was noted in several Division meeting minutes in April 2011 and October 2013. And in response to questions from the Panel regarding Dr. Campbell's statements in his in depth or 360 review in the Fall of 2013, Dr. G acknowledged that Dr. Campbell said he wanted to do neonates and index cases, but that he did not feel Dr. Campbell's actions coincided with his words.

[216] Dr. G testified he has an issue with Dr. Campbell's level of commitment to the Cardiac Sciences Program. He noted Dr. Campbell's absences and lateness on rounds and to CATH conferences, his inattentiveness by being on his phone while on rounds, his lateness and failure to do OR notes, not responding to cardiologists' calls, not responding in a timely manner when on call; not checking in on patients in ICU as often as Dr. G himself did, and generally his pattern of avoidance when cases became difficult or of work generally.

[217] Dr. G testified he felt this conduct was egregious and did not demonstrate someone who wants to do the complex cases or be there at all.

[218] The problem with all these issues is that none were documented or relied upon at all to discipline Dr. Campbell. Instead, this lack of passion and other transgressions have been used to terminate a highly specialized surgeon's privileges without any due process.

[219] Dr. Campbell agreed that Dr. G focused on early extubation and discharge. He agreed that morbidity has gone down since Dr. G's arrival but not significantly. Dr. G noted some improvements in Dr. Campbell's outcomes after he arrived in 2010 when Dr. Campbell started using Precedex which assisted in earlier extubation. Dr. G stated that Dr. Campbell did not have any problem using Precedex or extubating kids that were appropriate for early extubation. That was never the issue. He also noted that the Division's success in mortality and morbidity was also partly because of the cases that Dr. Campbell was allocated even if they were generally less complex than the ones that Dr. G assigned to himself.

[220] Further evidence that Dr. G's problem with Dr. Campbell was not his specific skills but his conduct and attitude can be found in Dr. G's evidence that he had locums do complex cases such as an arterial switch and had no problem assigning these cases to locums. However, Dr. G testified that arterial switch operations are a complex procedure and that is why he did not allocate those cases to Dr. Campbell.

[221] Dr. G also noted in cross examination that he considered another physician, Dr. KA. to replace Dr. Campbell, and acknowledged that Dr. KA. required significant initial mentorship. Dr. KA completed a fellowship at BCCH under both Drs. G and Campbell. If Dr. G was concerned about Dr. Campbell's lack of skills, then it seems incongruent that he would want a surgeon who required more training than Dr. Campbell to be his back-up.

[222] Dr. G's view that he had the sole responsibility to allocate surgical cases in the Division with no oversight also led to a significant conflict of interest arising as a result of contractual provisions that stated that if one of the surgeons left then the other surgeon would get 50% of the other surgeon's compensation. Dr. G also received all of the MOCAP on call fee under the MOCAP contract. As a result of Dr. Campbell's Contract termination, Dr. G received a pay increase of over 42%. The Panel does not think that Dr. G took the actions he did for financial gain, but the mere existence of such a financial gain puts Dr. G and his allocation decisions in an unacceptable conflict position.

[223] Regarding double scrubbing, Dr. Campbell talked about double scrubbing in Norwoods only and did not think there was a need if there was an equitable allocation. There was some evidence of Drs. G and Campbell both scrubbing in for

procedures, but it appears to have been a rare occurrence. Dr. G stated he was not opposed to double scrubbing where there was a need or to assist another surgeon.

[224] The Panel notes the provisions of the Medical Staff Rules which provide the responsibilities for Department Heads and Division Heads and provides that the Division Head has a responsibility to foster and mentor the professional development of the individuals in their division and to promote, cooperate and support the staff in their Division goals. Double scrubbing is a way for both surgeons to maintain their skills and meets the goals of the Division to have two competent surgeons capable of performing a wide array of procedures.

[225] Dr. G allocated cases on his mistaken belief, which was supported by Dr. K, the VP Medical Affairs, that he had the ultimate authority over case allocation decisions which were beyond the review of the Board of Directors. This Panel has found that Dr. G's allocation decisions were a modification of Dr. Campbell's privileges and therefore reviewable by the Board of Directors and, consequently, the HAB.

Role of Dr. Campbell's Conduct

[226] The Respondent's evidence about the dysfunctional relationship caused by Dr. Campbell centred around his conduct issues, yet the Respondent never initiated any form of discipline pursuant to the Bylaws, other than once for late OR notes. The Respondent's arguments evolved over the course of the proceedings and culminated in an effort to tender new morbidity evidence regarding the two surgeons on one of the last days of hearing. The Panel refused this request as it would have been a breach of procedural fairness for the Respondent to lead evidence about Dr. Campbell's morbidity results without previously identifying those as being an issue in this proceeding and giving him a proper opportunity to respond. It is unclear what purpose this evidence would have showed other than to refute the back and forth evidence of which surgeon was the cause of the dysfunction. As previously stated, there were many sources of the dysfunction in the Cardiac Sciences Program, and it is the view of the Panel that this evidence is only relevant in crafting a remedy that attempts to address the dysfunction that the Respondent failed to address.

[227] There was evidence from several witnesses about Dr. Campbell's conduct such as being late or absent from rounds or Monday afternoon CATH conferences, being on his phone or inattentive during rounds or CATH conferences, deflecting blame for complications with patients, significant and unreasonable delays in drafting and approving OR notes, inefficient use of OR time, and late or complete unavailability while on call or when his assistance was needed by other members of the Cardiac Sciences Program. Dr. G noted several times that Dr. Campbell appeared to avoid work and that it did not appear to him that Dr. Campbell had any real desire to do the work required to be a competent and reliable pediatric cardiac surgeon. Dr. G felt that Dr. Campbell's actions did not correspond with his stated desire to perform surgeries on complex cases and neonate cases and that he lacked the motivation and passion to be a surgeon that the Cardiac Team members could rely upon.

[228] Regarding his lateness or absences from rounds, Dr. Campbell testified the rounds were generally the same both before and after Dr. G's arrival. He noted that the rounds would often change depending on Dr. G's schedule, and that Dr. G instituted weekend rounds every weekend rather than alternating weekends as had occurred before his arrival.

[229] Dr. Campbell was very candid in cross examination that he was late for rounds occasionally and sometimes did not attend at all if he had no patients and that this behaviour increased during the notice of termination period.

[230] Dr. Campbell noted that sometimes he had teaching commitments and other times he had commitments at the Pacific Adult Congenital Heart (PACH) clinic at St. Paul's Hospital which conflicted with rounds at BCCH. Dr. Campbell also noted that given his Monday operating room time he would often be late for CATH conferences and other meetings. When pressed for specifics regarding his lateness for rounds in cross examination Dr. Campbell stated that he was late to rounds or CATH conferences around 20% of the time between 2012 and 2016, and that even taking into account his work at the PACH clinic at St. Paul's Hospital, he did not think he had any good excuses. He also noted that around 5% of the time after 2012 until his notice of termination he was completely absent from rounds. Dr. Campbell estimated that during the notice of termination period he was absent from rounds 20% of the time. However, the records kept by Dr. G during the notice of termination period showed significantly more absences than that. The Panel accepts that Dr. Campbell's absences and lateness on rounds during the notice of termination period were greater than he admitted.

[231] While Dr. Campbell's candor in admitting he had no good reason for some of his lateness and absences is appreciated by the Panel, it is also quite startling that someone with his skill and expertise in a two surgeon division would take his obligations so lightly while admitting there was no good reason for the conduct.

[232] There was evidence from several witnesses that Dr. Campbell was late in responding to calls from Cardiac Sciences Team members on patients generally and when he was on call. There was evidence that sometimes he simply did not respond and Dr. G was called to deal with matters.

[233] There was also an issue with Dr. Campbell's late completion of OR notes. Dr. Campbell did not deny or provide any reasonable justification for the significant delays in completing his OR notes. Article 3.3 of the Medical Staff Rules provides detailed guidance, which is mandatory, regarding the maintenance of patient health records. In particular Article 3.3.3(e) provides that "all operations **shall** be described fully by the operating surgeon or delegate within 24 hours of surgery", and article 3.3.5 (c) provides that "the patient's health record should be completed at the time of discharge, or at least **must** be completed within 14 days of discharge from Agency". Dr. Campbell's cavalier attitude towards these mandatory obligations is troubling. The evidence showed that as of April 11, 2019, 214 medical records were dictated but not signed (which means they were not reviewed for dictation or other errors or clarifications), and that there were 135 OR notes where the delay in dictation was longer than 30 days (where 24 hours is the mandatory obligation). Dr. Campbell says the situation was difficult after his notice of termination. Timely completion of OR notes is mandatory and a necessary component of patient care

and there are no circumstances that should prevent their timely completion. In any event, the records produced by the Respondent showed a chronic problem long before the notice of termination in March 2017 with the dictation of many OR notes beyond 100 days after the procedure, and several beyond 200, 300 and even 400 days. Dr. Campbell's 2012 reappointment documents indicate that there were three suspensions for incomplete medical records, but Dr. Campbell only noted one such suspension that he was notified of[48]. The Panel was provided with a documentary record of one suspension on November 29, 2011 that was addressed to Dr. Campbell[49].

[234] The Respondent has care and control over all the privileging documents and if there were in fact three suspensions for late OR notes, then it should have produced the documents to support that contention. The Panel finds that there was only one suspension for late OR notes, however, the Panel also notes that there was a chronic problem of Dr. Campbell not complying with the very clear provisions of the Rules regarding the completion of OR notes for which no discipline measures including suspensions were applied to him.

[235] The Panel accepts most of the evidence about Dr. Campbell's conduct regarding his lateness, absences, inattentiveness and late or missing OR notes, and understands why Dr. G, with his extreme passion and dedication to the practice and patients was exasperated by Dr. Campbell's conduct. The Panel understands why Dr. G felt that Dr. Campbell was not a fully engaged member of the Cardiac Sciences Team and why other team members may have lost confidence in him over time. Dr. G, at several times, sought the assistance of his superiors to deal with Dr. Campbell's conduct issues but no disciplinary action was taken by BCCH.

[236] BCCH did not provide Dr. G with the support he needed to make Dr. Campbell a fully functional member of the Cardiac Sciences Team, something he pleaded with his superiors Drs. S and K to do as early as December 2013 in the context of facilitated meetings BCCH set up between several senior members of the Cardiac Sciences Program, including Drs G and Campbell and a third Physician, Dr. C.[50] Instead of taking substantive actions to address both Dr. Campbell's conduct issues and Dr. G's allocation decisions, Drs. S and K set a meeting with Dr. C about respectful communication. While the Panel agrees that respectful communication is important, lack of respectful communication was just a symptom of an underlying problem that, until fixed, would just continue and hide the real issues. It is not surprising that this one series of facilitated sessions in 2013/2014 did not resolve any of the issues that were causing the dysfunction in the Cardiac Sciences Program.

[237] BCCH has responsibilities regarding physician conduct in the Medical Staff Rules. Under the Medical Staff Rules, Dr. G's responsibilities are "similar, but subordinate, to those of the Department Head".[51] The Department Head holds responsibility for investigating concerns of physician behaviour and delivery of

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[48] Tab 21 of the JBOD.
[49] TAB 31 of the JBOD.
[50] Tab 30 of the JBOD.
[51] Medical Staff Rule 5.5.1.

patient care and, where appropriate, initiating disciplinary proceedings in accordance with the Bylaws. The Department Head also holds responsibility for notifying the Senior Medical Administrator of certain behaviours, where necessary, and to recommend disciplinary measures including suspension of privileges[52].

[238] The Panel cannot find any evidence of investigatory or disciplinary measures taken or recommended by Dr. G, but we do find that Dr. G notified his Department Head, Dr. S, and the VP Medical Affairs, Dr. K, about issues regarding Dr. Campbell's conduct. We find both Drs. S and K were well aware of the general nature of issues with Dr. Campbell's conduct. In addition, the Panel notes that Dr. G was not involved in the approval of Dr. Campbell's privileges in 2018 and 2019; these were both approved by BCCH management without his involvement.

[239] The Respondent seeks to rely on Dr. Campbell's dysfunctional relationship as a bar to reinstate his full active and meaningful privileges, but if they wished to do that they were required to deal with those issues up front in a disciplinary matter and use the proper procedures in the Bylaws providing Dr. Campbell with basic procedural fairness rather than simply relying on this conduct without full pleadings and notification to Dr. Campbell in these proceedings.

[240] In the penultimate pettiness, the Panel heard evidence from both Drs. G and Campbell about their knowledge of who placed a star above Dr. Campbell's office and who placed a rat trap by Dr. G's office when Dr. Campbell left BCCH. Suffice it to say there was insufficient evidence to make a conclusive finding on that issue. However, the fact that it was raised in a serious proceeding before the HAB demonstrates the nature of the relationship and how the administration of BCCH allowed the relationship to deteriorate.

<u>Role of BCCH Administration in Dysfunction</u>

BCCH Administration Awareness of Case Allocation and Conduct Issues

[241] The BCCH administration includes the Department Head responsible for the Division of Pediatric Cardiovascular and Thoracic Surgery, the VP Medical Affairs, the Medical Advisory Committee and the management and Board of Directors of BCCH.

[242] BCCH administration was aware of Dr. Campbell's concerns about Dr. G's case allocation as early as 2013 and did not address them until the formal complaint brought by Dr. Campbell in 2017 during the notice of termination period. Dr. K's review of the allocation issue at that point was too late to have any meaningful effect and the review process was seriously deficient.

[243] BCCH administration was also aware of Dr. Campbell's conduct issues, particularly his late OR notes in breach of the Bylaws, as early as 2011. There were repeated notifications up the supervisory and management structure by Dr. G and others about conduct issues regarding Dr. Campbell. BCCH administration did not address these issues until 2017 during the notice of termination period which was

[52] Medical Staff Rules 5.3.10 and 5.3.11.

too late to address any effective change as the administration had already made the decision to terminate Dr. Campbell's Contract. The Panel was left with the impression that BCCH felt that discipline at that point would have been a futile exercise. The Panel notes that enforcing provisions of the Bylaws dealing with patient care and safety, such as timely completion of OR notes, is never a futile exercise and BCCH has an obligation to enforce these provisions at all times.

Lack of Response from BCCH Administration Regarding Case Allocation and Conduct Issues

[244] Both Dr. Campbell and Dr. G experienced the lack of response of the BCCH administration to their issues with the other surgeon over many years. This lack of response hardened their respective positions and it is not surprising that a dysfunctional relationship grew out of that discontent to the point where BCCH felt the only way forward was to terminate one of the surgeons.

[245] Starting in 2013 and into 2014, there were several events, including an in-depth or 360° review of Dr. Campbell and facilitated discussions with Dr. C. and senior team members of the Cardiac Sciences Team, through which BCCH management became aware of Dr. Campbell's case allocation problems in the Division. Both of these processes appeared to somewhat overlap in the Fall of 2013 and early 2014.

[246] The in-depth or 360° review process was completed by participants in September 2013. Under the section titled "Career Goals and Challenges", Dr. Campbell stated that his goals were challenged by the availability and distribution of complex surgical cases within the Division and the fact that he was not called for new consults when on call. This notification to BCCH management of a serious issue affecting Dr. Campbell's privileges could not have been clearer. Dr. G signed off on the in-depth review on October 28, 2013 and the Head of the Department of Surgery, Dr. S had a face to face meeting with Dr. Campbell about the in-depth review on that same date. There was also a signature line for VP Medicine, but there was no signature on the document. BCCH notified Dr. Campbell in a letter dated April 3, 2014 that his medical staff in-depth review recommendation for Active staff privileges in Surgery/Cardiovascular Surgery was approved by the PHSA Board of Directors.

[247] In cross examination, Dr. K stated that he did not read the in-depth review but signed off on it and he just asked the Division Head, Dr. G, if there were any problems. He also stated that there were no concerns in the review that required his attention. In light of Dr. K's evidence that Dr. Campbell never complained about allocation decisions until 2017, Dr. K's failure to even read the in-depth review of Dr. Campbell where he specifically raised these issues is a serious abrogation of his supervisory and management responsibilities. What is clear is that Dr. Campbell identified the problem early on and none of his superiors or management of BCCH took the concerns seriously or addressed them at all. This is a complete failure of BCCH's supervisory responsibilities over the medical staff and the privileging system found in the Bylaws. It is no wonder the situation worsened over time.

[248] In December 2013, senior members of the Cardiac Sciences Program, Dr. S and Dr. K agreed to have some facilitated discussion group meetings with Dr. Campbell and other senior team members. Dr. S viewed the purpose of the meeting to improve communication and functioning within the Cardiac Sciences Team and Dr. G viewed the purpose more directly about how to get Dr. Campbell the surgeon to be a fully functional member of the team.

[249] The Panel was provided with a document dated November 3, 2013 titled "Guiding Principles - Framework for Cardiac Sciences Discussion"[53]. The only reference to this document in the proceedings was in the cross examination of Dr. G to ask him who prepared it. Dr. G stated he thought Dr. S prepared it in the context of the facilitated meetings with Dr. C. Given the November 2013 date, it would appear that this may have a been a precursor to the discussions which occurred with Dr. C. It is unfortunate that Dr. S did not testify to clarify the points raised in the document as it appears to deal with many of the issues in this proceeding. The objectives in the document were to create guidelines for allocation of new surgical patients and OR time and on call responsibilities (which were Dr. Campbell's issues with Dr. G's case allocation decisions) and to set expectations around punctuality, engagement and active participation in rounds and other forms of communication including timely completion of operative reports, discharge summaries and STS data entry (which were Dr. G's issues with Dr. Campbell's conduct). If the issues identified in this document had been pursued more diligently by the management of BCCH, perhaps this proceeding would not have occurred. After the meetings with Dr. C had concluded, Dr. Campbell asked Dr. S what the follow-up steps were and Dr. S responded that they were finished with that process and there were no follow-up steps. It would have been helpful to have Dr. S's testimony to clarify the document that was attributed to him and why it was not pursued, but Dr. S was not called to testify.

[250] BCCH management was aware of Dr. Campbell's issue with Dr. G's case allocation decisions and did nothing to address the issue until Dr. Campbell made a formal written complaint to Dr. K in 2017 during the notice of termination period. The review of the allocation issue by Dr. K was completely flawed and simply too late. He relied primarily on the evidence of those whose decisions were being questioned, Dr. SA and Dr. G He did not investigate why the decisions were being made or what effect those decisions were having on Dr. Campbell as he was a resource of BCCH that was not being effectively used. He did not reach out to other hospitals to see how the allocation worked and he did not deal with any of the underlying issues between Dr. G and Dr. Campbell. At that point, the BCCH administration had already made a decision to terminate Dr. Campbell and it was apparent that there was no appetite from them to revisit the issue.

[251] Dr. G expressed his frustration directly to Dr. S as part of the facilitated discussions with Dr. C. in 2013/2014. Dr. G felt that Dr. Campbell's conduct was unacceptable and that he was not a functional member of the team.

[53] Tab 29 of the JBOD.

[252] The only action taken by Dr. K to deal with the issues in the Division was to bring in Dr. C to assist the parties in communicating. However, with the greatest respect for the work of Dr. C, these issues were way beyond communication and included conduct and allocation issues that needed to be addressed. It appears that even Dr. S recognized these critical underlying issues in his note prior to the facilitated meetings in late 2013.

[253] Dr. K testified that he followed up on all overdue OR reports. Given the evidence of the volume of overdue OR reports, this simply cannot be so as there is only one record for a suspension due to overdue OR notes in 2011. The evidence about the number and length of overdue operative reports when Dr. Campbell's Contract was terminated was significant. The lack of attention by BCCH administration to issues such as basic attendance at rounds and CATH conferences and the unexplained delays in OR notes was surprising to the Panel. The Board of Directors has the ultimate accountability for the quality of medical care which includes enforcing basic attendance and the rules set regarding patient records.

[254] Apart from termination of Dr. Campbell's privileges, the Respondent had many disciplinary tools it could have used to address the conduct issues raised. It chose not to avail itself of any of those tools. Dr. K stated that there was never any disciplinary action taken against Dr. Campbell apart from the one suspension in November 2011 regarding late OR notes. Other than this one suspension there was no record of formal discipline taken by BCCH against Dr. Campbell for any of the conduct issues raised in these proceedings which occurred over many years.

[255] Given the persistent conduct issues of Dr. Campbell which occurred over many years, it is surprising that his privileges were continually approved without any qualifications or conditions. Dr. G approved Dr. Campbell's privileges from 2011 to 2017 and admitted that he took the easy way out in approving the privileges as it creates a difficult path for a physician if you question privileges. After 2015, the privileges appointment document contained a detailed privileging dictionary which Dr. G assisted in drafting. After 2015, Dr. G approved Dr. Campbell's privileges with the full list of procedures set out in the privileging dictionary. There were no limitations set on Dr. Campbell's privileges by Dr. G.

[256] Privileges are generally approved by the Division Head, then approved by the Department Head of Surgery, and ultimately approved by the Board of Directors. Dr. G testified he did not recall reviewing or approving Dr. Campbell's privileges in 2018 and thought that Dr. S approved them. Dr. G gave evidence on July 5, 2019 that Dr. Campbell's 2019 privileges did not come to his attention and he did not know the status of them.

[257] There was an issue in these proceedings regarding the delay in renewing Dr. Campbell's 2019 privileges. In a letter dated October 31, 2019, after the close of argument in this matter, PHSA advised Dr. Campbell that his "Medical Staff membership and privileges have been reviewed and recommended by your Medical Leader(s), Credentials Committee, and Medical Advisory Committee, in accordance with Bylaws article 4.4 and 4.5." The letter further noted that the Board of Directors had approved of the renewal of his membership and active staff privileges.

Lack of Transparency in Communication Regarding Termination of Dr. Campbell's Contract

[258] BCCH also contributed to the dysfunction in the Cardiac Sciences Program and the larger medical community at St. Paul's Hospital and UBC, with its lack of transparency in the communication of the termination of Dr. Campbell's Contract.

[259] Dr. G testified that he was not consulted about the decision to terminate Dr. Campbell's Contract and he found the lack of consultation frustrating. He thought the result was going to be disciplinary or remedial action. Dr. G noted that Drs. S, SA (head of Cardiology) and SP (another Physician in the Cardiac Sciences Program) learned of Dr. Campbell's termination at the same time he did.

[260] Many of Dr. Campbell's peers and supporters at BCCH, St. Paul's Hospital and UBC sought clarification on the reason for the decision to terminate Dr. Campbell and did not get satisfactory answers. Some with similar contracts were concerned that the same action could be taken against them.

[261] Dr. K stated that he did not tell Dr. CA, a Cardiologist at St. Paul's Hospital who spoke with Dr. K about the reasons for Dr. Campbell's termination, that termination of Dr. Campbell's Contract was because of Dr. Campbell's lost skill and ability with neonates. However, Dr. CA testified that Dr. K did tell him that. Dr. CA made contemporaneous notes of the conversations he had with both Dr. K and Ms. L, the Interim Vice President of Provincial Child Health with the PHSA at the time, and his notes indicated that during both conversations the rationale provided for termination was a lack of skill with neonate surgery[54]. The Panel prefers the evidence of Dr. CA on this point. Dr. LT, a cardiac surgeon at St. Paul's Hospital who also contacted Dr. K to inquire about Dr. Campbell's termination shortly after it took place, also gave evidence that Dr. K told him that Dr. Campbell couldn't do the full complement of surgeries, including neonates.

[262] The actual notice of termination of Dr. Campbell's Contract states: "Your services will no longer be required as of March 14, 2018, and we look forward to your continued service in the meantime." This is not the language one would expect to see directed at a physician that had privileges at a hospital. A physician with privileges is able to perform services at a hospital and the hospital is obligated to provide the necessary resources and services to facilitate that.

[263] Dr. Campbell was told this was a without cause termination and that his privileges would still exist and was given no reason for the termination. The without cause termination of a contract is a legal concept which triggered the notice period stipulated in the contract. However, from a practical perspective, the failure to provide a reason to Dr. Campbell or the Cardiac Sciences Team members created much confusion and ultimately division amongst the team members, which appears never to have been resolved or addressed by BCCH.

[264] In a letter to Dr. Campbell dated June 1, 2017, the same day that a message was sent out to staff, Ms. L noted that at the meeting where Dr. Campbell was first given notice of his 12 month notice period for termination of his Contract, he was

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[54] Tab 147 JBOD and Exhibit "I".

asked to be involved in drafting a communication to BCCH staff announcing his "intended departure". She noted that he needed to be mindful of the disruption to BCCH staff and patient care. Ms. L signed the letter as the Interim Vice President, Provincial Child Health, PHSA, and she was at the meeting on March 14, 2017 where Dr. Campbell was advised that his privileges would still exist.

[265] The use of the phrase "intended departure" in the June 1, 2017 letter is odd considering Dr. Campbell still had privileges which included being a member of the Division and the Cardiac Sciences Program. BCCH had just decided to cancel the alternative billing arrangement with Dr. Campbell, but the remainder of their relationship governed by the privileging regime should have still been intact. Dr. K testified that he wanted to tell everyone in the Program that Dr. Campbell was no longer under contract so no more referrals would go his way. This is also a confusing statement as BCCH maintained that he still had active privileges.

[266] Dr. K talked to Dr. Campbell about sending out a message and Dr. Campbell said it was okay to send a message but did not really assist in drafting the message. If Dr. Campbell's privileges were not being modified or terminated and he was still welcome to practice at BCCH, one has to wonder what the notice would say. Dr. Campbell was confused about the reason for his Contract termination and his lack of participation in BCCH messaging was understandable.

[267] On June 1, 2017, almost three months after BCCH had given Dr. Campbell his notice of termination, Ms. L sent a letter to Child Health Management noting that BCCH wanted to move the program forward and BCCH would be introducing changes to the Division of Cardiac Surgery and Cardiac Sciences Program. She noted that as part of that change BCCH would be recruiting a new cardiovascular surgeon. The letter made no mention of Dr. Campbell or why he was terminated or thanking him for his contributions and wishing him the best in his future endeavours. The omission of any mention of Dr. Campbell in the letter did nothing to reduce the tension felt by some members of the Cardiac Sciences Program or to reinforce that the termination had nothing to do with Dr. Campbell's conduct[55].

[268] The Panel finds that BCCH made a difficult and complicated decision to terminate Dr. Campbell's Contract then unreasonably expected him to cooperate in his dismissal even though he was told throughout that he still had active privileges at BCCH. The letter that BCCH eventually sent out to hospital staff made no mention of Dr. Campbell or his termination and only created more dysfunction in the Cardiac Sciences Program.

[269] The evidence of Dr. LT's interactions with senior members of the Cardiac Sciences Program and BCCH was similar to what other members in the medical community were told regarding Dr. Campbell's termination. As mentioned earlier, Dr. LT was a cardiac surgeon at St. Paul's Hospital. He was the UBC Head of Cardiac Surgery and was involved in program oversight of cardiac programs at St. Paul's, VGH and BCCH, mainly to deal with residency programs and hiring committees. When he heard of Dr. Campbell's notice of termination from Dr. Campbell, he told Dr. Campbell he would look into it. He called Dr. K, who told him

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[55] Tab 86 of the JBOD.

that Dr. Campbell was disengaged. Ms. L told him that the program was going in a different direction and Dr. Campbell didn't have the full complement of surgical skills, particularly with neonates. Dr. S, the Head of Surgery at BCCH, said it was not his but administration's decision. Dr. G said Dr. Campbell was disengaged and the decision was not his but administration's decision. Dr. G also told Dr. LT that there were no issues with Dr. Campbell's technical skills.

[270] Dr. LT testified that he knew that administration at BCCH would not make a decision to terminate a surgeon without input from both Drs. S and G, the Department and Division Heads, respectively.

[271] Dr. LT continued to persist in his inquiries about Dr. Campbell's termination and wondered if technical skills were an issue why Dr. G would not scrub in with Dr. Campbell to assist. Dr. G maintained that technical skills were not the issue, but that disengagement was the issue.

[272] Dr. LT had a discussion around the end of April 2017 with Dr. K and Ms. L where it was stated that the program was going in a different direction and they needed a surgeon with the full complement of surgeries, Dr. Campbell could not do neonates and the program had to shut down when Dr. G was away. Dr. LT had no evidence one way or the other about Dr. Campbell's technical skills with neonates, but he knew that Dr. G said Dr. Campbell had good technical skills and Dr. Campbell had been working at BCCH for over 10 years so a sudden drop in his technical skills did not make sense. He also said it did not take 13 years to determine someone does not have the technical skills and even if that was the situation, the solution is to work with the surgeon to get him the skills. Ms. L alluded to something else but said she could not go into it because of Dr. Campbell's privacy. Whatever Ms. L was alluding to with Dr. LT, the Respondent never presented any evidence to elaborate on that statement and Ms. L did not testify at the proceedings.

[273] Dr. LT testified that he did not think he was getting the true story and he felt bad for Dr. Campbell. Dr. LT set up a meeting with Dr. N, who was the head of PHSA, in May 2017. He said he would bring along a couple of senior members of the medical community in Vancouver. He was surprised when Ms. L attended the meeting and said the meeting was more guarded as a result. Dr. N told those in attendance at the meeting that it was too late to reverse the decision, and Ms. L said the program was going in a different direction as Dr. Campbell could not do surgeries on neonates. There was a discussion about whether the concerns had been put to Dr. Campbell to allow him to address them, and the meeting attendees were told that such documents existed and they had done that. Dr. LT testified that he understood from Dr. Campbell that there was no process. The Respondent did not raise any issue with Dr. Campbell's technical skills during the course of his work at BCCH in this hearing, and no documents alluded to by Ms. L during the meeting with Dr. LT in May 2017 were produced or referred to in this hearing.

[274] Dr. LT was also involved in the hiring process for Dr. G in 2010. He noted that Dr. G was confident and wanted to build a program. He noted that Dr. L was ok referring some cases, while Dr. G wanted to do all types of cases and Dr. LT liked that idea. He thought Dr. G would act as a mentor to Dr. Campbell, and that given the lower work volume they could operate together on some cases. He

testified that before Dr. G was hired, Dr. Campbell was performing all the pediatric surgeries, including neonates, and there were no patient care concerns at that time or any urgency to hire Dr. G.

[275] Dr. LT had a follow up meeting with Dr. N and suggested that with Ms. L leaving and a new CEO at PHSA, maybe there was an opportunity to review Dr. Campbell's termination. At a meeting with the new CEO, she indicated to Dr. LT that there was no need to change direction with the decision regarding Dr. Campbell.

[276] Neither Ms. L nor Dr. S testified at the hearing. The Appellant argues that this Panel should draw an adverse inference against the Respondents for their failure to call Dr. S as a witness. The Appellant argues that as Head of the Department of Surgery, which the Division of Pediatric Cardiac Surgery reports to, his evidence would have provided assistance in understanding the issues in the Division. The Respondent argues that Dr. S would not have added anything material to the disposition of the case particularly as the Respondent argued that no evidence was necessary to determine the issues in this appeal. The Respondent notes witnesses with direct evidence of the events were called to testify including Drs. K, SA, H and G.

[277] The Panel finds that other than with respect to some administrative matters, Dr. K's evidence was not direct evidence on why the decision was made to terminate Dr. Campbell or why Dr. Campbell was not being allocated cases. The Panel does not feel there is any need to make an adverse finding on the Respondent's failure to call Dr. S as a witness. However, the evidence of Dr. LT and others about their interactions with Dr. S went virtually untested and the Panel accepts the evidence of Dr. LT and others that address information conveyed about Dr. S.

[278] For the reasons above, the Panel finds that the lack of transparency in the communication of BCCH's decision to terminate Dr. Campbell's Contract created confusion and distrust among other physicians under similar contracts at BCCH, the Cardiac Sciences Team members who were essentially left in the dark over the decision, and the larger medical community.

Currency of Skills

[279] The Respondent raised an issue regarding the currency of Dr. Campbell's surgical skills since the cancellation of his Contract in March 2018. There was evidence from many of the witnesses that Dr. Campbell was currently an unknown entity as it had been years since they worked with him. Several witnesses noted that the surgical and post-operative care for neonates had evolved in the time since Dr. G came to BCCH, with Dr. Campbell performing less cases on complex neonates.

[280] This Panel has found that over time at BCCH, Dr. Campbell's allocation of cases and in particular, index cases and those involving neonates diminished significantly and was a modification of his privileges that was not in accordance with the Bylaws and Rules. Therefore, the Respondent has to take the responsibility for any decline in skills during that time.

[281] The Appellant relies upon *Munro*[56] as precedent for the HAB ordering that a surgeon be re-integrated to his former privileges. Considering that Dr. Munro had not done any surgery for close to a year, the panel in *Munro* ordered that there be a period of reintroduction to a full surgical slate and that Dr. Munro's work be monitored to ensure that the quality of his surgical practice was restored to the level that existed before the modification of his privileges. *Munro* provides an example of when a hospital was ordered to reintegrate a surgeon back into a surgical practice in the Division even when it had to take additional steps to do so.

[282] The Panel notes that pursuant to the operation of article 5.3.15 of the Medical Staff Rules, Dr. G, as Division Head, has the responsibility to foster and mentor the professional development of individuals in the Division. This would include working with Dr. Campbell to ensure his surgical skills meet the standards of the Division and BCCH, and that the Division goal of having two surgeons capable of performing the full array of surgical procedures is met.

[283] Dr. Campbell gave evidence about his pediatric cardiac surgical practice in Oman. He started there in March 2018 and is a senior consultant focusing on complex and re-operative cases. He stated that from August of 2018 to March 2019 he had performed 150 index surgeries, both open and closed chest, involving a wide range of surgical procedures including arterial switches, VSD, ASD, epicardial placements, atrial septations, partial closures of AV canals, interrupted aortic arch, coarctations and occasionally a Ross procedure. He testified that he also performed one repair of an anomalous coronary artery and a Norwood procedure. In closing submissions the Respondent argues that Dr. Campbell has not proffered any documentary evidence of his surgeries or outcomes in Oman, and appears to question some of them including the Norwood procedure. The Respondent never cross examined Dr. Campbell on his practice in Oman and the Panel accepts Dr. Campbell has performed many of the operations he had performed at BCCH including index cases and surgeries involving neonates.

[284] As discussed above at length, Dr. R provided evidence about the pediatric cardiac surgical practice at Children's Hospital in Halifax where there are an insufficient number of cases for two surgeons to be proficient at every procedure. The solution used in that setting is for both surgeons to scrub in for most surgeries, and definitely for surgeries involving rare cases or complex neonates. The evidence regarding the practice at Hospital for Sick Kids in Toronto Hospital was that two surgeons scrubbed in when assistance was needed for a complex procedure or with a surgeon with less experience for a particular procedure. There has been nothing suggested by either party that would prevent Drs. G and Campbell from scrubbing in together, particularly early on if Dr. Campbell were to be reinstated, so that all team members could be comfortable with Dr. Campbell's skills.

[285] Dr. G stated that he has had Fellows perform surgeries on complex neonates without any trouble. While there may be a personal conflict between Drs. G and Campbell, it simply is unreasonable that Dr. G is comfortable with a Fellow performing surgeries on complex neonates and not Dr. Campbell when Dr.

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[56] *Munro, supra* fn 15.

Campbell had a history of performing them at BCCH prior to Dr. G's arrival and has continued to perform those surgeries in his practice in Oman.

[286] Currency and sufficiency of surgical skills is something that every new surgeon needs to address. Dr. Campbell noted that when Dr. L left, Dr. Campbell brought in Dr. NR as a locum and performed every surgery with her for the first couple of months and ensured he had seen her do surgeries before she did them alone. This is the responsibility of the Division Head.

Case Law

[287] The Respondent argues that granting the relief sought would effectively create a tenure system and procedural rights in a contract regime which could be exercised on issues unrelated to privileges. The Panel disagrees. The reality is that the contractual regime cannot alter the privileging regime and the contract is simply a vehicle for an alternative billing arrangement to attract highly trained specialists, and, perhaps, an effort to avoid competition among physicians for patients.

[288] The Respondent, referencing *Ready*[57], argues that absurdity would result from a finding by the HAB that the Appellant be given a certain number of patients. However, that is not what the Appellant is seeking in this case. He is seeking a fair and equitable allocation of surgical cases, something which happens at every other hospital we heard evidence about for this particular specialty. The Respondent argues that it would be required to keep programs open even when difficult decisions about community need and limited resource allocation decisions have to be made by a board of directors. This argument confuses the point in this case. This is not a case about reducing resources. All parties agree that there is a community need and resources available for two pediatric cardiac surgeons at BCCH. If at some time in the future, BCCH makes a decision to reduce its staff due to limited resources or changing needs in the community then the Board of Directors may need to make a reverse hiring decision regarding privileges which would still be subject to HAB review in the same manner as the granting of privileges to fill vacancies. This reverse hiring procedure to deal with decreased need or funding is supported by Article 3.1.6 and 3.1.7 of the Medical Staff Bylaws which specifically deal with situations where there is not a disciplinary, patient safety or quality of Medical Care issue. Therefore, the absurdity that the Respondent argues would happen if this Panel granted the Appellant his remedy would not result as that particular situation is accounted for in the Medical Staff Bylaws.

[289] The Respondent further cites *Young v Central Health*[58], as authority that it is critical to consider the impact on patient safety, and the health and well-being of all staff in considering the relief sought by the Appellant. However, the facts and matters in issue in *Young* are very different from the facts and issues in this matter. *Young* was a case where a physician was applying for privileges. In this case, the

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[57] *Ready, supra* fn 30 at para 385.
[58] *Young v Central Health*, 2018 NLCA 24 (*Young*), leave to appeal to SCC dismissed, 2019 CanLII 10531 (SCC).

Appellant already has privileges and the Respondent has not taken any disciplinary action or issue with the approval of those privileges for many years. In *Young*, the physician had privileges but gave them up and was suspended by the College of Physicians and Surgeons of Newfoundland for two incidents of inappropriate sexual relationships with patients. The issues of patient safety and the health and well-being of staff were properly applied in the context of an application for privileges following all of the procedures set out in the Bylaws for the hospital. However, in this case the procedures under the Bylaws was not followed or relied on in any way. It is inappropriate to rely on public interest factors outside of the procedures set out in the bylaws as it denies the Appellant of basic procedural protections which he has not been afforded under the procedure that BCCH has used in the circumstances of this case under its public interest argument.

[290] The Respondent also relies on *Griswold v Greater Victoria Hospital Society*[59], for its argument that it is in the public interest for BCCH to continue to seek the best candidate for its particular needs through the current recruitment process. This statement completely ignores the fact that there is currently no vacancy as far as privileges are concerned for pediatric cardiac surgeons at BCCH. The Respondent has completely misplaced the need for two surgeons under contract with the need for two surgeons with privileges at BCCH. *Griswold* was a case where the hospital followed the proper procedures in their Bylaws to determine whether there was need for a fourth cardiac surgeon and the Medical Appeal Board found that the hospital made a reasonable decision about the need for a fourth cardiac surgeon and that if a vacancy opens up then the hospital is entitled to seek the best possible candidate for its needs. The Medical Appeal Board did find that if there was an open competition then Dr. Griswold should be given serious consideration depending on the needs of the hospital at the time the vacancy opens up.

[291] Again, *Griswold* was a case where the hospital followed the procedures in the bylaws to determine whether there was a need for a fourth cardiac surgeon. In this case the Appellant already had, and still has, privileges and there was no identified need for a third pediatric cardiac surgeon with privileges at BCCH.

[292] The Respondent relies on these two cases to suggest similar public interest arguments could be made in this case to prevent allowing Dr. Campbell to fully utilize his privileges at BCCH if the Panel determines that case allocation is part of privileges in the circumstances of this case. It is very difficult to rely on public interest arguments which have as their foundation issues with alleged conduct and competency without any procedural fairness to Dr. Campbell. It is in the public interest that physicians with privileges be treated fairly and that is what the privileging regime attempts to do and why there is an independent de novo jurisdiction by the HAB. The Respondent chose not to avail itself of the procedures in the Bylaws to deal with any of the issues raised concerning Dr. Campbell and it would be completely unfair and improper to allow them to rely on those issues under the guise of public interest or patient safety. This is particularly the case

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[59] *Griswold v Greater Victoria Hospital Society*, (December 1986) BCMAB.

considering the Respondent's position that Dr. Campbell retains active privileges and would be permitted to operate at BCCH on patients.

[293] The Bylaws exist to protect patient safety and quality of care, and the Board of Directors is ultimately responsible for those issues and must address them through the procedures set out in the Bylaws, which have been approved by the Minister.

[294] In *Munro*[60] the panel found that the sudden modification of the appellant's privileges was inappropriate given the atmosphere of the division and the on-going recruiting and agreed with the characterization of the appellant's situation as a functional retirement. The panel concluded that the appellant was not treated fairly and reinstated his privileges to the status before the modification of his privileges took place.

[295] The Respondent argues that *Prairie North*[61], *Ready*[62] and *Sorokan v Fraser Health Authority*[63] say that it is simply inappropriate – and potentially dangerous – for the HAB to enter into the day-to-day operations of the Division and tell the Division Head and referring cardiologists which surgeon should be operating on which patients. These cases stand for no such proposition. These bold and inaccurate statements in the Respondent's submissions seek to unreasonably extrapolate principles to this case. The cases to which they refer deal in some respect with operational decisions of hospitals, but this general statement is not applicable or helpful to the analysis in this case.

[296] The Respondent repeatedly refers to decisions as "operational" in the apparent belief that this somehow excludes those decisions from the jurisdiction of the HAB. This is incorrect. As an example, the Respondent argues that decisions regarding on call schedules are operational and cites *Sorokan*.

[297] In *Sorokan*, the panel had to deal with whether on call obligations were an incident of privileges at a secondary site when the physician had privileges and on call responsibilities at a primary site. The panel concluded that a physician only had on call responsibilities at the primary site. Decisions by the hospital to grant on call responsibilities at a secondary site were purely operational to deal with coverage issues if the primary site physicians couldn't meet the on call obligations. The Panel fails to see how this case assists the Respondent in the circumstances of this case.

[298] The HAB has specifically ordered that a physician be included in the on call rota and operating room slate. See *Walker*[64] and *Behn*[65].

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[60] *Munro, supra* fn 15.
[61] *Prairie North, supra* fn 19.
[62] *Ready, supra* fn 30.
[63] *Sorokan v Fraser Health Authority*, HAB Decision No. 2014-HA-002(b) (*Sorokan*).
[64] *Walker, supra* fn 12.
[65] *Behn, supra* fn 12.

Nordal Case

[299] As discussed earlier, the Panel was informed of the decision of the Hospital Privileges Appeal Board in *Nordal v Alberta Health Services*[66] which was released after the close of argument in this case and sought further submissions.

[300] The HPAB in *Nordal* found that the without cause termination of Dr. Nordal's contract had the effect of terminating his privileges. The HPAB ordered Alberta Health Services to reinstate Dr. Nordal's privileges as they stood before the without cause contract termination.

[301] The HPAB did not specifically order the reinstatement of Dr. Nordal's contract but it is clear that Dr. Nordal was to be given all of the content of his privileges that he had before his contract termination. The HPAB did not specifically go into any payment arrangements or whether the content of the privileges included patient allocation. The HPAB ordered a general reinstatement and left the parties to deal with implementing the order with further directions from the HPAB if necessary.

Reinstatement of Dr. Campbell's Privileges

[302] The Panel is not convinced, based on the evidence and law presented at this hearing, that it should refuse Dr. Campbell the remedy of reinstatement of his full privileges. The Respondent has a procedure available to it under the Bylaws if it wants to properly modify Dr. Campbell's privileges or take any disciplinary action, and it is not proper to raise these issues in a summary manner under the guise of public interest or the dysfunction in the Cardiac Sciences Program, without the procedural safeguards found in the Bylaws. Public interest dictates adherence to the proper procedures for the protection of everyone involved, including the public.

[303] The Respondent was adamant that it was not raising any conduct or competency issues, which could only be raised in the context of the privileging regime, and therefore it must be bound by that decision and cannot raise it in a collateral fashion.

[304] This Panel has found that the decreasing and eventual elimination of cases allocated to Dr. Campbell in the Division was a significant modification of his privileges at BCCH. The Panel has the authority under section 46(2) of the *Hospital Act* to substitute its own decision on the terms and conditions it considers appropriate, taking into account the nature of the modification of the privileges. The Panel has decided to craft a remedy which will allow both surgeons in the Division to be effective and functional members of the Division and the Cardiac Sciences Program. This process may not be easy given the lengthy time that the issues have been outstanding both before these proceedings were commenced and over the course of these proceedings, however, difficulty is no reason to avoid the imposition of the appropriate remedy.

[66] *Nordal*, supra fn 17.

REMEDY

Case Allocation

[305] The goal of the Division is to have two pediatric cardiac surgeons capable of performing a full array of procedures. This does not necessarily mean every possible procedure, but it does mean the standard index cases and cases involving neonates. The Appellant seeks a fair and equitable allocation of surgical cases. There was evidence in this hearing from both Dr. R and Dr. G about the number of surgeries to keep surgical skills at a competent level. Dr. G, as Division Head, has to determine what that exact number for surgeons in his Division, but the evidence was that it was generally between 125 to 200 total cases with around 100 open cases.

[306] We find that Dr. Campbell's privileges include a fair and equitable allocation of cases in the Division. Fair and equitable means that each surgeon in the Division has to have the same opportunity to develop and maintain their skills. This generally means a relatively equal division of open and closed cases and a sharing of complex cases including neonates.

[307] As the Panel has noted above in the *Currency of Skills* section, Dr. G, as Division Head, has the responsibility to determine the current skills and competence of Dr. Campbell and it seems to us that scrubbing in for surgeries with Dr. Campbell for whatever period of time Dr. G determines is necessary to be comfortable with Dr. Campbell's skills and competence is appropriate unless Dr. G can come up with another viable process which meets the terms of this decision. Until Dr. G, as Division Head, is comfortable with Dr. Campbell's skills, he needs to scrub into the surgery with Dr. Campbell. This reacquaintance process should not be too lengthy or used to marginalize Dr. Campbell again. This process should be reviewed by the Head of Surgery and if there are ongoing issues outside of the normal process that would be put in place for fellows or locums then a remedial plan needs to be developed by the Head of Surgery in conjunction with the Division Head and the Cardiac Sciences Program.

[308] If there are insufficient cases to meet the required level of open or closed or complex neonates or index cases then the Division needs to institute the same procedures that are utilized in IWK Children's Hospital in Halifax or at Sick Kids Hospital in Toronto, where two surgeons scrub in for the procedures to ensure both maintain their skills. Dr. G said he did not have any problem scrubbing in with Dr. Campbell and Dr. Campbell gave evidence that he was willing to scrub in with Dr. G, particularly with Norwoods, but also with other procedures.

[309] As stated, this process is not easy and requires the dedication and cooperation of both surgeons in the Division. The Panel orders that the case allocation process should be reviewed quarterly by the Head of the Department of Surgery. The Head of the Department of Surgery shall enlist an outside practicing pediatric cardiac surgical expert in Canada, such as Dr. R, who is accepted by both members of the Division to provide input into any disputes arising from allocation under this directive. The dispute resolution of issues regarding privileges are ultimately the responsibility of the Board of Directors but it was clear to the Panel

that outside consultation in this specialty would have been of assistance in understanding and addressing the issues.

OR Schedule

[310] The Appellant has asked for 2 OR days a week. Dr. G, as Division Head, at first instance has the responsibility for scheduling of OR days in accordance with the procedures and availability at BCCH. However, as Division Head, Dr. G must give consideration to any time spent by Dr. Campbell at the PACH clinic at St. Paul's Hospital or any teaching commitments. As far as scheduling of rounds and CATH conferences, there was some evidence that Dr. Campbell's attendance at St. Paul's Hospital or OR days at BCCH affected his attendance at these events. Rounds and CATH conferences are a key component in the Division and attendance at these events should be considered to be mandatory unless there is a conflict with other obligations or reasonable excuse provided. Therefore, as there are only two surgeons in the Division, the Division Head should be able to organize a schedule for these meetings that does not conflict with the provision of other medical services of both surgeons.

[311] The Panel Orders that the OR days that are required for Dr. Campbell to exercise his privileges by having a fair and equitable allocation of surgical cases while taking into account his research time and PACH clinic time, should be provided to him. There is no need to set specific days as long as the above parameters regarding case allocation are met.

On Call Schedule

[312] In these circumstances, given the Panel's findings on case allocation, the division of patients through the on call system is not as critical but it should be established as a requirement of every physician with privileges. A failure to attend while on call can lead to the termination of a physician's privileges. BCCH needs to set standards such as response time and method and enforce those standards. Failure to respond while on call is a serious issue and should be treated so by BCCH management. The Panel orders that an on call schedule in accordance with the Bylaws and Rules including Drs. G and Campbell be created and maintained.

Office Space

[313] This Panel finds that office space at BCCH is an incident of privileges. It is simply not practical for a pediatric cardiac surgeon to attend an office off site and away from the patients he serves and the members of the Cardiac Sciences Program with which he works. PHSA provided offices to its two pediatric cardiac surgeons and it must continue to do so on equal terms for both.

Conciliation Between Dr. G and Dr. Campbell

[314] The Panel was impressed with the statements made by both physicians that the most important thing was the care of the patients being served. While there were clearly some disagreements that devolved beyond what would be expected in

a tense surgical setting, both surgeons have stated their primary goal is the same. If PHSA thinks that a conciliation would be beneficial, then they can require parties to attend. Conciliation generally is productive if both parties want to get something out of it and, as in this particular case, if both parties recognize some responsibility for the events that lead to the dispute. If the parties continue on the path that lead them to this dispute, then conciliation will not assist them.

Dr. Campbell's Conduct Going Forward

[315] There was much discussion and analysis of Dr. Campbell's conduct issues which the Respondent argued was a reason that the HAB should not exercise its discretion to order the remedy the Appellant seeks in this case. The Respondent was aware of many of Dr. Campbell's conduct issues for many years and never took any steps under the Bylaws or the Contract to deal with those issues. Dr. Campbell never received a fair opportunity to respond to those issues and that was one of the considerations this Panel made in rejecting the Respondent's argument on remedy.

[316] The Panel has imposed some difficult obligations on Dr. G, as Division Head, regarding case allocations. On the other hand, the Panel's order reinstating privileges should not be seen by Dr. Campbell as a free ride for to carry on with the problematic conduct that was identified in these proceedings. The Panel notes that as Division Head, Dr. G has the responsibility, along with the Department Head, to investigate concerns of physician behaviour and delivery of patient care and, where appropriate, to initiate disciplinary proceedings and recommend suspension or limitation in privileges in accordance with the Medical Staff Bylaws, Rules and Health Authority policies.

[317] In *Figurski v Interior Health Authority*[67], the panel found that the delays and incompleteness in medical documentation was a violation of the Medical Staff Rules which, in part, supported a finding by the HAB to uphold the termination of a physician's hospital privileges. The panel stated (at paras 133 and 136):

> [133] Notwithstanding these observations, the Panel has concluded that the clinical tendencies - or habits - of the Appellant during his duties in the four cases at issue, were not of an appropriate standard. In particular, his disregard for proper documentation in the patients' charts is of concern. The dictation of a full summary and discharge note was often delayed. In an emergency room situation, such a practice does not adequately fulfill the requirement for patient safety or for the integrity of quality of patient care. This is especially the case where the patient remains under observation and treatment in an emergency room. Even where the unit is small, a minimum of clear case notes is expected. During his testimony, the Appellant acknowledged that he had "communications issues" and that his charting "might be deficient". The Appellant admitted in Case #4 that he had not checked that the nursing staff had administered the TNK nor did he check the patient's ECG. ...
>
> [136] The Panel concludes that the Appellant violated the requirements of the Bylaws and Medical Staff Rules where he failed to meet the accepted standards

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[67] *Figurski v Interior Health Authority*, HAB Decision No. 2015-HA-001(a) (*Figurski*).

of care of the IHA with respect to documentation, appropriate clinical decision making, following the IHA-accepted patient care protocols, and providing quality medical care for the patients in the four subject cases.

[318] The timeliness and completeness of medical records including OR notes is equally significant in a pediatric cardiac surgical practice.

[319] In addition, pursuant to article 5.3.4 of the Medical Staff Rules the Division Head can also develop standards of clinical practice and behaviour for the Division, as delineated by Agency policies, the Medical Staff Bylaws and the Rules. Subject to other BCCH policies, these standards could include attendance at required procedures, such as foetal echos, or other practice requirements that are designed to make the Cardiac Sciences team work efficiently, cooperatively and effectively, meeting all the goals of the Division and the Cardiac Sciences Program.

[320] It must be clear that there are certain standards of behaviour that must be followed and failure to follow those standards or rules must have consequences. BCCH cannot complain about the conduct of physicians while at the same time neglecting to address any of the conduct under the Bylaws or Rules. Attendance on call, timely completion of operative reports, timely attendance at rounds and CATH conferences are simply not optional. However, breaches of any standards of practice that are set must be followed up in accordance with the provisions of the Bylaws.

[321] In *Nordal*, the HPAB noted that issues such as timeliness, presence at some rounds and completion of documents are matters that are routinely dealt with by hospital administration and can be readily managed using the available procedures in the bylaws[68]. This is equally applicable to the parties in this case.

[322] Dr. G gave evidence that there was no specific problem with Dr. Campbell's surgical skill set but that he lacked the level of engagement that Dr. G felt was required in this difficult practice. Dr. G, by all accounts is a very driven and dedicated surgeon with immense passion for the practice he has chosen. It may be unreasonable to expect that of all surgeons, but there is a level of engagement that Dr. Campbell will be required to meet to be a functional member of the team in the Division. Now that Dr. Campbell's allocation issues have be dealt with, both members of the Division must work together to serve the vulnerable population they were granted privileges at BCCH to serve.

[323] The Panel notes the evidence of Dr. SA, the Head of Cardiology, that most of the members of the Cardiac Sciences Program, particularly the cardiologists, tried to stay out of the dysfunction between the two surgeons. In fact, other than Dr. SA, there was only one other cardiologist who is still working at BCCH that testified, namely Dr. H. Dr. H's evidence was balanced and credible. He stated that was willing to work with Dr. Campbell if he returned but that he needed to know what Dr. Campbell had been doing over the past couple of years to gain confidence in him and his surgical skills. The process this Panel has ordered is designed to give the cardiologists confidence in Dr. Campbell if he earns it.

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[68] *Nordal, supra* fn 17 at para 76.

[324] Dr. SA, who had significant issues with Dr. Campbell's conduct, noted in an email in February 2017, before the notice of termination was given to Dr. Campbell, that his communication to Dr. Campbell was not ideal and that he liked Dr. Campbell's proposal regarding a patient and wanted to move forward in the best interests of the patients[69]. The Panel acknowledges this may have been an isolated case, but it shows the ability of the professionals in the Cardiac Sciences Program to work together for the best interests of the patients.

CONCLUSION

[325] In answer to the questions set out at the beginning of this decision, and for the detailed reasons give above, the Panel finds as follows:

1. Dr. Campbell's privileges were modified through the unequal case allocation over time, and his privileges were constructively revoked when the Respondent stopped allocating cases to him altogether after the Contract was terminated.
2. The HAB has the jurisdiction to order the Remedies sought by Dr. Campbell; in particular, the remedy of fair and equitable case allocation amongst the surgeons in the Division.
3. It is appropriate and in the public interest in the present appeal to grant the Remedies sought by the Appellant.

[326] As a result of these findings, the Panel makes the following Order:

1. The Respondent shall restore meaningful access to the Appellant's Privileges by providing him with fair and equitable case allocation in accordance with the reasons in this decision, and in particular, in accordance with the reasons set out at paragraphs 305-309.
2. The Head of the Department of Surgery shall review the case allocation process quarterly, and, in the event of a dispute, shall enlist an outside practicing pediatric cardiac surgical expert in Canada, who is accepted by both members of the Division, to provide input.
3. The Respondent shall provide the Appellant with an adequate number of, and schedule for, OR days such that he can meaningfully complete work on the cases he is allocated.
4. The Respondent shall restore the Appellant to the Division on call schedule.
5. The Respondent shall provide office space to the Appellant on terms equal to the other Surgeon in the Division.
6. If both Dr. G and Dr. Campbell agree it would be beneficial, the Respondent may engage an independent outside third party to facilitate conciliation between the surgeons.

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[69] Tab 72 of the JBOD.

7. The Respondent shall implement each of the above elements of this Order, as soon as is reasonably possible, taking into account the need for the Respondent to develop and implement a suitable return to work program. In any event, each of the above elements of this Order must be initiated by **no later than 60 days from the date of this decision**.

[327] The Panel is cognizant that, unfortunately, this decision is not the end of this matter and further action by the parties in the future is required. The Panel has ordered a remedy which attempts to put Dr. Campbell in the place he was prior to the modification of his privileges.

[328] Up to six months from the date of this decision, either party shall be at liberty to seek clarification by the Panel on the terms of this order.

"Stacy Robertson"

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Stacy Robertson, Panel Chair
Hospital Appeal Board

"Paul Champion"

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Dr. Paul Champion, Member
Hospital Appeal Board

"Cheryl Vickers"

____

Cheryl Vickers, Member
Hospital Appeal Board

August 20, 2020