From the College

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This newsletter is forwarded to every licensed medical practitioner in the Province of Manitoba. Decisions of the College on matters of standards, amendments to regulations, by-laws, etc., are published in the newsletter. The College therefore expects that all practitioners shall be aware of these matters.

In This Issue……

FROM YOUR PRESIDENT
DR. BRENT KVERN

"A people that values its privileges above its principles soon loses both."
— Dwight D. Eisenhower

"Service to others in their time of need is a privilege and an honor."
— Harley King

This edition of the College newsletter may be unsettling for some physician members and yet, for others there will be no disquiet at all – perhaps even some relief. For in this newsletter, you will learn about a significant cultural shift our profession in Manitoba is about to undertake.

Your College Council has ratified a statement requiring that all physicians who care for patients must participate in a system that ensures coverage for their practices both for after-business-hours and while on vacation. According to the statement, all of your patients must "…have access to medical care for urgent medical issues that arise after regular office hours, on week-ends or during the physician's vacation periods."

This statement applies to both family physicians / general practitioners regardless of where they work (e.g., private practice, walk-in clinics, urgent-care centres or community clinics) and to specialists and other focused-practice physicians who are involved in the treatment of patients in Manitoba.

For many Manitoba physicians, being part of a system that provides after-hours patient contact and assessment is part of their normal lives. These existing call systems are varied and have been designed to meet the needs of local communities. These systems include, but are not limited to: phone access; patients presenting to a designated after-hours clinic; or being directed to an emergency room which has a pre-arranged formal agreement with the physician to cover the after-hours practice. The goal of this statement is not to prescribe a specific form of after-hours and vacation coverage - just that it must exist, and to outline the underlying principles.

Thus the days of a clinic utilizing after-business-hours or during vacation period answering machines to direct callers to a local emergency room (where no formal arrangement exists) will soon be unacceptable. Each physician in Manitoba will need to make a specific arrangement with one or more physicians to provide for the assessment and care of his or her patients when the physician is unavailable to provide that care. In order to provide a six month time to arrange necessary coverage, the statement will not become mandatory until July 1, 2015.

Why is your Council doing this? We live in a society where being a physician means we are very fortunate – we are well schooled, well paid, and do important worthwhile work. Society has granted us many privileges – including professional autonomy. With the privileges of being a physician in our society come significant responsibilities.

For many reasons, a significant number of our profession have drifted away from participating in an after-hours on-call system or coverage while on vacation. But the world is changing, including the expectations placed upon physicians. Just as community laboratories must be able to contact any practising physician with urgent results after-hours, so occasionally do our patients need to speak to a physician to determine the best course of action to take, given worrisome and frightening symptoms. We know, for example, that it is unsafe for an office to be closed for a significant period of time because patient issues and concerns may potentially need urgent attention and action.

We are currently a self-regulated profession; this is not an inherent right but a privilege granted by society through government. If we as physicians do not hold ourselves to the highest standards of patient care and patient safety, others may impose system changes upon us. As physicians, expecting excellence in patient care and patient safety is a key value of our profession – and those values, standards and expectations we set for ourselves as a profession mean we must continually adapt how we care for patients and how we work together.

We are not the first medical regulatory authority in Canada to move in this direction. But your councillors at the College feel that

expecting the best from ourselves is in the best interests of our patients and thus in all our best interests.

You will find the College Statement in this edition of the newsletter, as well as a document that addresses many of the initial concerns and questions that have arisen. For many of you, nothing will change. For a significant number of you, connecting with colleagues and forming teams to ensure this happens, is now or will be the normal.

Thank you to all the members who reached out to contact me after the last newsletter. Your concerns were brought forward, either in discussions with the Registrar or in other appropriate venues. To remind you, please feel free to contact me at President@cpsm.mb.ca.

Finally, I must close these comments with thanks and recognition of two important people. The first person I wish to thank is Dr. Bill Pope, our outgoing College Registrar. His mentorship, guidance and friendship have been very important to me personally for many years. I know I speak on behalf of the Councillors and the members of the College when I wish Dr. Pope a happy, productive and fun retirement.

The second person I wish to thank is Dr. Anna Ziomek, our incoming College Registrar. We are extremely fortunate, both as an organization and as a province, to have someone as capable and insightful as Dr. Ziomek as our new Registrar. Welcome and *bon chance*!

Sincerely yours
Brent Kvern, MD

NOTES FROM THE REGISTRAR

MEETING OF COUNCIL– SEPTEMBER 19TH, 2014

At this meeting, Council was brought further up to date on the implementation of *The Regulated Health Professions Act*. It is expected that the Legislative Drafters will provide the material to the Secretariat to review and discuss with the President's Working Group so that a special meeting of Council may be held in January 2015. The consultation and further discussion would then occur in early 2015 with Council's final approval at the meeting of Council in either April or June, 2015 for final approval.

STATEMENT # 1202 – ANESTHESIA: GRANTING OF PRIVILEGES

This College Statement identifies training required before a physician is granted family practice anesthesia privileges. Standard A initially required six months of formal training in anesthesia in an approved teaching centre. Council approved the change to twelve months of formal training in family practice anesthesia in an approved teaching centre before a physician is granted privileges to administer family practice anesthesia.

COLLEGE STATEMENT – PRACTICE COVERAGE – AFTER HOURS AND VACATION

This newsletter contains the broad announcement that the above Statement has been approved by Council. All members are encouraged to read the specific article in this newsletter. The Statement is an important move forward by the College to ensure that appropriate coverage for patients is available and that all physicians practise in an acceptable and professional manner with regard to their patients. The Council item also includes a question and answer section. There will be a six month time frame for members who need to develop call groups to implement the processes. The Statement will become effective July 1st, 2015. Members who have further questions about what would be appropriate coverage are encouraged to email them to the College's General Counsel, Mr. Marvin Giesbrecht at: mgiesbrecht@cpsm.mb.ca.

NEW REGISTRAR - It is with enormous pleasure that I welcome Dr. Anna Ziomek as the College's 11th Registrar when she takes office on January 1, 2015. It has been an extraordinary privilege to have served you, the members of this College and the people of Manitoba, for the past 20 years. Thank you for all of your support, interactive communication and most especially for honouring the traditions of the medical profession. The privileges that we have been granted by the people of Manitoba through the Legislature are extraordinary and I know that under Dr. Ziomek's leadership, the College will continue to support members and ensure the best medical care for the people of Manitoba.

William D.B. Pope
Registrar/CEO

Dr. Brent Kvern and the Council of the College of Physicians and Surgeons of Manitoba announce with pleasure the appointment of

Dr. Anna Ziomek

as Registrar

of the College of Physicians and Surgeons of Manitoba commencing January 1, 2015

Congratulations

Congratulations to ***Mr. Ian Jones*** on being re-elected to Council for the 2014 – 2015 term.

College of Health Sciences Update

Since 2010, the College of Medicine has been undergoing an extensive Undergraduate Medical Education (UGME) curriculum review and renewal process. The new clerkship program for the Class of 2015 launched in 2013 for the Med III students. The new pre-clerkship program commenced last August for first-year students in the Class of 2018.

This is the most significant change to how medical school is taught at the University of Manitoba in nearly two decades.

It is the first time there has been a complete four-year 'overhaul' in institutional memory. This ensures the pre-clerkship changes are closely linked and spiraled into an identifiable and governed clerkship curriculum.

It is all-encompassing and we should be very proud of what we have accomplished including: internal reviews, external consultations, establishment of specific task groups, stakeholder consultation, and faculty development.

The new curriculum expresses a commitment to the community highlighting the importance of social responsibility, health advocacy, professionalism, while assuring the principles of scholarship and discovery, excellence and critical thinking are enhanced.

Pre-clerkship will comprise four modules (Modules0-3):

- Foundation of Medicine Module(M0)
- Human Biology & Health Module (M1)
- Health & Disease Module (M2)
- Consolidation Module(M3)
- Clerkship (Modules 4-7) A reorganized clerkship (M5), integrating some related specialty areas, accompanied by structured regular mandatory academic time preceded by a five-week Transition to Clerkship(M4). The 4th year electives period (M6) will not change but after the CaRMS match there will be a more structured curriculum Transition to Residency (M7).

Longitudinal Courses include Professionalism, Clinical Skills, Clinical Reasoning, Indigenous Health, and Public Health and Prevention. Longitudinal Themes such as Diagnostic Imaging, Generalism, Geriatrics, Genetics, Health care systems, Interprofessional activities, Health Psychology, and Palliative care will be incorporated into all four years.

This has been a mammoth undertaking by many faculty and staff in UGME, medical education, departments, sections as well as students and our partners.

I want to thank everyone for their dedication to the curriculum renewal process and acknowledge all of the hard work across the College of Medicine to date (and continuing) to develop and implement a new curriculum that exceeds the Association of Faculties of Medicine of Canada's *Future of Medical Education in Canada* recommendations and accreditation standards.

Special thanks to Dr. Ira Ripstein, Associate Dean, UGME; Dr. Keevin Bernstein, Director of Curriculum Renewal; and Dr. Dianne Moddemann, Director of Curriculum for their leadership and commitment to ensure our new curriculum's success.
For more information, visit:
http://umanitoba.ca/medicine/education/undergraduate/curriculum/curriculumrenewal.html

Brian Postl, MD FRCPC
Vice-Provost (Health Sciences) and Dean,
College of Health Sciences,
University of Manitoba

University of Manitoba

SYPHILIS OUTBREAK

The Winnipeg Health Region (WHR) is continuing to experience an outbreak of infectious syphilis. There have been 60 cases reported in the first ten months of 2014, which is the fastest spreading and highest number ever recorded in the WHR**.** Most cases are being diagnosed in men who have sex with men. About one third of cases are HIV positive and cases are spread evenly throughout almost all community areas in Winnipeg. Cases have also been reported in all other RHAs.

TESTING

- ALL persons who present with symptoms of syphilis such as painless genital or oral ulcers, generalized maculopapular rash (typically including palms and soles) and/or lymphadenopathy.
- See MHHLS protocol (link below) for details on clinical presentations. In addition to testing symptomatic persons, also screen the following persons:
- ALL pregnant persons - congenital syphilis is often severe, disabling, and life-threatening.
- ALL persons reporting unprotected sex with casual or anonymous partners should be routinely tested for sexually transmitted infections (STI) every 3-6 months.
- ALL persons requesting STI testing.
- ALL persons with any confirmed or suspected STI such as gonorrhea or chlamydia.
- Consider offering serology for all patients as part of routine care.

WHAT TO SEND TO CADHAM PROVINCIAL LABORATORY (CPL)

- 5-10 ml blood in a red-stoppered tube or a serum separator tube (red top with yellow cap)
- CPL requisition form should request syphilis serology testing and HIV antibody testing; and should provide information on reason for testing, including symptoms or suspected stage of syphilis.
- (Consider choosing CPL's STI panel which includes serology testing for syphilis, HIV and hepatitis B.)
- Swab ulcers, sores, or moist skin lesions with a dacron swab of the lesion and place into viral transport medium. The sample must remain refrigerated until sent to CPL and the CPL requisition should clearly indicate the site and test requested (i.e., *T. pallidum* PCR testing).

TREATMENT

- Benzathine penicillin G (Bicillin®) 2.4 million units IM in a single session (separated into 2 injections). See MHHLS protocol for information on allergy, pregnancy and HIV positive persons.
- The Bicillin® in preloaded syringes is provided free of charge by MHHLS (see link below for order form)
- *Sex contacts of known syphilis cases MUST ALSO be treated immediately for syphilis, without awaiting testing results.*

REPORTING

Syphilis is reportable under *The Public Health Act.* If you are contacted by a public health nurse for follow up of your patient who has an STI, your collaboration and assistance would be greatly appreciated.

RESOURCES

- Manitoba Health Healthy Living and Seniors (MHHLS) - Syphilis Protocol
- http://www.gov.mb.ca/health/publichealth/cdc/protocol/syphilis.pdf
- Cadham Provincial Laboratory (CPL) - Serology: 204-945-6123
- Manitoba Health Healthy Living and Seniors (MHHLS) STI Medication Order Form http://www.gov.mb.ca/health/publichealth/cdc/protocol/form11.pdf

Dr. Joss Reimer, M.D., FRCPC
Medical Officer of Health
Phone: 204-940-3607
Email: jreimer4@wrha.mb.ca

Manitoba
Health, Healthy Living and Seniors

Health Professions Registrars/Executive Directors,

Manitoba Health, Healthy Living and Seniors has developed the following three PHIA online training programs primarily for private practitioners and their staff:

1. Direct PHI Version - for health professionals and their staff who are required to access personal health information in providing care and services to patients and clients;
2. Indirect PHI Version – for individuals who are not required to access personal health information in carrying out their duties, but may have access to it, including for example custodial staff; and
3. Administrator Version – for office managers and IT administrators of a private professional practice who are responsible for developing office policies and procedures.

You can access the training versions noted above at: http://www.trainingtodo.com/mbhealth/secure/index.asp.

In addition to the training program, revised Guidelines have been approved respecting the legislated requirement for the creation and auditing of Records of User Activity by trustees that maintain personal health information in an electronic information system (eg: an electronic patient record or electronic medical record).

Finally, MHHLS has developed a list of the policies and procedures required by trustees, including health professionals in private practice, to comply with PHIA. This list and other PHIA resources are available on the MHHLS website at: http://www.gov.mb.ca/health/phia/resources.html.

Questions on the above-noted matters can be directed to the Legislative Unit of Manitoba Health, Healthy Living and Seniors at 204-788-6612 or by email at PHIAinfo@gov.mb.ca.

MANITOBA HAS AN APOLOGY ACT - LEARN MORE ABOUT IT!

THE IMPORTANCE AND IMPACT OF AN APOLOGY
An Information Sheet from the Manitoba Institute for Patient Safety and the Manitoba Alliance of Health Regulatory Colleges

Patients[a] *and their families expect to be told when something has happened that has harmed them or had the potential to harm them. Patients have a right to know this information. Informing them honestly and fully is the right thing to do.*

Disclosing and apologizing go hand in hand.

After advising a patient of a harmful event, including a critical incident[b1], it is natural to follow with a sincere and honest expression of regret (an apology).

Why patients need to hear an apology.

An apology, given sincerely, can help lessen the emotional impact of the harm, be therapeutic for the patient and health professional as well as lead to healing, regaining trust, and a greater possibility of reconciliation[2-3]. Apologizing - demonstrating our humanity and the concern we feel makes it possible for the patient and family to forgive.

By apologizing am I admitting liability?

No. An apology can't be admitted as evidence of fault or legal liability. The majority of Canadian Provinces and Territories, including Manitoba[4], have enacted apology legislation which prohibits apologies from being used in court.

Why do we have Apology Legislation?

A significant number of patients want a sincere apology for what has happened to them. Health professionals may be afraid that apologizing to a patient will create legal liability, or will negatively affect their malpractice insurance coverage. This is not the case in Manitoba. The Apology Act allays these fears and concerns. Allowing health professionals to apologize freely, without creating liability, provides an opportunity to begin making amends.

Why apologizing can also heal the practitioners involved.

After a patient is harmed, health professionals often feel fear, remorse, guilt, shame, self-anger and depression for what has happened. They "are the second victims, devastated by having been the unwitting instrument that seriously harmed another"[5]. Apologizing, expressing remorse, and a desire to make amends, can lead to forgiveness and healing for health professionals as well.

How to apologize / What you can do.

Talk with your team about who will apologize and how the apology should occur. The words "I'm sorry" should be part of any apology[2]. Apologize as soon as possible. Be compassionate, honest and sincere in your apology. An apology will not be as easy to accept if the patient feels you are forced to apologize or are not genuine in your apology[236]. The following may take place over several meetings. These are guidelines. Check your organizational policies for further information.

- Acknowledge that something (e.g. a critical incident) has happened.
- Explain the facts of what has happened without accepting or assigning blame.
- Explain how the incident will affect the health of the patient.
- Make a genuine apology for the incident that shows remorse, humility and compassion. Consider using words like "I feel badly for what happened." "We are sorry." "We know that what happened has caused you unnecessary pain/anguish/ health complications...."
- Explain what can happen to help remedy the situation.
- Document the conversation with the patient and family.
- If possible, explain what will change so this same situation is less likely to happen to other patients in the future. People usually want to know that some good may come about as a result of the situation that has caused them emotional or physical pain.
- Once the event has been reviewed, follow-up with the patient to see how they are doing and advise them on what progress has taken place to reduce the likelihood that it does not happen again to others.

Under Manitoba's Apology Legislation[4]...

- apologizing does not create legal liability
- an apology does not void, impair or affect your malpractice or liability insurance coverage
- an apology is not admissible in court, including "a tribunal, an arbitrator and any other person who is acting in a judicial or quasi-judicial capacity"[4] such as disciplinary and grievance hearings, and civil litigation
- it does not apply to criminal offences, such as sexual or physical assault, which fall under federal jurisdiction

Where can I get reliable, confidential advice about apologizing?

Review your regional health authority or health facility policies and procedures or consult the regulatory body governing your profession. You may also consult your

professional insurer or protective association.

[a]The term "patient" includes any recipient of care by a health professional in any setting

[b]A critical incident[1] is an unintended event that occurs when health services are provided to an individual that result in serious and undesired effects such as death, disability, injury, harm, an unplanned admission to hospital, or an extension of care in hospital. The unintended event is not as a result of the patient's illness or the risk in treating the illness, but from the healthcare provided.

References

1. Government of Manitoba. *The Regional Health Authorities Act.*
   http://web2.gov.mb.ca/laws/statutes/ccsm/r034e.php
2. Disclosure Working Group. *Canadian disclosure guidelines: being open and honest with patients and families.* Edmonton, AB: Canadian Patient Safety Institute; 2011. http://www.patientsafetyinstitute.ca/english/toolsresources/disclosure/pages/default.aspx
3. College of Occupational Therapists of Ontario (COTO). *Guide to the Apology Act (2009).* Toronto, ON: COTO; 2011.
   http://www.coto.org/pdf/guide_to_the_apology_act.pdf
4. Government of Manitoba. The Apology Act. http://web2.gov.mb.ca/laws/statutes/ccsm/a098e.php
5. Leape LL. Full disclosure and apology-an idea whose time has come. *Physician Executive.* 2006 Mar; 32 (2): 16-18.
6. Lazare A. *On apology.* New York, NY: Oxford University Press; 2004.

Download MIPS' resource *"The Facts about Critical Incidents and their Disclosure: Frequently Asked Questions for Healthcare Providers"* at www.mips.ca

MEMBERS

Manitoba Alliance of Health Regulatory Colleges

College of Audiologists and Speech-Language Pathologists of Manitoba
College of Dental Hygienists of Manitoba
College of Dietitians of Manitoba
College of Licensed Practical Nurses of Manitoba
College of Medical Laboratory Technologists of Manitoba
College of Midwives of Manitoba
College of Occupational Therapists of Manitoba
College of Pharmacists of Manitoba
College of Physiotherapists of Manitoba
College of Podiatrists of Manitoba
College of Registered Nurses of Manitoba
College of Registered Psychiatric Nurses of Manitoba
Denturist Association of Manitoba
Manitoba Association of Optometrists
Manitoba Association of Registered Respiratory Therapists
Manitoba Chiropractors Association
Manitoba Dental Association
Manitoba Naturopathic Association
Psychological Association of Manitoba
The College of Physicians and Surgeons of Manitoba
The Opticians of Manitoba

Manitoba Institute for Patient Safety
www.mips.ca www.safetoask.ca

The Manitoba Institute for Patient Safety promotes, coordinates and facilitates activities that have a positive impact on patient safety throughout Manitoba.

MAHRC

Manitoba Alliance of Health Regulatory Colleges

Protecting your right to safe and ethical care.

FROM THE INVESTIGATION COMMITTEE

Sensitive examinations include breast, pelvic and rectal examinations. Physicians should be aware that patients may find these examinations embarrassing and distressing as well as uncomfortable. Physicians should be sensitive to these feelings when explaining and carrying out these examinations.

Patient complaints frequently arise from sensitive examinations, as well as examinations of nearby areas of the body. For optimal patient care and in their own best interests, many physicians have a chaperone present for such examinations. The College encourages the use of chaperones in these circumstances and wishes to give guidance regarding best practices in the use of chaperones:

1. The presence of a chaperone should be explained to the patient before the examination takes place. Notices in the waiting room and in the examination rooms may be helpful.
2. The chaperone must be properly trained to recognize what constitutes a proper examination, to recognize and deal with patient discomfort, and to know what to do during a sensitive examination.
3. The chaperone should be capable of supporting and reassuring a patient as necessary, and may assist with aspects of the examination, for example providing lubricant or gloves for the physician.
4. The chaperone should not be a member of the patient's family, although the patient may wish to have a family member present in addition to the chaperone.
5. The identity of the chaperone should be recorded in the medical record.

Remember that a patient always has the right to request a chaperone be present for any examination.

FROM THE STANDARDS DEPARTMENT

Reporting Unfit Drivers

You have a young patient with epilepsy who is not compliant with medications and is continuing to have intermittent seizures. You are aware that he/she has a learners permit. Do you need to report this driver? Are you aware of the types of medical conditions that should be reported?

Members should be aware that a physician who determines that a patient is unfit to drive has a legal responsibility to report to the Registrar of Motor Vehicles (Manitoba Public Insurance). Under Section 157(1) of The Highway Traffic Act, physicians are required to report drivers whose medical condition may adversely affect their safe operation of a motor vehicle.

Physicians are reminded that there is a potential for civil liability if they fail to report a medically unfit driver who causes injury or damages while driving.

Resources for physicians:

- Doctors Manitoba: *Reporting of Medically Unfit Drivers* (May 2014). Available at www.docsmb.org

- CMA: *Determining Medical Fitness to Operate Motor Vehicles* (2012). 8th ed. Available at www.cma.ca

- CMPA: *Reporting Patients with Medical Conditions Affecting Their Fitness to Drive* (February 2011). P1004-1-E. Available at www.cmpa-acpm.ca

DR. LYNNE WARDA
CHILD HEALTH STANDARDS COMMITTEE

Consultation Process

Members frequently require the assistance and opinions of their colleagues when providing care to their patients. This referral must be provided in writing to the consultant, except in an emergency situation. The consultant, or a designate, must contact the patient directly within 30 days to schedule the appointment and send a copy of that information to the referring member unless otherwise agreed to by the referring member.
It is not acceptable for the consultant to require the referring physician to provide the details of the appointment to the patient. Please refer to statement 178 – Collaboration in Patient Care – for further details.

Meetings of Council for the 2014-2015 College Year

Council meetings for the remainder of the College year will be held on the following dates:

- Friday, December 12, 2014
- Wednesday, April 29, 2015
- Wednesday, June 24, 2015

If you wish to attend a meeting, you must notify the College in advance. Seating is limited.

Officers and Councillors 2014-2015

President:	Dr. B. Kvern
President Elect:	Dr. A. Vorster
Past President:	Dr. D. Lindsay
Treasurer:	Dr. M. Boroditsky
Investigation Chair:	Dr. K. Bullock Pries
Registrar:	Dr. W. Pope
Deputy Registrar:	Dr. T. Babick
Assistant Registrar:	Dr. A. Ziomek

Term expiring September 2015

Associate Members Register	Mr. I. Jones

Term expiring June 2016

Brandon	Dr. S. J. Duncan
Eastman	Dr. K. Bullock Pries, Steinbach
Westman	Dr. A. Vorster, Treherne
Winnipeg	Dr. H. Domke
	Dr. B. Kvern
	Dr. M. Boroditsky
	Dr. H. Unruh
University of Manitoba	Dean B. Postl
Public Councillor	Dr. E. Boldt
Public Councillor	Ms L. Read

Term expiring June 2018

Central	Dr. E. Persson, Morden
Interlake	Dr. D. Lindsay, Selkirk
Northman	Dr. H. Tassi, Thompson
Parkland	Dr. J. Elliott, Grandview
Winnipeg	Dr. W. Manishen
	Dr. M. West
	Dr. N. Riese
	Dr. E. Sigurdson
	Dr. D. Pinchuk
University of Manitoba	Dr. I. Ripstein
Public Councillor	Mr. R. Dawson
Public Councillor	Mr. R. Dewar

PRACTICE COVERAGE – AFTER HOURS AND VACATION

As we continue to strive, as professionals, to further strengthen patient care, Council has approved a new Statement relating to Practice Coverage – After Hours and Vacation.

We ask you to review this Statement carefully so that we may all work to provide consistency in the delivery of urgent care to our patients.

The complete Statement follows including a question and answer section. Please note that there will be a six month time frame for members to develop call groups to implement these new processes.

This Statement will become effective July 1st, 2015. Members who have further questions about what would be appropriate coverage are encouraged to email them to the College's General Counsel, Mr. Marvin Giesbrecht at: mgiesbrecht@cpsm.mb.ca

STATEMENT

No.190

PRACTICE COVERAGE – AFTER HOURS AND VACATION

BACKGROUND:

The Code of Conduct of the College of Physicians and Surgeons of Manitoba states that a physician must:

"Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for

the patient; or until the patient has been given adequate notice that you intend to terminate the relationship."

The College supports the concept that continuity of care is the best medical practice for patients. It is therefore in the best interests of the patient that he/she have access to medical care for urgent medical issues that arise after regular office hours, on week-ends, or during the physician's vacation periods.

The College recognizes that there are different types of physician-patient relationships, including continuous care physician-patient relationships and episodic care relationships. The College does not regard the practice setting as determinative of the nature of the relationship.

SCOPE:

This Statement applies to all physician-patient relationships.

REQUIREMENTS:

It is the position of the College that:

a. The provision of ongoing medical care is not only the responsibility of the family physician, but also of specialists and other focused-practice physicians who are involved in the treatment of patients.

b. This Statement also applies to physicians who are providing medical service in locations such as urgent care centres and walk-in clinics.

c. Each physician must ensure that medical care is continuously available to the patient in his or her medical practice.

d. Each physician must make a specific arrangement with another physician or physicians or call group for the care of his or her current patients when the physician is unavailable to provide that care.

e. Each physician must ensure that the other physicians or call groups who are available for after hours or vacation care for his or her patients is aware of and have agreed to the arrangements for the periods that the coverage is required.

f. Each physician must ensure that his or her patients are aware of the coverage arrangements the physician has made.

g. It is not acceptable for a physician's answering service to direct patients to attend an emergency room or other episodic care facility unless the physician has a formal arrangement with the specific facility or with a physician working in that facility.

h. As part of the specific arrangement, there must be an expressed willingness on the part of the receiving party (e.g. an on-call physician or an emergency department) to accept responsibility for all patient care that is required.

i. Physicians who provide episodic care to patients should determine at the outset of the visit whether the patient has a primary care physician. If so, the physician providing episodic care is responsible to promptly communicate significant findings of the examination and plan for treatment to the primary care physician.

j. When a physician providing episodic care is attending a patient with an acute condition, the physician has the right to limit the care provided to that current episode of acute care, subject to the requirement that a physician who provides care for a particular medical episode assumes responsibility for the patient until that medical episode is complete or until care is transferred to another physician. However, the physician who wishes to limit the care in this way must explicitly communicate his/her intention to the patient. An exception exists for physicians attending a patient in an emergency room, where the limited nature of the relationship is self-evident.

A statement is a formal position of the College with which members shall comply.

Questions and Answers

Practice Coverage - After-Hours and Vacation

What are focused-practice physicians?

Physicians who:

- Practise in a Royal College specialty but are not on the CPSM Specialist Register; or
- Family physicians who do not have a full family medicine practice but instead limit or devote a significant portion of their practice to a specific field (such fields, for example, include sports medicine, family medicine anaesthesia, family medicine palliative care).

What is the definition of a primary care physician?

In this Statement primary care physician is intended to include the family physician who is generally the patient's first level of contact with the health care systems or a treating specialist or focused-practice physician dealing with a patient's particular issue.

Does this also apply to physicians working in walk-in clinics?

It applies to all physicians in all situations. If a person attends a walk-in clinic with a specific medical issue, the physicians at the clinic must provide after-hours coverage for that particular issue unless they are satisfied the patient's primary care physician is following up on the issue.

What is an urgent care centre?

Urgent care centres are established by the Regional Health Authorities at specified locations. In essence they are the same as emergency rooms except they do not accept patients transported by ambulance.

Are there any additional or different responsibilities on physicians at urgent care centres?

The obligations are essentially the same as those for physicians working in emergency departments. All physicians must ensure appropriate care is available for the patients.

What is appropriate for sufficient notice to patients of coverage arrangements?

Each physician must ensure that his or her patients obtain clear information on coverage arrangements that are available to them. The patient should be able to access this information easily when required.

Are there limits on the size of a call group?

Call groups may be any size which works practically for the individual physicians. In fact, more than one clinic of multiple physicians could arrange to share call.

What are the expectations on a solo practitioner in a rural remote location with no hospital?

The physician is required to make the arrangements with other physicians to be available at those times when the solo practitioner is unable to respond. This includes evenings, weekends, and extended times away from the office. Telephone access to another physician at an alternate location may be acceptable.

In small communities, is it acceptable for one physician to cover hospitals in a number of different communities?

This would be acceptable as long as someone is available to initially triage the problem and direct the issue to the physician or an emergency room as required.

What constitutes a formal arrangement?

A formal arrangement is a clear arrangement which has been agreed to by both parties. The arrangements should be understood and accepted by all members to ensure there are no misunderstandings or gaps in coverage. We strongly encourage arrangements to be put in writing to avoid misunderstandings.

May a group of on call physicians or a department charge a physician for providing this service?

The College's position is that physicians have an ethical and legal obligation to ensure necessary medical services are provided on a timely basis. The College's mandate does not include regulating the business arrangements between physicians.

Is a referral to a local emergency room or a referral to a service which is not managed by physicians (such as Health Links or a similar service) sufficient if the arrangement is formalized?

It is important that any such arrangement be clear, unambiguous, and understood and agreed to by all parties.

If there is a formal arrangement with a local emergency room or physicians in the emergency department, (which would be more likely to occur in smaller communities), it would be acceptable. In that case the physicians providing coverage in the emergency department are often the same physicians providing coverage in the hospital and in the clinics.

If the non-physician organization (such as Health Links or a similar service) is able to provide ready access to a physician if necessary, the arrangement would be acceptable. However, if the service only provides some triage and a direction to an emergency department it would not be acceptable.
Physicians are reminded that telephone assessment and management of patient issues requires a skill set that lies within the expertise of physicians. In addition, knowledge of how to appropriately communicate that assessment to community services, such as suicide counselling lines, crisis stabilization units, police and paramedics also requires a skill set that lies within the expertise of physicians.

What are the requirements for access to medical records?

In an ideal situation there should be universal access to a patient's medical records by the health care providers. This is more easily accomplished with electronic medical records. Obviously appropriate management is best accomplished if all information is available.

However, the system is not perfect and not all records, particularly paper records, are accessible. To the extent that it is reasonably possible, physicians should provide information to others in their call group about any anticipated medical issues or specific patients who may be expected to call.

What does "must ensure that medical care is continuously available to the patient" mean? Does a physician have to answer every call?

A physician may be part of an arrangement in which initial calls are screened by other individuals. The physician must be able to respond either by telephone or in person, as the needs require, should medical advice or should any medical service be necessary as a result of the call. If a physician is a first line responder, that physician must respond to all calls.

Physicians are not required to provide medical service to people who are not patients of their call group. The answering service or the triage service should be clear about which matters a physician will respond to promptly, which matters may be left to the next working day, and which matters should be sent to the emergency department.

In true emergencies, a referral to the nearest emergency room will generally be the best medical advice. It is expected that the physician on call will notify the appropriate emergency room of the details of the referred call.

Members are encouraged to educate their patients about which matters are urgent and which may be deferred to the next working day.

CENSURE: IC1902
DR. AARON MATTIS MELLON

On September 19, 2014, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Mellon as a record of its disapproval of the deficiencies in his conduct. Censure creates a disciplinary record which may be considered in the future by the Investigation Committee or an Inquiry Panel when determining the action to be taken following an investigation or hearing.

I. PREAMBLE

Physicians are required to take an adequate history from a patient and conduct a physical examination appropriate to the complaint presented. When a presenting complaint indicates a focused physical examination is warranted, it is inappropriate to defer that examination until the patient has scheduled a complete physical examination.

Physicians are required to keep legible and adequate records of the care they provide to patients, including a record of any diagnosis made and any treatment prescribed. When a patient declines a proposed treatment, that refusal must also be documented.

Physicians are required to be proactive when a patient presents with a medical condition of some urgency, including endeavouring to obtain expedited appointments for investigations and/or for specialist appointments.

Physicians are required to communicate with their patients, fully informing the patient respecting the diagnosis, the treatment options, and the possible adverse consequences of declining a treatment which is offered.

Physicians are required to be scrupulously honest in their dealings with the College.

II. THE RELEVANT FACTS ARE:

The Committee assessed the facts as follows:

1. At all material times X, who was born in 1945, was a patient in Dr. Mellon's family medicine practice.

2. On or about April 11, 2011, X presented to Dr. Mellon complaining of increased frequency of voiding, nocturia and periods of loss of bladder control. Dr. Mellon's record does not adequately detail these complaints. Dr. Mellon did not conduct a physical examination and instead advised X to make an appointment for a complete physical examination. Dr. Mellon prescribed Flomax. Dr. Mellon's record documents that X was following up with a urologist.

3. Laboratory results reveal that X's creatinine was 91 in March 2010, 111 in November 2010 and 122 in April 2011.

4. X did see his urologist on May 30, 2011, at which time they discussed his voiding difficulties and the urologist conducted a physical examination of X's prostate. X commenced taking the Flomax.

5. X next saw Dr. Mellon on June 20, 2011. Dr. Mellon documented "BPH" and he renewed a prescription for Flomax. Dr. Mellon's record does not adequately detail this complaint. X advised that he wanted to wait until he had assisted a family member with that person's medical concerns before booking his annual physical.

6. X next saw Dr. Mellon on June 23, 2011, at which time Dr. Mellon stated that X was concerned about symptoms of mild dysuria on Flomax, and Dr. Mellon suggested he book a physical so that Dr. Mellon could assess his prostate. Dr. Mellon ordered a 24 hour creatinine clearance and bloodwork.

7. On July 7, 2011 the 24 hour urine creatinine clearance Dr. Mellon ordered was reported as being 111 mls per minute.

8. The bloodwork results revealed elevated potassium. In Dr. Mellon's absence from the office, a colleague contacted X on July 12, 2011 and directed him to attend the Emergency Department for care.

9. On July 12, 2011, X attended Victoria Hospital Emergency Department and was treated with Kayexalate. The discharge summary, a copy of which was sent to Dr. Mellon, documented the Emergency Department physician's assessment that the hyperkalemia was secondary to progressive renal insufficiency, the etiology of which was unclear. The Emergency Department physician advised X to stop taking any NSAID, to continue to take Kayexalate and to follow-up with Dr. Mellon. The discharge summary states that the Emergency Department physician deferred to Dr. Mellon for management of X's potassium and renal insufficiency, but presumed X would be referred to nephrology at some point.

10. X next saw Dr. Mellon on July 14, 2011. Dr. Mellon ordered bloodwork for him to be repeated every week, and agreed to refer X to a nephrologist. Dr. Mellon assessed X's vital signs, and documented his cardiac sounds as normal and his respiration as clear, but he did not conduct a physical examination to assess the possibility of obstructive uropathy as a cause for the findings. Dr. Mellon's record contains no documentation of discussions with X about the cause of his renal failure.

11. Dr. Mellon's letter dated July 15, 2011 to the Nephrology Department states:

    > Patient is a 66-year-old male with history of hyperkalemia. Was sent to Emergency and received kayexalate. Potassium returned to normal. Recheck pending. Creatinine trending from 90 – 120 over the last year. Recent creatinine clearance normal. Patient concerned.
    >
    > Past Medical History: BPH, RA, previous inguinal hernia.
    >
    > Past Surgical History: Appendectomy.
    >
    > Social History: [states marital status, offspring].
    >
    > Allergies: No known drug allergies.
    >
    > Current Medications: Patient was on Celebrex sporadically, has now been discontinued. Continues to be on Lipitor 5mg po od.
    >
    > Physical Examination: [states height and weight].

12. X next saw Dr. Mellon on July 20, 2011, but he has no note of this visit.

13. X next saw Dr. Mellon on July 27, 2011. X expressed concern about his elevated potassium level at 5.8 and his creatinine at 130. X reported increased night time distress with incontinence. Dr. Mellon did not conduct a physical examination other than blood pressure and a cardiovascular examination. Dr. Mellon's note of the visit documents BPH as a possible cause. Dr. Mellon told X that obstruction was a possibility, but did not explain to or discuss with X the potential risks to his kidney function, as Dr. Mellon assumed that X would be aware as a result of his knowledge of anatomy and physiology. Dr. Mellon ordered a renal ultrasound and documented an intent to make a referral to X's urologist.

14. The requisition for the renal ultrasound which Dr. Mellon completed on July 27th gives a clinical history of "BPH & CRI". The renal ultrasound was scheduled for September 19, 2011, and Dr. Mellon made no effort to obtain an earlier appointment.

15. Dr. Mellon's letter dated July 27, 2011 to X's urologist states:

    This patient is a 66-year old male with increasing mild chronic renal insufficiency. He also has lower urinary tract symptoms worsening secondary to BPH. There is some concern about obstructive uropathy.

    I will obtain a renal ultrasound and repeat blood work is pending.

    I would appreciate your assessment. I am wondering about urodynamics or possibly cystoscopy.

    Past medical history includes BPH, RA (stable), white-coat hypertension, inguinal hernia, appendectomy.

    He is [states marital status and offspring]. No known drug allergies.

    Current medications include Lipitor 5 mg. p.o. o.d. The patient is unable to tolerate Flomax.

    He is [states height and weight].

    Please assess for BPH.

16. X's medical record documents that the letter to the Nephrology Department and to X's urologist were not mailed until August 5, 2011.

17. X next saw Dr. Mellon on August 11, 2011. Dr. Mellon's note states "BPH, incontinence, CRI". Dr. Mellon prescribed Xatral and noted the referral to urology. Dr. Mellon did not conduct a physical examination.

18. At the August 11, 2011 visit, X inquired about travel to the United States and Dr. Mellon advised him it was acceptable to travel but not to remote areas and that he should always be accessible to a washroom.

19. While X was in the United States, he contacted Dr. Mellon's office for laboratory results and was advised that Dr. Mellon wished to see him.

20. X next saw Dr. Mellon on September 6, 2011 at which time Dr. Mellon told him that he needed to be catheterized. X declined catheterization as he had an appointment with his urologist scheduled for September 13. Dr. Mellon's response to X was "they are your kidneys." X continued to decline the catheterization.

21. Dr. Mellon stated to the College that X had previously declined catheterization on July 14, July 27, and August 11, but there is no record of such in Dr. Mellon's clinic chart for X, and no mention of X declining catheterization in Dr. Mellon's letters to the Nephrology department or the urologist, although neither letter was sent until August 5, 2011.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. MELLON'S CONDUCT IN:

1. When X presented to Dr. Mellon in April and June 2011 with a history of steadily progressive lower urinary tract symptoms and a slowly but steadily rising creatinine level, Dr. Mellon recommended that X book an appointment for a complete physical examination and Dr. Mellon offered no focused physical examination.

2. Although Dr. Mellon stated that on July 27th he was aware that obstructive uropathy was a possible cause of X's symptoms, and a focused physical examination to assess his prostate or to assess for distended bladder was appropriate, despite symptoms there is no record of Dr. Mellon conducting such an examination or of X declining such an examination in July or August 2011.

3. Although Dr. Mellon stated that he appreciated the severity of X's condition and the urgency regarding X's condition, Dr. Mellon failed to take appropriate steps to have the condition treated:
   a. Dr. Mellon did order blood work which revealed progressively deteriorating renal function, but he took no action on the results until he ordered a renal ultrasound on July 27th,
   b. Dr. Mellon was aware that the renal ultrasound was scheduled for September 19th, and yet he made no effort to expedite the test or refer X to the Emergency Department for a bladder scan on an urgent basis,
   c. Dr. Mellon made referrals for specialty appointments but did not send these until August 5, 2011 and did not document in his referral letters all relevant information respecting X's condition, and
   d. When X consulted Dr. Mellon about travel to the United States, Dr. Mellon did nothing to assess for a distended bladder, he did not explain to X the potential risks to his kidney function, and he did not counsel X not to travel despite his steadily rising creatinine levels and progressive urinary symptoms, which by this point included frequent incontinence.

4. Dr. Mellon's record does not document any discussion with X about:
   a. obstructive uropathy as a cause for his renal failure until July 27,
   b. the potential risks to kidney function,
   c. his planned trip to the United States, or
   d. the potential consequences of declining catheterization on September 6th.

5. When the College requested a transcript of Dr. Mellon's handwritten chart notes, Dr. Mellon submitted a document which contained information additional to that which is contained in his chart entries.

6. In Dr. Mellon's correspondence to the College and in his interview with the investigator, Dr. Mellon indicated that he offered X catheterization in July and August 2011, when his record indicates that he first offered catheterization on September 6, 2011, and his letters referring X to specialists do not document any such refusal even though that information would have been highly relevant to the referral.

Dr. Mellon paid the costs of the investigation in the amount of $4,874.15.

INQUIRY: IC1866
DR. ANTON KLOPPERS

On August 15, 2014, a hearing was convened before an Inquiry Panel (the "Panel") of the College of Physicians & Surgeons of Manitoba (the "College"), for the purpose of conducting an Inquiry pursuant to Part X of *The Medical Act*, into charges against Dr. Anton Kloppers ("Dr. Kloppers"), as set forth in a Notice of Inquiry dated April 25, 2014.

The Notice of Inquiry charged Dr. Kloppers with committing acts of professional misconduct, with contravening By-Law No. 1 of the College and with contravening Statement 104 of the College. The Notice of Inquiry alleged that:

1. During the period between in or about September 2009 and December 2011, Dr. Kloppers permitted claims to be submitted to Manitoba Health for house call services as if he had provided the services when in fact the services were provided by a nurse practitioner, thereby committing acts of professional misconduct.

2. During the period between in or about September 2009 and December 2011, when Dr. Kloppers assumed responsibility for supervising a nurse practitioner making house call visits which were billed to Manitoba Health in his name, he participated in an arrangement which he knew or ought to have known was inappropriate and which resulted in the creation of electronic medical records which were misleading as to the nature and extent of his involvement in the visits in question thereby:
   a) breaching the recordkeeping requirements of By-Law No. 1 of the College in effect at the material time, and/or
   b) breaching Statement 104 of the College, and/or
   c) committing acts of professional misconduct.

3. Dr. Kloppers attempted to mislead the College with respect to his role in the nurse practitioner's care of the patients seen by the nurse practitioner and billed in his name, thereby committing acts of professional misconduct.

In addition to the foregoing, the Notice of Inquiry also contained extensive factual particulars.

The hearing proceeded before the Panel on August 15, 2014, in the presence of Dr. Kloppers' counsel, and in the presence of counsel for the Investigation Committee of the College. A letter from Dr. Kloppers, dated August 14, 2014, was provided to the Panel by his counsel, and marked as Exhibit "5" in the proceedings. Dr. Kloppers' letter explained that due to a medical condition from which he was recovering he would not be in attendance at the hearing. Counsel for Dr. Kloppers confirmed that he and his client wished the hearing to proceed in Dr. Kloppers' absence, and the lawyer for the Investigation Committee confirmed that she had no objection to the hearing proceeding in Dr. Kloppers' absence.

The hearing therefore proceeded, and Dr. Kloppers, through his counsel, entered a plea of guilty to all of the charges outlined in the Notice of Inquiry, thereby acknowledging that the facts alleged in the Notice of Inquiry were true and also acknowledging that he was guilty of multiple acts of professional misconduct and of breaching By-Law No. 1 of the College and breaching Statement 104 of the College.

Counsel for the Investigation Committee moved for an Order under subsection 56(3) of *The Medical Act* for the non-disclosure of the names of any patients or other third parties referred to in the proceedings. Counsel for Dr. Kloppers consented to such an order with respect to the names of patients but noted that any order under subsection 56(3) of *The Medical Act*, as it relates to other third parties, should only apply to information referred to during the hearing. Therefore, Dr. Kloppers' counsel submitted that an order under subsection 56(3) of *The Medical Act* should not operate to prevent Dr. Kloppers from disclosing other information, not referred to in the hearing, relating to third parties, other than patients.

The Panel granted the order sought by counsel for the Investigation Committee for the non-disclosure of the names of patients and other third parties, specifically referred to during the hearing, or in any documents filed as exhibits at the hearing. The Panel recognized that it has no jurisdiction or authority to issue an order for the non-disclosure of information, including the names of certain third parties, if that information is available from other sources separate and apart from this hearing.

The Panel reviewed and considered the following documents, all of which were filed as exhibits in the proceedings by consent:

1. Notice of Inquiry (Exhibit 1)
2. Statement of Agreed Facts containing 50 paragraphs (Exhibit 2)
3. Book of Agreed Documents, containing 33 documents (Exhibit 3) and
4. Joint Recommendation of the parties as to disposition (Exhibit 4).

REASONS FOR DECISION

Having considered the guilty plea of Dr. Kloppers in the context of the above-noted exhibits, and the submissions of counsel for the Investigation Committee of the College and counsel for Dr. Kloppers, the Panel is satisfied that all of the charges and the particulars recited therein have been proven. The Panel is also satisfied that the Joint Recommendation as to disposition is appropriate and ought to be accepted. The Panel's specific reasons for its decision are outlined below.

Background of Dr. Kloppers:

1. Dr. Kloppers obtained his medical degree from the Faculty of Medicine, University of Pretoria, South Africa in 1974. He completed his internship in South Africa in 1975. He has practiced medicine in Manitoba since 2002. He initially practiced as a conditional registrant in Northern Manitoba. In July 2008, he met the requirements for full registration. He has lived and practiced in Winnipeg since July 2008.

2. On or about September 15, 2008, Dr. Kloppers began practicing at a Winnipeg medical clinic. His practice includes providing care to regular patients and walk-in patients at the clinic and participating in a house call service which is organized through the clinic.

3. In September 2009, Dr. Kloppers became involved in house call visits made by a nurse practitioner ("NP") through the clinic's house call service. He ceased to be involved in the house call visits made by the NP in December 2011. Dr. Kloppers has continued to see his own patients and walk-ins at the clinic and to do his own house calls through the house call service.

Overview of Events Leading to the Charges Against Dr. Kloppers

1. In or about September 2009, Dr. Kloppers entered into an arrangement whereby the NP who worked at the clinic made house call visits to patients and those visits were billed to Manitoba Health in Dr. Kloppers' name as the provider of the service. This arrangement continued from September 2009 to December 2011. Billing records establish that during this period, Manitoba Health paid Dr. Kloppers a total of approximately $230,787.00 for house call services provided pursuant to this arrangement.

2. When the College first contacted Dr. Kloppers about this matter, he responded advising that all house call visits by the NP and billed in Dr. Kloppers' name occurred through the Librestream camera system which established a live link enabling him to participate in the visit from a distance. Dr. Kloppers maintained that this occurred on every one of the visits in question and that the live feed was maintained for the entire visit. Dr. Kloppers also maintained that although the NP made a record for each visit by creating an electronic medical record (EMR), Dr. Kloppers personally reviewed and signed off on the EMR for every visit. Dr. Kloppers stated that it was he who provided the service through his supervision of the NP and that he adopted the EMR as his own record for the service he provided.

3. Eventually, Dr. Kloppers acknowledged that the live link was not established for each visit and that he did not review the records as he had initially maintained.

Arrangement between Dr. Kloppers, the NP and the Clinic

1. In or about September 2009, Dr. Kloppers was approached by the management of the clinic and the NP about participating in a house call service involving the NP. The arrangement involved the NP making house call visits to patients and those visits being billed to Manitoba Health in Dr. Kloppers' name. Dr. Kloppers states that he was told that:
   a) Another physician who had left the clinic had participated in the same arrangement
   b) The arrangement was acceptable to Manitoba Health as long as Dr. Kloppers was available to the NP by telephone in case the NP needed his assistance.

   Dr. Kloppers also stated that he had seen other doctors use nurse practitioners without direct supervision when he practiced in Northern Manitoba and the proposed arrangement seemed consistent with what he had seen there. However, Dr. Kloppers has admitted that he made no independent inquiries about whether the arrangement was acceptable to Manitoba Health and that he "did not give it much thought".

2. The house call service coordinated all house call services provided by the NP and physicians providing house call services through a dispatch system described below:
   a) The dispatcher received patient requests for service and assigned the responsibility for the call to a particular care provider, either a physician or the NP.
   b) The scheduled house calls were entered by the dispatcher into the Health Suite software program, which was used for tracking appointments and planning the schedule for care providers who were doing house calls.
   c) The Jonoke EMR system was used by the NP and other physicians for the house call visits.
   d) Dr. Kloppers did not use Jonoke to create records for his own house calls. He created paper charts.

3. The specific arrangements and the nature and extent of Dr. Kloppers' involvement in the visits made by the NP and with the records relating to the visits in question changed over time. There were three stages of Dr. Kloppers' involvement:
   a. Stage 1 - September 2009 - May 28, 2010
   b. Stage 2 - May 28, 2010 to early May 2011
   c. Stage 3 - mid May 2011 to December 2011

4. During Stage 1 there was little, if any, involvement on the part of Dr. Kloppers with the NP's visits. Dr. Kloppers understood his role to make himself available by telephone when the NP had a question or concern about patient care. The NP was responsible for creating the medical record for the visit using the Jonoke EMR system. There was no expectation on the part of the clinic, the NP or Dr. Kloppers, that Dr. Kloppers would review the EMRs created and he did not review them.

5. The visits were billed by the clinic to Manitoba Health using Dr. Kloppers' billing number based on information about the visit provided by the NP, including the EMR. Manitoba Health paid Dr. Kloppers for the visits in question every two weeks. The fees paid to Dr. Kloppers by Manitoba Health for the visits were split amongst the NP, the clinic and Dr. Kloppers every two weeks. Dr. Kloppers paid the NP and the clinic their share based on the following formula:
   a. 30% kept by Dr. Kloppers
   b. 60% paid to the NP
   c. 10% paid to the clinic

6. During Stage 2 (May 28, 2010 to early May 2011), a decision was made by the clinic, the NP, and one of the other physicians working under a similar arrangement to use a camera system as part of the house call service provided by the NP. The other physician and the NP purchased the Librestream camera system in early May 2010. This system:
   a) utilizes mobile collaboration technology for functional telemedicine applications;
   b) involves the use of mobile, hand-held cameras, intended for use at the patient's location, and a computer based application on the physician's computer; and
   c) is intended to permit the physician to see and hear what was occurring at the patient's location.

7. Dr. Kloppers stated that at some point he came to understand that having a camera available was required in order to comply with the requirements of Manitoba Health for the billing of the house call services provided by the NP in Dr. Kloppers' name.

8. On or about May 28, 2010:
   a) Dr. Kloppers became licensed to use the Librestream camera system and the software was set up on a computer located in his office at the clinic. This was the only location from which Dr. Kloppers could use the system. If he were not in his office, he could not participate in a visit via the system.
   b) The clinic staff activated Dr. Kloppers' pre-existing account with the
   c) Jonoke EMR system, which Dr. Kloppers had never used up to that point.

d) Dr. Kloppers was assigned a password to access the Jonoke EMR system through his unique identifier within the system. The purpose was to allow him to access the EMRs created by the NP for the visits in question from his office computer so that he could review and sign off on the records.

e) Dr. Kloppers has stated that:

i. The password was provided to the NP by the the clinic staff and the NP provided the password to Dr. Kloppers;

ii. He did not change the password at that time and that he kept the same password, which was known to the NP, throughout his involvement in the house call services provided by the NP and billed in his name.

9. With respect to the services being provided to patients during Stage 2, a summary is outlined below:

a) The NP made approximately 2379 house call visits on 165 days which were billed in Dr. Kloppers' name.

b) Dr. Kloppers was away from the office and not available to the NP to supervise the NP via the Librestream camera technology or respond to questions on approximately 14 days during which approximately 244 of these visits were billed in his name.

c) Dr. Kloppers states that, for the visits in question, he and the NP utilized the Librestream camera system for some of the visits, but not consistently.

10. With respect to record keeping during Stage 2, Dr Kloppers had access to the EMRs created by the NP and he reviewed some of them, but he did not review or sign off on the EMR consistently. Dr. Kloppers has acknowledged that he did not consider whether the records he reviewed and signed off on related to visits he had participated in via Librestream. He has also acknowledged signing off on records for visits in which he was not involved via a live link through the Librestream system or otherwise. The NP had Dr. Kloppers' password for accessing the Jonoke system and the NP regularly signed off on the records on Dr. Kloppers' behalf.

11. During Stage 2, the billing and fee split arrangements and Dr. Kloppers' involvement in those arrangements were the same as during Stage 1.

12. In early May 2011 (at the beginning of Stage 3 which lasted from mid-May 2011 to December 2011), an investigator from Manitoba Health obtained a search warrant for Dr. Kloppers' files. Dr. Kloppers became aware that Manitoba Health had concerns about the house call service billings and was investigating the circumstances surrounding the arrangements he had with the clinic and the NP. Dr. Kloppers asked the owner of the clinic about the investigation at that time, and was advised that Manitoba Health had been aware of the arrangements since May 2010.

13. Dr. Kloppers understood that Manitoba Health was concerned that he had billed for patients he had not seen. For that reason, he tried to make a point of seeing each patient and his use of the Librestream system and the establishment of a live link for house call visits made by the NP and billed in Dr. Kloppers' name became more frequent. He emphasized to the NP that he should patch Dr. Kloppers in on every visit and he tried to be present at some point of the visit every time. His review of the EMRs created by the NP for the visits also became more frequent. On that basis, he continued the arrangement until December 2011.

14. During Stage 3, the NP made approximately 403 house call visits on 56 days which were billed in Dr. Kloppers' name. Dr. Kloppers has stated that, for the visits in question, he and the NP utilized the Librestream camera system much more regularly, but that he could not say that it was used for all of the visits in question. There was one day in late May 2011 when Dr. Kloppers was out of the office and the NP made 11 visits which were billed in Dr. Kloppers' name. Dr. Kloppers stated that this was done without his knowledge.

15. With respect to record keeping, Dr. Kloppers used Jonoke to review some, but not all of the EMRs created by the NP for the visits in question. Dr. Kloppers did not usually consider whether the records he reviewed and signed off on related to visits he had participated in via Librestream. He has acknowledged signing off on records for visits in which he was not involved via a live link through the Librestream system or otherwise. The NP had Dr. Kloppers' password for accessing the Jonoke system and the ability to sign off on the records on Dr. Kloppers' behalf.

16. During Stage 3, the billing and fee split arrangements and Dr. Kloppers' involvement in those arrangements were the same as during Stage 1.

17. Dr. Kloppers continued to participate in this arrangement until in or about December 2011. Dr. Kloppers has stated that although he had been aware that Manitoba Health objected to the practice of physicians billing for services provided by a NP before then, it was not until he learned that, on at least one occasion, the clinic had submitted billings to Manitoba Health in his name when he was not available to supervise the NP. At that point, he withdrew from the arrangement with the NP and the clinic.

Dr. Kloppers' Participation in the Creation of Misleading Records

1. The Investigation Committee of the College has done a substantial amount of work to prove and establish that Dr. Kloppers participated in the creation of misleading medical records in a variety of ways. It is not necessary, for the purposes of these Reasons, to outline in detail the ways in which Dr. Kloppers participated in the creation of misleading records, because Dr. Kloppers has acknowledged by his guilty plea and by agreeing to the Agreed Statement of Facts that he did so as described in the Agreed Statement of Facts. However, a brief summary of some of the salient background facts relating to the creation of misleading medical records is outlined below.

2. Statement 104 of the College sets out responsibilities for security and audit of electronic medical records. Among the requirements is a requirement for a permanent file log which serves as an audit trail and identifies and records who accessed the system, what alterations were made to the record, by whom and when the alteration was made.

3. The house call service used the Jonoke EMR keeping system for charting. Within that system, each user has a unique identifying number.

4. Dr. Kloppers has acknowledged that:

    a) At no time did he review all of the records of the NP's patient care for the house call visits for which he had assumed responsibility as a supervisor.

    b) None of the entries documenting the NP/patient encounters on the patient encounter histories in the EMRs for visits which Dr. Kloppers assumed responsibility as a supervisor contain any indication of his involvement in the care. The only exception to this is some EMRs from Stage 1 which are not accurate in that the records indicate that the patient was seen by Dr. Kloppers when in fact the patient was seen by the NP.

c) The only indication that Dr. Kloppers may have reviewed and/or signed off on an EMR is found in the permanent file log in the audit trail for the EMRs for the visits in question. The fact that Dr. Kloppers is shown as having signed off on a particular record and/or as having reviewed it in the audit trail does not mean that it was actually Dr. Kloppers who reviewed and/or signed off on the record. The NP had his password and the NP signed off on many records on Dr. Kloppers' behalf.

d) There is no way of knowing from the records created for the visits in question whether or not Dr. Kloppers did in fact participate in a particular visit or review the EMR created or sign off on the record created for that visit. This is the result of Dr. Kloppers having shared his password with the NP and allowing the NP to sign off on records on his behalf.

5. In the Agreed Statement of Facts, there are detailed descriptions of the medical records which were created with respect to five patients, and Dr. Kloppers' participation in the creation of medical records relating to those five patients which were misleading, and in breach of the requirements as set forth in Statement 104 of the College. With respect to those specific patients, and with respect to many other patients, Dr. Kloppers has admitted that the manner in which the records were kept for the house calls made by the NP and billed in Dr. Kloppers' name resulted in the creation of misleading records and was inappropriate. Dr. Kloppers has specifically acknowledged that:

   a) Supervision by Dr. Kloppers was never shown on the patient's charts. His review of a chart was only apparent, if it was apparent at all, in the audit trail. Another caregiver would not look at the audit trail and so would not be able to tell that Dr. Kloppers had been involved; and

   b) The records that do suggest Dr. Kloppers' involvement in the audit trail are not reliable because the NP had his password and the ability to sign into the Jonoke system in Dr. Kloppers' name.

      i. In some cases, it must have been the NP who accessed the system in Dr. Kloppers' name to remove a review button and/or a supervise button because Dr. Kloppers was away and had no means of accessing the system.

      ii. In other cases, Dr. Kloppers could have accessed the system to remove a review button and/or a supervise button, but it is not possible to determine by the audit trail if indeed it was he who signed off on records for visits, including some that occurred while he was away.

      iii. In a few cases, the NP signed in as Dr. Kloppers and wrote on a chart that Dr. Kloppers saw the patient when he did not.

None of this could have occurred if the NP did not have Dr. Kloppers' password.

Billings to Manitoba Health

1. The total paid by Manitoba Health for house calls where the NP attended and the billing was issued in Dr. Kloppers' name was approximately $230,787.00.

2. As previously stated, the billings were shared by Dr. Kloppers, the clinic and the NP as follows:
   a) 30% kept by Dr. Kloppers
   b) 60% paid to the NP
   c) 10% paid to the clinic

3. Dr. Kloppers has admitted that the billing arrangement was inappropriate.

Misleading the College

1. As is usual practice, when the College became aware that Dr. Kloppers had billed for services which the NP had provided, the College wrote to Dr. Kloppers requiring his response. Dr. Kloppers, or lawyers on his behalf, responded to the College's inquiries by way of five separate letters between November 25, 2011 and March 9, 2014. Dr. Kloppers was also interviewed by the Investigation Chair of the College on two occasions, December 7, 2011 and February 1, 2012.

2. Paragraphs 38 to 48 of the Agreed Statement of Facts outline numerous examples of statements made by Dr. Kloppers, either in the above-noted letters, or during his interviews, which Dr. Kloppers ultimately admitted that he knew or ought to have known were not true.

3. Although those numerous examples of false and misleading statements to the College will not be specifically summarized in these Reasons, it must be noted that counsel for the Investigation Committee stated at the hearing that the significant number of false and misleading statements made by Dr. Kloppers, and the extended period of time during which he persisted in making those false and misleading statements are "the most troubling and concerning aspects of his misconduct". The Panel is satisfied that many of his false statements to the College were intended to conceal or minimize his own wrongdoing and to avoid accepting responsibility for his misconduct.

Dr. Kloppers' Arrangements with Manitoba Health

1. As noted above, Dr. Kloppers has stated that he received only 30% of the total amount billed to Manitoba Health (approximately $237,787.00) and that the remainder was paid to the NP and to the clinic.

2. Nonetheless, Dr. Kloppers entered into a settlement agreement with Manitoba Health, pursuant to which he agreed to repay, in a series of payments over time, the full amount owing.

3. Manitoba Health subsequently became concerned about the payments being made over the length of time contemplated in the agreement in the absence of any security. Further negotiations ensued, but ended when Manitoba Health decided to unilaterally deduct 10% of Dr. Kloppers' billings until the remainder of the amount owing had been paid.

4. According to Manitoba Health, as of March 31, 2014, the balance owing was $171,717.96.

Quality of Care

1. Paragraph 20 of the Statement of Agreed Facts indicates that during the course of the College's investigation, no patient care or patient safety issues were identified. Nonetheless, the Panel is mindful that the arrangements between Dr. Kloppers and the NP and the clinic were such that there was a distinct possibility that patient care could have been compromised.

The Joint Recommendation as to Disposition

On the basis of the above-noted summary of the background facts, and the more detailed Statement of Agreed Facts, it is clear that Dr. Kloppers' professional misconduct and contravention of By-Law No. 1 of the College and his contravention of Statement 104 of the College are troubling and problematic. Given the seriousness and unacceptability of Dr. Kloppers' conduct, the Panel must decide upon the appropriate disposition pursuant to Section 59.6 of *The Medical Act.* The Panel has been assisted in its task by the Joint Recommendation as to Disposition made by counsel for the Investigation Committee of the College and counsel for Dr. Kloppers.

In determining the types of orders to be granted pursuant to Section 59.6 of *The Medical Act*, it is useful to consider the several objectives of such orders. Those objectives are:

a) the protection of the public in a broad context. Orders under Section 59.6 of *The Medical Act* are not simply intended to protect the particular patients of the physician involved, but are also intended to protect the public generally by maintaining high standards of competence and professional integrity among physicians;

b) the punishment of the physician involved;

c) specific deterrence in the sense of preventing the physician involved from committing similar acts of misconduct in the future;

d) general deterrence in the sense of informing and educating the profession generally as to the serious consequences which will result from breaches of recognized standards of competent and ethical practice;

e) protection against the betrayal of the public trust in the sense of preventing a loss of faith on the part of the public in the medical profession's ability to regulate itself;

f) the rehabilitation of the physician involved in appropriate cases, recognizing that the public good is served by allowing properly trained and educated physicians to provide medical services to the public.

g) the sentence should be proportionate to the conduct of the physician involved.

The Joint Recommendation as to Disposition being made in this case is that:

1. Dr. Kloppers should receive a reprimand.

2. Dr. Kloppers' license to practice medicine in Manitoba should be suspended for a period of five months.

3. The costs of the investigation and inquiry in the amount of $30,000.00 are to be paid by Dr. Kloppers to the College by certified cheque on or before the date of the hearing.

4. There shall be publication of the circumstances relevant to the findings and order of the Panel, including reference to Dr. Kloppers' name. The details of such publication are to be determined by the Investigation Committee of the College.

ANALYSIS

The Panel has reviewed the objectives of orders which are granted pursuant to Section 59.6 of *The Medical Act*, relative to the Joint Recommendation of the parties in this case, to satisfy itself that those objectives will be fulfilled by an acceptance of the Joint Recommendation.

A reprimand represents a severe and formal rebuke of Dr. Kloppers' conduct as particularized in the Notice of Inquiry. It is a statement by this Panel of its disapproval and denunciation of Dr. Kloppers' behaviour and conduct. The reprimand, coupled with the publication of the disposition in this case are the means by which the College strives to protect the public in a broad sense.

The five-month suspension which is part of the Joint Recommendation, represents a significant punishment of Dr. Kloppers. Such punishment is warranted.

There were a number of aggravating factors present in this case. Although patient care may not have been directly compromised, there were serious deficiencies in the medical records relating to many patients, and there is the possibility that those deficiencies may have negative consequences in the future. Dr. Kloppers' participation in the arrangements with the NP were motivated, at least in part, by greed on the part of Dr. Kloppers. His conduct also involved a betrayal of the public trust by virtue of the misuse which he allowed to be made of his Manitoba Health billing number. His false and misleading statements to the College over an extended period of time were designed to cover up his own wrongdoing, to avoid accepting responsibility for his own actions, and also reflected a disrespect for the governing body of his own profession.

The existence of the above-noted aggravating factors satisfies the Panel that a five-month suspension, and the loss of income and humiliation which the suspension entails is an appropriate punishment.

The Panel has also considered the mitigating factors which are present in this case, including that Dr. Kloppers has no prior disciplinary record and that he has acknowledged his responsibility to repay Manitoba Health the total amount of improper billings, not just the 30% which he personally retained.

Balancing the aggravating and mitigating factors which are present in this case, the Panel accepts that a five-month suspension combined with the other elements of the Joint Recommendation represent a sentence which is proportionate to the misconduct of Dr. Kloppers.

In terms of specific deterrence, the reprimand, the suspension, the payment by Dr. Kloppers of the College's costs and the publication of the circumstances of this case with reference to Dr. Kloppers' name, should operate to prevent Dr. Kloppers from committing similar acts of misconduct in the future.

Publication of the circumstances of this case and the order of this Panel will fulfill the objectives of general deterrence by informing and educating the profession generally as to the serious consequences which will result from misconduct of the type engaged in by Dr. Kloppers.

In a case such as this, a question arises as to whether the misconduct of the physician warrants a more severe penalty, and specifically, a longer suspension or even a cancellation of the physician's registration and licence. However, in this case, there are at least two reasons why the Panel has concluded that a five-month suspension, combined with a reprimand, the payment of the College's costs and publication, are sufficient and adequate penalties. Those reasons are:

1. The absence of any quality of care issues arising from the background facts; and

2. The realistic prospect of rehabilitating Dr. Kloppers. The College expects that Dr. Kloppers will have learned from this experience and that after his suspension has expired, he will be committed to providing medical services competently and ethically. As noted above, one of the objectives of an order granted under Section 59.6 of *The Medical Act* is the rehabilitation of the physician, recognizing that the public good is served by allowing properly trained and education physicians to provide medical services to the public.

The Panel also believes that by accepting and implementing the Joint Recommendation, a properly informed public will be satisfied that the medical profession is able to properly regulate itself.

The Panel has therefore decided that the objectives of an order granted pursuant to Section 59.6 of *The Medical Act* will be fulfilled, if the Joint Recommendation of the Investigation Committee and Dr. Kloppers is accepted. The Panel was advised at the hearing that immediately prior to the hearing Dr. Kloppers had paid to the College the costs of the investigation and inquiry in the amount of $30,000.00.

The Panel's decision is therefore to accept the Joint Recommendation.

Accordingly, the Inquiry Panel, pursuant to Section 59.6 of *The Medical Act*, orders that:

1. Dr. Kloppers is hereby reprimanded;
2. Dr. Kloppers' licence to practice medicine will be suspended for a period of five months from October 1, 2014 to February 28, 2015;
3. Dr. Kloppers must pay to the College the costs of the investigation and inquiry in the amount of $30,000.00 forthwith;
4. There will be publication, including Dr. Kloppers' name, as determined by the Investigation Committee.

IN THE MATTER OF: "*THE MEDICAL ACT*"

AND IN THE MATTER OF: DR. ANTON KLOPPERS, a member of the College of Physicians and Surgeons of Manitoba

RESOLUTION AND ORDER OF AN INQUIRY PANEL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

WHEREAS Dr. Anton Kloppers (Dr. Kloppers), a member of the College of Physicians & Surgeons of Manitoba (the College) was charged with professional misconduct, and with contravening By-Law No. 1 of the College and Statement 104 of the College, as more particularly outlined in a Notice of Inquiry, dated April 25, 2014.

AND WHEREAS Dr. Kloppers was summoned and appeared through counsel before an Inquiry Panel (the Panel) of the College on August 15, 2014.

AND WHEREAS Dr. Kloppers, through counsel, entered a plea of guilty to all of the charges outlined in the Notice of Inquiry.

AND WHEREAS the Panel reviewed the exhibits filed, including a detailed Statement of Agreed Facts and a Book of Agreed Documents, heard submissions from counsel for the Investigation Committee of the College and counsel for Dr. Kloppers, and received a Joint Recommendation as to the Disposition of the charges outlined in the Notice of Inquiry.

AND WHEREAS the Panel decided that the Joint Recommendation as to Disposition was appropriate in the circumstances and ought to be accepted.

NOW THEREFORE BE IT AND IT IS HEREBY RESOLVED AND ORDERED THAT:

1. Pursuant to Section 56(3) of *The Medical Act*, *R.S.M.,* the identities of the patients of Dr. Kloppers, and of other third parties as referred to in these proceedings, shall be protected in the record of these proceedings by referring to them in a non-identifying manner.

2. Pursuant to Section 59.6 of *The Medical Act*:

    a) Dr. Kloppers is hereby reprimanded;

    b) Dr. Kloppers' licence to practice medicine will be suspended for a period of five months from October 1, 2014 to February 28, 2015;

    c) Dr. Kloppers must pay to the College the costs of the investigation and inquiry in the amount of $30,000.00 forthwith;

    d) There shall be publication, including Dr. Kloppers' name, as

    e) determined by the Investigation Committee.

Dated this 23rd day of September, 2014.

INQUIRY PANEL DECISION

WARNING

Publication Restrictions

1. The Inquiry Panel dismissed the charges against Member A and did not make any findings or orders against Member A under section 59.5, 59.6 or 59.7 of *The Medical Act*. In these circumstances, the following restrictions apply:

    a. Subsection 56(1) of *The Medical Act* provides that there shall be no reporting in the media of anything that would identify the member whose conduct is the subject of the hearing, including the member's name, the business name of the member's practice or partnership, or the location of practice, unless and until the panel makes a finding under section 59.5.

    b. Subsection 59.9 of *The Medical Act* permits publication by the College of the circumstances relevant to the findings and any order of the Panel, however, the College cannot publish the member's name unless the Panel makes an order against the member under section 59.6 or 59.7.

2. The Inquiry Panel ordered that Pursuant to Subsection 56(3) of *The Medical Act,* the identities of the Complainant and of other third parties referred to in these proceedings, shall be protected in the record of these proceedings by referring to them in a non-identifying manner.

INQUIRY: IC1631
MEMBER A

INTRODUCTION

On December 14, 2011, a Notice of Inquiry was issued by the Investigation Committee of the College of Physicians & Surgeons of Manitoba (the "College") to Member A alleging that he was guilty of professional misconduct, and/or had breached Article 2 of the Code of Conduct of the College, and/or had demonstrated an unfitness to practice medicine. More particularly, the Notice of Inquiry alleged, among other things, that Member A, during the period commencing in or about November, 1991 and continuing until in our about May, 1994, had failed to maintain appropriate boundaries with a particular patient (the "Complainant") in several different ways.

An Amended Notice of Inquiry was subsequently issued, the details of which will be referred to later in these Reasons.

Member A denied and continues to deny all of the allegations in the Notice of Inquiry and Amended Notice of Inquiry.

These proceedings have had a relatively complex and protracted procedural history.

On March 24, 2012, counsel for Member A filed a Notice of Motion for production and disclosure of further documentation from the Complainant, the College, and various other parties referred to in the Notice of Motion.

Member A's motion for production and disclosure was heard by the Inquiry Panel on May 23, 2012. The Inquiry Panel reserved its decision, and provided written Reasons for its decision which were dated and issued on July 6, 2012. A formal Order based on the Inquiry Panel's written Reasons was issued on July 18, 2012.

The Inquiry Panel's written Reasons dated July 6, 2012 and the formal Order of July 18, 2012 represented the completion by the Inquiry Panel of the first stage of a two-stage process, based on Section 278 of *The Criminal Code of Canada (the "Code")* as interpreted and outlined by the Supreme Court of Canada in *R. v Mills [1999] 3 SCR 688* (hereinafter referred to as "Mills").

After receiving certain documentary materials from various third parties in response to the Order dated July 18, 2012, the Inquiry Panel met to undertake the second stage of the Mills process by reviewing the responses received from the above-noted third parties and by reviewing and considering the specific documents which had been provided by the third parties.

On November 21, 2012, the Inquiry Panel issued written Reasons for Decision relating to the second stage production issues. A formal Order referred to as the "Second Stage Production Order" was issued on January 9, 2013, whereby the Inquiry Panel ordered, among other things, that excerpts from certain records be provided to legal counsel for the parties and the Complainant, subject to certain stipulated conditions.

On February 13, 2013, counsel for Member A filed another motion seeking a stay of the Notice of Inquiry, a dismissal of the Complaint and a determination that no further proceedings be taken by the College with respect to the allegations raised by the Complainant and referred to in the Notice of Inquiry.

The essential ground for the motion was that the significant delay between the events referred to in the Notice of Inquiry and the filing of the Complaint had substantially impaired Member A's ability to answer the Complaint and to make a full defence to the allegations made against him.

This second motion brought by Member A (the delay motion) was heard by the Inquiry Panel on May 30, 2013. The Inquiry Panel reserved its decision and issued written Reasons for its Decision dated August 19, 2013, dismissing Member A's delay motion, concluding that as a result of the passage of time, Member A may have suffered some prejudice, but that he had not been so significantly prejudiced in his ability to defend the allegations in the Notice of Inquiry, that he had been deprived of his right to a fair hearing.

Accordingly, this matter proceeded by way of a full hearing of the allegations contained in the Amended Notice of Inquiry on June 2, 3 and 5, 2014.

The Amended Notice of Inquiry alleged that Member A was guilty of professional misconduct, and/or had contravened Article 2 of the Code of Conduct of the College and/or had demonstrated unfitness to practice medicine. Specifically, the Amended Notice of Inquiry set forth allegations that:

"…

1. During the period commencing in or about November 1991 and continuing until in or about May 1994, on one or more occasions when (the Complainant) attended at your office for medical care you failed to maintain appropriate boundaries with her and/or exploited her for your personal advantage and thereby violated Article 2 of the Code of Conduct and/or committed an act or acts of professional misconduct.

PARTICULARS

A. You made inappropriate sexual comments to (the Complainant) about her ability to have multiple orgasms.

B. You inappropriately touched (the Complainant's) breasts and/or genitals, including fondling her breasts and/or stimulation of her clitoris, purportedly for what you represented to (the Complainant) as being the medical purpose of checking her fluids and/or making sure she was ovulating when there was no medical justification for your actions.

C. During (the Complainant's) last visit to your office:

   i. you failed to respect (the Complainant's) privacy in that you watched her undress;

   ii. you made inappropriate sexual comments to (the Complainant) about:
      a. her panties;
      b. your desire to have a romantic and/or sexual relationship with her, including your desire to have sexual intercourse with her;

   iii. you had sexual contact with (the Complainant) in that:
      a. you fondled (the Complainant's) genitals and/or breasts, unzipped your pants and rubbed your penis against her;
      b. you pressed your lips against (the Complainant's) lips;
      c. while (the Complainant) was standing, you stood behind her and pressed your body against her body.

2. By reason of one or more of the foregoing, you have demonstrated unfitness to practice medicine."

Member A, through his counsel, entered a plea of <u>not guilty</u> to all of the allegations against him as outlined in the Amended Notice of Inquiry.

At the outset of the proceedings on June 2, 2014, counsel for the Investigation Committee and counsel for Member A filed a stipulation which stated as follows:

> "Counsel for the Investigation Committee and counsel for the Member agree and stipulate that if the Panel of the Inquiry Committee finds that the matters set out in Paragraph 1, Particulars A, B and C or any part thereof have been proven to the satisfaction of the Panel, the Member is guilty of professional misconduct and has contravened Article A2 of the Code of Conduct of the College without the need to hear expert testimony in that regard."

THE EVIDENCE

The evidence in these proceedings consisted of several exhibits, one of which was an Agreed Book of Documents (consisting of nine documents) and the testimony of five witnesses. Three witnesses were called by counsel for the Investigation Committee of the College. Those witnesses, listed in the order in which they were called, were:

i. the Complainant;
ii. a friend of the Complainant, X.;
iii. the mother of the Complainant, Y.

Two witnesses were called by counsel for Member A, namely:

i. Member A;
ii. Z, the wife of Member A.

A brief summary of the evidence of each witness will be useful in providing a context for the analysis which follows.

The Complainant

At the time of the hearing, the Complainant was 41 years old. She provided a brief summary of her background, including her arrival in Canada in 1991 when she was 18 years old, with her mother and father and two older brothers, as political refugees.

The Complainant explained that all of the members of her immediate family became patients of Member A, having been referred to him by an Immigration Services Agency because he was fluent in their native language and was also from the same country of origin. The Complainant was a patient of Member A from November, 1991 to approximately May, 1994.

In 2000, the Complainant moved to the United States where she met and married her husband. The Complainant (along with her husband and their children) moved back to Winnipeg in 2010 to be close to her family.

In the Complainant's direct examination, she testified that she became a patient of Member A in November, 1991. At that time, she was experiencing irregular periods, which she described as follows: "I would get my period one month and then it would be four months and then maybe six months, and maybe a little bit the next month, and just all over the place".

The Complainant recalled that on the first visit, or on one of her first visits with Member A, she was accompanied by her mother. In her direct examination, she testified that according to her best recollection, she discussed her irregular periods with Member A on her first visit with him. At some point, he prescribed birth control pills as a means of regulating her period. The Complainant also testified that the birth control pills were effective in regulating her periods, and that once she was on the pill, she did not encounter any problems with menstruation.

The Complainant stated that throughout the period of time she saw Member A, she was a virgin and was not sexually active.

In the Complainant's direct examination, she also testified that once she became a patient of Member A, she saw him "almost monthly". With the assistance of records from Manitoba Health, relating to Member A's billings for his attendances upon the Complainant, (which were part of the Agreed Book of Documents), the number and regularity of her visits between November, 1991 and May, 1994 were established. There were several months during that period when no visits occurred, but there were also periods when the Complainant was seeing Member A at least once a month and sometimes more frequently.

The Complainant testified that Member A explained to her that he wanted her to attend on a monthly basis in order "to make sure that I was ovulating. That everything was working well". The Complainant acknowledged that she was also seeing Member A for other things, such as sore throats, skin rashes, and sinus infections.

According to the Complainant, during many of her monthly visits to Member A, he acted in a way which she subsequently realized was highly inappropriate. The Complainant testified in detail describing actions by Member A which she says occurred on a repeated basis which actions are as described in the Particulars outlined in paragraph 1B of the Amended Notice of Inquiry. The Complainant also testified that on one or more occasions, he made comments to her as outlined in paragraph 1A of the Amended Notice of Inquiry.

At the time those events were occurring, the Complainant testified that she was a naïve young woman with respect to sexual matters and did not understand that the alleged actions of Member A were wrongful and that his explanation (to make sure she was ovulating) was illogical, if not nonsensical, given the fact that she was on the birth control pill.

The Complainant testified that she stopped seeing Member A in the spring of 1994. The last visit noted in the Manitoba Health Records occurred on Tuesday, May 10, 1994. The Complainant explained that she stopped seeing Member A after a visit to his office in Winnipeg on a Saturday (i.e. a date that was most likely after Tuesday, May 10, 1994). According to the Complainant, as a result of what occurred on that Saturday visit, she was profoundly upset and never returned to see Member A again.

The Complainant provided details of what allegedly occurred on the Saturday visit in her direct examination. Her testimony was consistent with the Particulars outlined in paragraph 1C (i), (ii) and (iii) of the Amended Notice of Inquiry.

On the Saturday in question, the Complainant testified that she was alone with Member A in his office and that Member A had locked the door behind her after she entered his office.

The Complainant described her emotional state immediately after the Saturday visit. She indicated she was crying and confused. She drove around for a while and then went to a local park. She parked by the dock trying to make sense of what had happened. At the time, she was unaware that there was an organization, like the College, to which she could complain about Member A's conduct.

The Complainant also testified that sometime after the Saturday visit, she spoke to a friend, namely X, about what had happened with Member A. Thereafter she also spoke to her mother about what had happened with Member A.

In terms of the impact of these events on the Complainant, she described having had a lot of dreams and nightmares, and having her relationships with other people adversely affected by her interactions with Member A. She also explained that after her experiences with Member A, she had a very hard time trusting doctors and was very sensitive to the way doctors interacted with her own children.

She was first advised about the possibility of making a complaint to Member A's regulatory body from a therapist she was seeing in the United States. When the Complainant returned to Winnipeg, she was experiencing anxiety, and when she saw a counsellor in Winnipeg, she was advised of the existence of the College and that a complaint could be made to the College relating to Member A's conduct. The Complainant's initial letter of complaint was sent to the College on or about November 6, 2010, more than 16 years after she had stopped seeing Member A.

Counsel for Member A, in his cross-examination of the Complainant challenged her evidence in some respects and attempted to establish inconsistencies between her evidence at the hearing and statements she had made previously, and between her evidence and other objectively established facts. By way of example:

(i) Counsel for Member A was able to establish that during the period the Complainant was a patient of Member A, she received treatment from him, and saw him for a variety of conditions other than irregular periods. Counsel for Member A then sought an acknowledgement from the Complainant that nothing inappropriate occurred on any of the numerous visits she had with Member A relating to those other conditions. The Complainant did not acknowledge that nothing inappropriate occurred on any of those visits, but did state that she did not recall anything inappropriate occurring on any of these visits.

(ii) By referring to the Manitoba Health records and the brief entries in those records relating to the service provided on each visit, counsel for Member A sought to establish that the Complainant did not consult with Member A about irregular periods or anything else under the general description of "disorder of menstruation" during any of the first eight visits she had with him. The Complainant, when being cross-examined acknowledged "it was possible" that the first time she discussed irregular periods with Member A may have been on January 30, 1992, not November 4, 1991. (Member A's own evidence on that point will be commented upon elsewhere in these Reasons).

(iii) Again, with reference to the Manitoba Health records, counsel for Member A suggested to the Complainant that there were periods of time of up to two months when she was seeing Member A relatively frequently, but not about any issues relating to menstruation, and that there was one period in which there was a four month interval between attendances relating to menstruation. The Complainant's answer to the first series of questions was that she couldn't agree because "I don't recall", and her answer to the second series of questions (at page 68, question 412) "Sir, I don't recall. I don't know. I didn't write the printouts. I don't know what they are claiming for." On two other occasions in her cross-examination, it was suggested to the Complainant, based on the Manitoba Health records, that there had been other intervals of six and eight months between visits relating to menstruation. The Complainant responded to those questions by stating that she could not recall.

(iv) The Complainant was confronted with an apparent inconsistency between her testimony in Chief (that Member A had worn latex gloves on only one occasion when he allegedly conducted pelvic examinations of her), and a statement she had made previously to the Chair of the College's Investigation Committee in which the Complainant apparently agreed with the suggestion that Member A had worn gloves on all but one occasion. Any inconsistency was not conclusively established in this area because the record of what the Complainant had told the Investigation Chair was not clear. The Complainant did acknowledge that it was possible Member A had worn gloves on more than one occasion.

(v) The Complainant readily acknowledged that she had initially seen a counsellor in the United States for post-partum depression, and that she had also discussed two other prior traumas in her life relating to abuse, with that counsellor;

(vi) The Complainant was challenged over the fact that she had changed the information she gave to the College with respect to when she ceased seeing Member A (from 1993 to 1994) and whether she had discovered that "error" on her own, or whether she had become aware of that error after being told by counsel for the Investigation Committee that the Manitoba Health records showed that she had continued seeing Member A until May, 1994. Although it was established that the Complainant had had a discussion with counsel for the Investigation Committee in April, 2011 in which the date of her last visit with Member A was discussed, the Complainant maintained her position that she realized she had continued to see Member A as a patient until the spring of 1994 (rather than 1993) independently of any discussions with counsel for the Investigation Committee.

(vii) With respect to the "Saturday visit", the date of the Complainant's last attendance upon Member A, she was challenged for not mentioning or apparently not remembering that on a Saturday visit to the office, she would have had to provide her name to the security guards in the main lobby of the building to be cross-referenced against a list of authorized entrants provided by Member A's office, and would have gone through a "sign in" procedure at the security desk in the main lobby of the building, in order to gain access to Member A's office on one of the upper floors. The Complainant acknowledged that it was possible she had gone through such a protocol;

(viii) The Complainant was challenged more vigorously with respect to her recollection of

the weather conditions on the Saturday in question. In the Complainant's letter of complaint to the College, she had referred to snow melting on the day in question. Weather records from Environment Canada (entered as an exhibit in the proceedings) established that Winnipeg had experienced a warm and early spring in 1994 and that there was no snow on the ground after April 4, 1994. In the Complainant's cross-examination at the hearing, she initially referred to snow melting on the river and later she referred to snow floating down the river. Counsel for Member A suggested that the change between the contents of her letter of complaint and her testimony at the hearing represented a significant inconsistency, raising doubts as to the credibility of her account of what allegedly happened on that Saturday. The Complainant, during her cross-examination, expressed frustration over the time spent discussing the weather and temperature, when she asserted that her memory was very clear as to what had occurred that day in Member A's office.

X

The evidence of the witness X, a friend of the Complainant, was very brief and very focused. She explained that sometime in the spring of 1994 or 1995, the Complainant had told her about the concerns she had with Member A. X under the careful direction of counsel for the Investigation Committee did not testify as to what the Complainant had told her about Member A. X's testimony was limited to describing the Complainant's emotional state (page 118, question 598 - "She was very upset. She was scared…She was crying...She was saying she couldn't talk about it again"). X also stated that she advised the Complainant she should report the matter to the police (which the Complainant was not prepared to do) and that the Complainant should tell her mother.

X was not cross-examined by Member A's counsel.

Y

Y, the mother of the Complainant, provided background information relating to herself, her family, and her family's move from their country of origin to Winnipeg. She stated that shortly after moving to Winnipeg, all of her immediate family members became patients of Member A, including the Complainant. She explained that the Complainant had had problems with her periods before moving to Canada, had received some treatment for that condition in their country of origin and had consulted with Member A with respect to that condition.

Y also testified that when the Complainant talked to her about not seeing Member A anymore, and going to see another doctor, the Complainant was crying and was upset.

In cross-examination, Y confirmed that both she and her husband had continued as patients of Member A until 2010. It was also suggested to Y that she had asked Member A and/or Z (Member A's office manager at the time) to see Y's niece as a patient and that in 2001 she had asked Member A and/or Z to see Y's sister, her husband and their two daughters as patients.

Y responded by acknowledging that her niece and her sister and her sister's family had become patients of Member A but indicated that she could not remember asking Member A to take them on as patients.

In re-examination, and in response to questions from the Inquiry Panel, Y indicated she could not remember the month or the year in which she had had the conversation with the Complainant about the Complainant no longer seeing Member A. Y also clarified that she had had two conversations with her daughter on that topic. The first conversation was with respect to her

daughter not wanting to see Member A anymore. In that first conversation, her daughter had been crying. The second conversation occurred sometime later and related to the fact that her daughter was seeing another doctor, a female doctor.

In re-examination, Y was also asked to explain why she and her husband had stopped seeing Member A as patients in 2010. Y replied: (at question 682, at page 156) "Just talk to the whole thing about what happened to her. The thing. We just go closer to her when she back, and just like, I say no, we had to stop to see him. How it affect her".

Member A

In his direct examination, Member A provided details as to his personal background, having been born in his country of origin in the early 1950s and growing up and going to medical school there. Member A explained that he took extended medical training in his home country in order to become a specialist. He became an assistant professor in that specialty and practised in that specialty in his home country.

Member A married in late 1970s and moved to Canada in the mid-1980s with his wife and children. When he moved to Canada, he was not able to immediately practice medicine and therefore worked first as a janitor and then as an orderly, while taking English as a second language. He then took the necessary qualifying examinations in order to become entitled to be registered and licensed as a physician in Manitoba. Member A also did a two year rotating internship at a Winnipeg hospital and some additional rotations at another Winnipeg hospital.

Thereafter, Member A commenced private practice in family medicine, working firstly at one Winnipeg location commencing in August, 1991, moving to an office in another Winnipeg location briefly in 1992, and then moving his private practice to another Winnipeg location in October, 1992. He continues to practice from that location to the present.

Member A's wife, Z, has worked with him at his current office from the time of the opening of that office, performing a variety of functions as "office manager".

Following receipt of the Complainant's letter of complaint to the College in November, 2010, Member A and his wife undertook a search of their files and records, for the medical records relating to the Complainant. However, they were not able to locate any charts, notes or records relating to the Complainant. Member A explained (and his evidence was corroborated by his wife) that their protocol, which was consistent with the applicable standards at the time, was to destroy records after more than ten years had elapsed from the date of the patient's last visit. Member A said it was therefore likely that the charts, notes and records relating to the Complainant had all been destroyed pursuant to that protocol, many years prior to receipt of the Complaint.

As a result, the only records relating to the Complainant's attendances upon Member A from November, 1991 to May, 1994, which were introduced in evidence in these proceedings, were the Manitoba Health summaries (at Tabs 5 and 6 of the Agreed Book of Documents) and the billing cards from Member A's practice at the current location from November 16, 1992 to May 10, 1994 (which were included at Tab 7 of the Agreed Book of Documents).

Member A stated that from the outset of his private practice at the initial location, he dealt with a significant number of patients who speak the same language as he and the Complainant, many of

whom had been referred to him by the International Center. He indicated that although he was aware that the Complainant had been a patient of his, based on the Manitoba Health summaries and the billing cards, he had no recollection of the Complainant's personality. He remarked that when seeing her at the commencement of the hearing (after approximately 20 years), he had not recognized her.

In Member A's direct examination, he also outlined:

(i) in very general terms, the office procedures at the first two clinics in which he worked with respect to staffing, "walk-in" and appointment procedures and the basic physical layout of each office;

(ii) in somewhat greater detail, those same types of procedures at his current office. He also outlined the manner in which patients could gain access to his office on a Saturday (by having their name on a list provided to security personnel at a security desk in the front lobby of the building) and by going through a "sign-in" and "sign-out" procedure at the security desk;

(iii) his practice at all of the above-noted offices of having a "chaperone", or other attendant present when he was conducting a pelvic examination on a female patient.

The balance of Member A's direct examination was spent reviewing various entries on the Manitoba Health summaries and on the billing cards in order to explain what type of service he might have been providing to the Complainant or what type of tests he may have ordered in relation to treating her. Member A acknowledged that he had no specific independent recollection of his various interactions with the Complainant or the treatments he may have provided to her. For example, he could not remember whether he had ever prescribed birth control pills for her. His comments with respect to what might have been discussed with the Complainant, or what treatment might have been afforded to her, were based on the limited information available from the Manitoba Health summaries, the billing cards, and to a lesser extent, the oral testimony of the Complainant, which Member A had heard prior to his own testimony.

Member A denied all of the allegations against him as particularized in the Amended Notice of Inquiry.

In cross-examination, Member A's evidence and his denials of wrongdoing were challenged in several respects.

Counsel for the Investigation Committee attempted to establish that on the Complainant's very first visit to Member A on November 4, 1991, issues relating to menstruation were discussed. The Manitoba Health summaries show that on that day lab tests were ordered, and there are two entries relating to the lab as follows:

"TRF - CULTURE OF THROAT SWAB"
"DIAG - DISORDER OF MENSTRUATION"

The previous entry, from the same day relating to the Complainant's attendance on Member A refers to:

"DIAG - AC URI MULT SITES/NOS"

Member A, notwithstanding a vigorous cross-examination on that point, maintained that it was likely that he simply ordered a throat swab because he was exploring the possibility of an upper respiratory tract infection, particularly because the Manitoba Health records indicate that the Complainant had visited another physician two days previously with respect to an upper respiratory infection. Member A did concede that the lab entry referring to "Disorder of Menstruation" would have been based on information coming from him**.**

Counsel for the Investigation Committee also reviewed with Member A, the practices he would have followed in the early 1990s in relation to treating a young lady who was a virgin, and who was experiencing irregular periods. Member A indicated that one of the acceptable treatments at that time would have been the prescription of birth control pills for the purpose of imposing regularity on the menstrual cycle. He further testified that a responsible physician would be cautious about prescribing birth control pills for that purpose because birth control pills may produce various side-effects. Member A also indicated that if birth controls had been prescribed to such a patient, regularity of the menstrual cycle would have been achieved within two or three months. When it was suggested by counsel for the Investigation Committee that there would be no need for a follow-up thereafter, Member A indicated some follow-up would be required, because of the side-effects which birth control pills may produce, but he stated that any side-effects would normally manifest themselves within the first several months of commencing taking the pill. Member A acknowledged that if matters then proceeded satisfactorily, there would be no need to do pelvic examinations thereafter.

A significant portion of the balance of the cross-examination of Member A was devoted to a review of the Manitoba Health summaries and the numerous and repeated references in those summaries to "Disorder of Menstruation". Counsel for the Investigation Committee also referred Member A to the testimony of the Complainant that Member A had provided birth control pills as a way of dealing with her irregular periods and that once she was on the pill, she did not experience difficulties thereafter with irregular periods nor with any other aspect of her menstruation.

Member A, while acknowledging he could not remember whether or not he had prescribed the pill for the Complainant, pointed out that the Complainant did not specify when he had prescribed the pill for her. He also described some scenarios in which follow-up attendances and tests of the type which had been ordered would have been appropriate for a young woman on the pill.

Counsel for the Investigation Committee also pointed out to Member A that the Manitoba Health summaries for the period during which the Complainant was his patient contained multiple references to "Disorder of Menstruation", whereas there were no such references during the period from July to December, 1994 when a female physician was the Complainant's physician. Member A responded by pointing out that many of the lab tests ordered by the female physcian (eg: hemoglobin and cell counts) related to blood issues generally and that the female physician did diagnose anemia, which could be related to the Complainant's menstruation. Member A also referred to references to "contraceptive management" in the Manitoba Health summaries related to the female physician's treatment of the Complainant.

In cross-examination, all of the allegations of misconduct being made against Member A were specifically put to him. He steadfastly denied all of those allegations.

Z

Z provided some background information indicating that in their country of origin she had been a physiotherapist. She also testified that when she came to Canada with her husband and their children in mid 1980s. Within a year, she was working as a nurse's aide.

When Member A opened his own office in the fall of 1992, Z started working there immediately. When asked to described her duties there, she stated (Question 1112, page 254): "… I am the office manager. I book appointments. I phone patients for follow-up. I buy the supplies. I do the billing. I do his scheduling. I do almost everything."

Z reviewed the appointment process which was utilized in Member A's practice during the fall of 1992 and thereafter. She then reviewed each appointment with the Complainant which was noted in the appointment book and related those appointments to the Manitoba Health summaries. Z stated that she was the person responsible for making appointments and noting the appointments in the appointment book. In most cases, on the basis of the notations she had made at the time in the appointment book, Z was able to identify whether the appointments were appointments scheduled in advance, or whether they were "emergency" appointments scheduled on very short notice. The majority of the Complainant's appointments were scheduled in advance.

Z also pointed out that in some instances the Complainant came in with other family members who had appointments either immediately before or immediately after her appointment.

Z also confirmed that while Y was a patient of her husband, Y had asked that Member A take on her niece as a patient. Member A agreed. Later, Y also asked that Member A take on her sister, her husband and their children as patients. Initially, Member A refused because he was not taking new patients at the time. However, as a result of Y's repeated requests, he ultimately accepted them as patients.

In her direct examination, Z also reviewed the procedures utilized for seeing patients on a Saturday. Z was generally responsible for making the list of patients and providing it to the security guards on the main floor of the building. She stated that if patients were being seen on a Saturday, she would also be present at the office along with Member A.

In cross-examination, Z acknowledged that her husband had the authority to provide a list of patients to the security guards, and there were Saturdays when he would go to the office alone to do paper work and she would not be present.

THE ONUS OF PROOF

Given the contentious nature of the evidence in these proceedings, the proper application of the standard of proof is of particular significance to the outcome of this case.

It is therefore understandable that in their final submissions, both sets of counsel seriously and thoughtfully outlined their respective positions on the standard proof, and the way it ought to be applied to the facts this case.

The starting point for all counsel was the 2008 Decision of the Supreme Court of Canada in *C(R) v McDougall [2008] 3 SCR 41*. That case was an appeal from a decision of the British Columbia Court of Appeal, which had overturned the trial decision finding a defendant liable for sexually assaulting the plaintiff, who had been a resident at an Indian Residential School between 1966 and 1974. The case was a civil claim for damages.

The Supreme Court noted in paragraph 26 of its Decision that:

> "Much has been written as judges have attempted to reconcile the tension between the civil standard of proof on a balance of probabilities and cases in which allegations made against a defendant are particularly grave. Such cases include allegations of fraud, professional misconduct, and criminal conduct, particularly sexual assault against minors."

At paragraph 39 of its Decision, the Supreme Court summarized various approaches in civil cases where criminal or morally blameworthy conduct is alleged, as follows:

"I summarize the various approaches in civil cases where criminal or morally blameworthy conduct is alleged as I understand them:

(1) The criminal standard of proof applies in civil cases depending upon the seriousness of the allegation;

(2) An intermediate standard of proof between the civil standard and the criminal standard commensurate with the occasion applies to civil cases;

(3) No heightened standard of proof applies in civil cases, but the evidence must be scrutinized with greater care where the allegation is serious;

(4) No heightened standard of proof applies in civil cases, but evidence must be clear, convincing and cogent; and

(5) No heightened standard of proof applies in civil cases, but the more improbable the event, the stronger the evidence is needed to meet the balance of probabilities test."

At paragraph 40, of its Decision, the Supreme Court stated:

> "Like the House of Lords, I think it is time to say, once and for all in Canada, that there is only one civil standard of proof at common law and that is proof on a balance of probabilities. Of course, context is all important and a judge should not be unmindful, where appropriate, of inherent probabilities or improbabilities or the seriousness of the allegations or consequences. However, these considerations do not change the standard of proof. I am of the respectful opinion that the alternatives I have listed above should be rejected for that follow."

Notwithstanding that clear articulation by the Supreme Court of the principle that there is only one civil standard of proof at common-law (namely, proof on a balance of probabilities) and notwithstanding the Supreme Court's specific rejection of all five of the stated alternatives, some controversy in the law has persisted.

Counsel for Member A cited decisions from various tribunals and Courts, decided after the Supreme Court's decision in *McDougall,* which refer to the "Bernstein" standard (the name being derived from a 1977 decision of the Ontario High Court involving the College of Physicians & Surgeons of Ontario and a physician named "Bernstein"). For many years, the "Bernstein" standard was said to be the standard applicable to the determination of allegations of professional misconduct. The Bernstein standard stipulated that the cogency of evidence required in such a hearing must be commensurate with the serious consequences of such a finding.

Counsel for Member A argued that the "Bernstein" standard should apply in this case, because it is a civil standard and its requirement for clear and convincing evidence, given the serious consequences of a finding of guilt, is consistent with the Supreme Court's articulation of the law in paragraph 40 of the *McDougall* decision.

The Inquiry Panel does not agree that the "Bernstein" standard ought to be applied in this case, given the Supreme Court's specific rejection of the five alternate approaches which it cited, particularly its rejection of approaches 3, 4 and 5. The Inquiry Panel also agrees with and adopts the reasoning of the Alberta Court of Appeal in *Fitzpatrick v Alberta College of Physical Therapists 2012 Carswell Alta 1130 (Alta CA))*. In the *Fitzpatrick* decision, the Alberta Court of Appeal accepted that there is only one civil standard of proof, namely the balance of probabilities, and that it applies in professional disciplinary proceedings, and that there is no separate "clear, convincing and cogent standard".

Therefore, the standard of proof which the Inquiry Panel will apply in deciding this case will be proof on a balance of probabilities. Specifically, on the basis of the evidence presented to it, the Inquiry Panel will consider, whether it is more probable than not, that Member A made the comments and committed the acts which are alleged in the Amended Notice of Inquiry.

ANALYSIS

The Positions of the Parties

In his final submissions, counsel for the Investigation Committee outlined many reasons why the Complainant ought to be regarded as truthful and why her evidence ought to be accepted as accurate. According to counsel for the Investigation Committee:

(i) the Complainant's demeanor was impressive. She gave her evidence in a convincing way and she was composed throughout her testimony. She did not appear to be vindictive or motivated by vengeance. Her accounts of the material facts were consistent throughout the investigation process and the hearing;

(ii) the Complainant's motivations are clear. She wants Member A to know that what he did was wrong and unacceptable and she wants to make certain that Member A cannot do something similar to any other patient;

(iii) it is not logical that the Complainant would put herself through this painful process, if her allegations were not true;

(iv) the Complainant was not challenged on any of the substantive details of her Complaint. She testified in detail as to what occurred on many of her "monthly" visits and in relation to the events occurring during the "Saturday visit" at the office. Although the

Complainant was cross-examined on extraneous matters, her evidence on the specific allegations in the Amended Notice of Inquiry, and the details of that evidence were not challenged, or in any way undermined.

(v) the Complainant's evidence was consistent with most of the other evidence introduced in the proceedings. Her evidence about the frequency of her visits, and her many consultations with Member A about her menstruation was supported by the Manitoba Health summaries;

(vi) the Complainant has provided a credible and logical explanation for the delay in submitting her Complaint to the College. She was young, a recent arrival from a foreign country, confused about what had occurred, and unaware of her options. With the passage of time, she came to better understand the seriousness of Member A's conduct and that there was a complaint process which she could initiate. While her conversations with X and her mother cannot be used to establish the truth of the Complainant's allegations against Member A, those conversations can be used to establish her emotional state shortly after the occurrence of the events alleged in the Amended Notice of Inquiry.

Counsel for the Investigation Committee also outlined several reasons why the evidence of Member A ought not to be believed. Some of those reasons were:

(i) Member A provided no satisfactory explanation for the frequency of the Complainant's visits generally;

(ii) more specifically, there was no reason for Member A to be seeing the Complainant frequently for issues relating to "Disorder of Menstruation", after he had prescribed birth control pills and her periods had become regular;

(iii) at one point, Member A had suggested that the Complainant may not have been taking the pill regularly, but counsel for the Investigation Committee argued that assertion was inconsistent with his other statements that he had no specific recollections of his interactions with the Complainant or his medical treatment of the Complainant;

(iv) Member A's refusal to acknowledge that he had dealt with menstruation issues with the Complainant on her very first visit (November 4, 1991) indicate a lack of candor and honesty with respect to that specific visit and his testimony generally, particularly given the entries on the Manitoba Health summaries relating to the lab tests ordered on November 4, 1991;

(v) the failure of Member A to refer the Complainant to a gynaecologist casts considerable doubt on any suggestion that there were legitimate reasons for him to see the Complainant as frequently as he did relating to menstrual issues.

Counsel for the Investigation Committee also emphasized that this is a case in which the Inquiry Panel must decide as between the evidence of the Complainant on the one hand, and the evidence of Member A on the other. It is not possible that both of them testified truthfully, when their respective versions of the facts as alleged in the Amended Notice of Inquiry are so diametrically opposed. Counsel for the Investigation Committee submitted that a comparative credibility assessment must be made between the Complainant and Member A and that in any such assessment, the evidence of the Complainant should be accepted, rather than the evidence of Member A, for all of the reasons outlined above.

Counsel for Member A fundamentally disagreed with the submissions of counsel for the Investigation Committee. Counsel for Member A advanced two broad and important arguments in support of their position that the Complaint and all of the allegations in the Amended Notice of Inquiry ought to be dismissed.

Firstly, counsel for Member A strongly disagreed with the submissions of counsel for the Investigation Committee relating to the evidence of both the Complainant and Member A.

With respect to the credibility of Member A, his lawyers asserted that:

(i) Member A's evidence was entirely credible. He testified in a straightforward non-evasive manner. His comments about the Manitoba Health summaries relating to the lab tests of November 4, 1991 were sensible and logical based on his understanding of how the Manitoba Health summaries are created and his review of the surrounding entries on the summary. His explanation for some of the other entries on the Manitoba Health summaries were not inconsistent with his testimony that he had no independent recollection of his treatment of the Complainant. Rather, he was being pressed for explanations in cross-examination and he provided potential explanations which were plausible and logical from a medical perspective;

(ii) Member A's basic position is that all of the Complainant's attendances upon him and all of his actions toward her had a sound medical explanation. However, as a result of the delay in the Complaint being made, and the consequent destruction of his notes, files and records relating to the Complainant, he was greatly prejudiced in his attempts to demonstrate that his actions had a sound medical basis. Notwithstanding the destruction of his records, he provided reasonable explanations for his actions based on the Manitoba Health summaries and his billing cards from his office practice;

(iii) Member A was unshaken in his denial of any wrongdoing.

With respect to the credibility of the Complainant, Member A's counsel asserted that there were important inconsistencies in her evidence. For example:

(i) her assertion that she saw Member A initially and thereafter on an almost monthly basis relating to menstruation issues is not consistent with the entries in the Manitoba Health summaries. There were several extended intervals when she did not see Member A for menstruation issues. Although she saw Member A relatively frequently, many of her attendances upon him related to other issues. Moreover, she also saw the female physician she saw after Member A relatively frequently between July and December, 1994;

(ii) there was a significant inconsistency between the Complainant's initial evidence that she consulted with Member A about menstruation issues on her first visit or on one of her first visits, and her concession in cross-examination that she may not have consulted with him on that issue until late January, 1992;

(iii) the Complainant's lack of recollection with respect to the security procedures in place for Saturday visits at the office is inconsistent with her having a vivid and reliable memory of the events relating to the alleged Saturday incident;

(iv) the Complainant's inconsistent and potentially contradictory testimony with respect to "snow melting" or "snow floating down the river" on the day of the alleged Saturday incident is inconsistent with her having a vivid and reliable memory of the events which allegedly occurred on that day.

Secondly, counsel for Member A also strongly disagreed with the submissions of the Investigation Committee relating to the manner in which credibility issues ought to be assessed by the Inquiry Panel, and more particularly, whether or not the Inquiry Panel must choose between two stark alternatives, namely to accept the evidence of the Complainant (thereby rejecting the evidence of Member A), or to accept the evidence of Member A (thereby rejecting the evidence of the Complainant).

Counsel for Member A referred the Inquiry Panel to the 2013 Decision of the Superior Court of Justice of Ontario in *The College of Physicians & Surgeons of Ontario v Beitel, [2013] OSC 1599*. In that case, the evidence of the complainant and the evidence of the physician involved, were directly contradictory. In paragraph 30 of that Decision, the Court quoted with approval the following statement of O'Neill J. in *Olegario v Cabaraban [2007] O.J. No. 631 (ONT. S.C.)* at paragraph 33:

> "I am not restricted to simply choosing whether I accept the evidence of the plaintiff or the evidence of the defendant. Rejection of one does not equate to acceptance of the other. The stark alternative of believing the plaintiff's evidence or the defence's evidence excludes the legitimate possibility of being unable to resolve conflicting evidence. The issue in this civil trial is not which of the two versions with respect to Terra Cotta and Grand Valley are true but rather, on the totality of the evidence, viewed as a whole, has the plaintiff proved her case on balance of probabilities."

The Attitude and the Demeanor of the Witnesses

One of the challenges faced by the Inquiry Panel in this case is that all of the witnesses who testified presented their evidence well. Based solely on their own testimony, there was nothing in the manner in which any of them gave their evidence, or in their attitude or mannerisms which would suggest that they were not being truthful.

The collateral witnesses, namely, X, Y and Z were sincere and credible. The Inquiry Panel is satisfied that all three of those witnesses made genuine efforts to testify truthfully and accurately about events which had occurred more than 20 years ago.

With respect to the Complainant, she testified calmly and competently during both her direct examination and cross-examination. She did not appear vengeful. She generally maintained her composure, even when testifying as to matters which were distressing to her, and even when being challenged by counsel for Member A.

With respect to Member A, he testified calmly and provided straight-forward, non-evasive answers to the majority of questions put to him, including questions put to him in cross-examination. His answers to questions of a medical nature were logical and sensible.

Findings and Conclusion

It is tempting in a case such as this for an Inquiry Panel to accept the evidence of a complainant on the basis that his or her allegations must be true, because no complainant would put themselves through the tribulations of an investigation and an adversarial hearing involving painful and embarrassing issues, unless his or her allegations were true. Although such reasoning has a

certain appeal, it is problematic for two reasons:

(i) it comes close to effectively putting the onus on the person who is accused of wrongdoing, to prove his or her innocence, whereas the onus is on the prosecuting authority to prove the alleged wrongdoing;

(ii) it detracts from the importance of the evidence of the person who is accused, and who is denying the allegations of wrongdoing.

An Inquiry Panel is required to consider all of the evidence, and then to decide whether or not the case has been proven on a balance of probabilities.

This Inquiry Panel recognizes that the Complainant's specific evidence as to Member A's alleged misconduct was not directly challenged on cross-examination. Specifically, her allegations about Member A's statements to her relating to her ability to have multiple orgasms, his fondling of her breasts and his stimulation of her clitoris, and his many comments and inappropriate contacts with her during the alleged "Saturday visit", were not challenged on cross-examination. Member A's counsel apparently made a decision not to deal with those issues on cross-examination in order to avoid the risk of the Complainant repeating what she had said on those issues in her direct examination. Instead, Member A's counsel chose to simply advise the Complainant that her allegations of wrongdoing would be denied by Member A and to subsequently have Member A deny those allegations during his direct examination.

The Complainant was challenged in cross-examination on other aspects of her testimony in an attempt to establish inconsistencies and to otherwise weaken or discredit certain aspects of her testimony, thereby raising uncertainties about the substantial accuracy of her evidence on an overall basis.

Many of Member A's counsel's attempts to establish inconsistencies did not detract from the overall impact of the Complainant's testimony. For example, the Complainant's initial error with respect to when she ceased seeing Member A (i.e. saying it was 1993 rather than 1994) and her insistence in her cross-examination that she became aware of that error independently of any discussion with counsel for the Investigation Committee, did not cast much doubt, if any, over the rest of her testimony.

However, some other aspects of the Complainant's testimony were curious and somewhat troubling to the Inquiry Panel. Examples included:

(i) her evidence in direct examination that Member A acted inappropriately toward her on almost a monthly basis, relative to her evidence in cross-examination that Member A treated her for several things other than menstrual issues and she could not recall him acting inappropriately on any of the visits relating to other issues. Furthermore, the Manitoba Health summaries demonstrate that Member A was in fact treating her for other conditions and that there were several intervals of two or more months when she was not seen for issues relating to menstruation;

(ii) the number of times she responded to questions in cross-examination indicating that she could "not recall" or with respect to which she would reply that a suggestion put to her

on cross-examination, (which was somewhat different from her evidence during her direct examination), was "possible". The Inquiry Panel recognizes that given the passage of time, it is entirely understandable that the Complainant cannot remember many of the details she was asked to recall by counsel for Member A. Nonetheless, the passage of time and the imperfections of the human memory are factors which the Inquiry Panel must consider in determining whether the Complainant's allegations have been proven on the balance of probabilities;

(iii) her recollection of the weather conditions on the day of the "Saturday" visit. The Complainant testified that the Saturday visit was the last time she attended upon Member A. There is no reference to such a visit in the Manitoba Health summaries. The last entry in the Manitoba Health summaries with respect to an attendance by her on Member A was May 10, 1994. The Saturday visit therefore must have occurred after May 10, 1994. On the basis of the evidence as to the weather that spring, it is highly unlikely there was snow melting on the ground or even snow floating down the river after May 10, 1994. Although the Inquiry Panel would not expect the Complainant to recall the weather conditions in Winnipeg in the spring of 1994, the Complainant herself referred to the presence of snow on the day in question during the complaint process, as part of her recollection of the events of that day. It is concerning that the weather records establish that her recollection of that aspect of the day in question is likely not correct.

None of the above-noted aspects of the Complainant's evidence are determinative of any of the important issues in this case. They do not establish that the Complainant was being untruthful in her testimony. Nonetheless, they are factors which the Inquiry Panel has considered in its overall assessment of all of the evidence.

Another portion of the evidence which the Inquiry Panel noted with interest was the Complainant's evidence that she had experienced two other traumas earlier in her life (when she was growing up in her home country) relating to abuse and that she had discussed those traumas with her counsellor in the United States.

Similarly, the Inquiry Panel was mindful of the evidence that Y had referred female patients to Member A, including her niece and sister, after her daughter had told her about her concerns relating to Member A.

Conversely, the evidence of X and Y, relating to their separate conversations with the Complainant with respect to her interactions with Member A and her emotional state at the time, also received thoughtful consideration by the Inquiry Panel.

As noted above, X was a credible witness. As directed by counsel, she did not testify as to what the Complainant told her, only that it was about Member A, and that in the conversation, the Complainant was very upset. X testified that her conversation with the Complainant occurred either in the spring of 1994 or 1995. X's testimony cannot be used to corroborate the truth of the Complainant's allegations against Member A. Nonetheless, the Inquiry Panel must have regard for X's evidence that she was told by the Complainant in either 1994 or 1995 about problematic interactions with Member A, and that the Complainant was frightened and very upset when describing those interactions.

Furthermore, Y's evidence on that issue was substantially similar.

The evidence of X and Y with respect to the Complainant's emotional state when describing her problematic interactions with Member A cannot be determinative of the truth of the Complainant's allegations against him. However, the Inquiry Panel recognizes that it is important evidence which has been given considerable weight by the Inquiry Panel in its deliberations.

The following aspects of Member A's testimony were of significance to the Inquiry Panel:

(i) his answers to questions were simple, direct and non-evasive. His denials of any wrongdoing appeared reasonable and genuine, even when challenged in a skillful cross-examination;

(ii) when challenged with respect to issues relating to the Complainant's treatment (eg: not referring her to a gynaecologist notwithstanding the persistence of issues relating to her menstruation), he provided possible explanations which were logical from a medical perspective, notwithstanding that he had no independent recollection of his treatment of the Complainant;

(iii) Member A's files, charts and records relating to his treatment of the Complainant were unavailable to him as a result of the substantial delay in the Complaint being made to the College. The lack of those records potentially prejudiced Member A's ability to establish that all of the steps he took in relation to the Complainant were medically necessary. Notwithstanding the absence of his records, and his lack of any independent recollection of his treatment of the Complainant, Member A responded reasonably to questions put to him in cross-examination relating to the frequency and the nature of the Complainant's attendances upon him as a patient;

(iv) the organization of Member A's practice, particularly at the current location from the fall of 1992 onwards and the presence of his wife at the office as Office Manager, and her significant role in making the Complainant's appointments, are inconsistent with Member A being predatory in his behaviour toward the Complainant and of him taking advantage of the Complainant on a regular basis over an extended period of time;

(v) the Complainant's lack of recollection of the security protocol in place for Saturday visits to Member A's office, as that protocol was described by both Member A and Z, was surprising, particularly given the Complainant's evidence that she had attended at the office on a previous occasion on a Saturday;

None of the above-noted elements of Member A's evidence, either alone, or in combination with each other, are determinative of the truth of Member A's denials. Nonetheless, they are factors which the Inquiry Panel has considered and afforded some weight in its deliberations.

In undertaking its review of all of the evidence in these proceedings, the Inquiry Panel has been very cognizant of:

(i) the Supreme Court's comments at paragraph 40 of the *McDougall* decision that "context is all important and a judge should not be unmindful, where appropriate, of inherent probabilities or improbabilities or the seriousness of the allegations or consequences";

(ii) the Supreme Court's comments at paragraph 46 of the *McDougall* decision that evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test;

(iii) the comments of O'Neil J. in *Olegario v Cabaraban* quoted with approval in *The College*

of Physicians & Surgeons of Ontario v Beitel, referred to earlier in these Reasons, to the effect that the issue in a civil proceeding is not which of two competing versions of a series of events is true, but whether "on the totality of the evidence, viewed as a whole, has the plaintiff proved her case on the balance of probabilities".

Having regard to:

(a) the significant contradictions in the evidence between the Complainant and Member A and the conflicting and competing considerations noted elsewhere in these Reasons;

(b) the significant passage of time between the occurrences alleged in the Amended Notice of Inquiry and the hearing before this Panel and the negative effect of the passage of time on the overall quality of the evidence;

(c) the seriousness of the allegations which have been made against Member A;

the Inquiry Panel is simply unable to conclude that it is more probable than not that Member A made the comments and committed the acts which are alleged in the Amended Notice of Inquiry.

The College has therefore not proven the case against Member A on the balance of probabilities. As a result, the decision of this Inquiry Panel is that the charges and the allegations set forth in the Amended Notice of Inquiry must be dismissed.

DECISION

The charges against Member A of professional misconduct, of contravening Article 2 of the Code of Conduct of the College and of having demonstrated an unfitness to practice medicine as set forth in the Amended Notice of Inquiry and all of the allegations contained in the Amended Notice of Inquiry are dismissed.

RESOLUTION AND ORDER OF AN INQUIRY PANEL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

WHEREAS Member A, a member of the College of Physicians and Surgeons of Manitoba (the College) was charged with professional misconduct, and with contravening Article 2 of the Code of Conduct of the College, and with demonstrating an unfitness to practice medicine, as more particularly outlined in an Amended Notice of Inquiry dated December 14, 2011.

AND WHEREAS Member A was summoned and appeared represented by counsel before an Inquiry Panel (the Panel) of the College at a hearing conducted on June 2, 3 and 5, 2014, which hearing was also attended by counsel for the Investigation Committee of the College;

AND WHEREAS Member A entered a plea of not guilty to all of the charges outlined in the Amended Notice of Inquiry;

ON HEARING THE EVIDENCE that was introduced at the hearing and on reviewing all of the exhibits filed at the hearing and on hearing submissions from counsel for the Investigation Committee of the College and counsel for Member A,

THE INQUIRY PANEL HEREBY ORDERS THAT:

1. Pursuant to Subsection 56(3) of *The Medical Act RSM,* the identities of the Complainant and of other third parties referred to in these proceedings, shall be protected in the record of these proceedings by referring to them in a non-identifying manner.

2. The charges against Member A of professional misconduct, of contravening Article 2 of the Code of Conduct of the College and of having demonstrated an unfitness to practice medicine as set forth in the Amended Notice of Inquiry and all of the allegations against Member A contained in the Amended Notice of Inquiry are dismissed.

DATED this 22nd day of September, 2014.

CENSURE: IC2402
DR. EMMETT JOSEPH ELVES

On November 7, 2014, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Elves as a record of its disapproval of the deficiencies in his conduct. Censure creates a disciplinary record which may be considered in the future by the Investigation Committee or an Inquiry Panel when determining the action to be taken following an investigation or hearing.

I. PREAMBLE

The Code of Conduct states:

> Recognize your limitations and the competence of others and when indicated, recommend that additional opinions and services be sought.

When a patient's medical condition is outside the physician's experience or expertise, the physician must recognize that fact and consult with a colleague who has expertise in the field and, when warranted, transfer the patient's care to a colleague with the required expertise. Such consultation must occur in a timely way to avoid the risk of patient harm.

II. THE RELEVANT FACTS ARE:

1. At all material times, Dr. Elves practised as a pediatrician in Brandon, Manitoba.

2. X was born at 0330 on February 21, 2014.

3. Dr. Elves was called to attend X on February 21, 2014, as there was meconium at delivery and initial major depression, with an Apgar of 1 at 1 minute.

4. Dr. Elves treated X with initial intubation resuscitation and then fluid resuscitation. Saline bolus did improve X's metabolic status.

5. At about 5 hours of age, X developed hematochezia, although his vital signs remained stable. Dr. Elves ordered an abdominal x-ray and a CBC.

6. Dr. Elves reviewed the x-ray with a radiologist. The x-ray showed no gas past the stomach. Dr. Elves' interpretation of the x-ray was that it showed signs of a higher bowel obstruction. Dr. Elves' differential diagnosis included obstruction such as atresia or obstruction for reasons of functional impairment. Dr. Elves' plan was to monitor the vitals, the obstruction and any changes in the status.

7. Dr. Elves continued to monitor X on February 21, 2014. The record documents that Dr. Elves last examined X at 19:07 on February 21, 2014.

8. Another physician assumed X's care at approximately 20:00 on February 21, 2014. That physician documented a telephone consultation with a neonatologist at 20:30 on February 21, 2014. Thereafter, X was transferred to Winnipeg.

9. X had intestinal malrotation with volvulus. By the time X arrived in Winnipeg, X had complete and irreversible intestinal necrosis and died at day four.

9. In Dr. Elves' response to concerns about his care of X, he stated that:

   (a) he had never seen a mid-gut volvulus before and in his experience a volvulus would present with vomiting, which X did not have.

   (b) in retrospect, although he believed the obstruction was functional, he ought to have called the NICU and further investigated the cause of the obstruction.

   (c) he regrets his delay in referral.

11. Timely diagnosis of the intestinal malrotation with volvulus may have resulted in a greater chance of salvaging X's bowel.

12. On or about May 4, 2011, Dr. Elves saw Y, born on February 7, 2011, on referral for jaundice. The referring physician reported that bilirubin and liver enzyme results were high. In Dr. Elves' report to the referring physician, he documented that stool was occasionally yellow but a lot whitish, and that the liver did not feel enlarged but that there was possibly a palpable gallbladder, so an urgent ultrasound of liver, gallbladder and bile ducts was ordered. Dr. Elves noted his concerns as being whether there was a choledochal cyst causing obstruction or some degree of problem with the biliary tree. Dr. Elves ordered repeat liver enzymes and bilirubin.

13. Dr. Elves transferred care of Y back to the referring physician after his May 4, 2011 assessment.

14. The ultrasound of May 19th was reported as normal. The liver enzymes and bilirubin test results continued to be abnormally high.

15. On June 28, 2011, after reviewing the ultrasound report, Dr. Elves spoke with Y's father, who reported that Y's colour was improving. Dr. Elves advised Y's father to return to the referring physician for repeat bloodwork.

16. Dr. Elves next saw Y on September 28, 2011. He noted that she had normal bowel movements, yellow in colour and that she was obviously jaundiced with scleral icterus. Dr. Elves' examination revealed some liver enlargement and a distended belly. Dr. Elves ordered a hepatic panel and an urgent ultrasound. Dr. Elves' advice documented was "congenital jaundice, previously cholestatic pattern with no definite diagnosis and liver enlargement." Dr. Elves planned to follow Y for her liver issues.

17. The ultrasound done on October 13, 2011 did not show abnormality; however, Y's biochemical profile continued to be abnormal.

18. On November 2, 2011, Dr. Elves saw Y and noted increased distention. He noted that Y needed a biopsy and a liver scan and that he attempted to contact the pediatric gastroenterology service by telephone on November 2, 2011 and afterwards, but was unsuccessful.

19. Another physician saw Y on November 10, 2011 for respiratory concerns, and referred Y to Winnipeg for further investigations.
20. In Winnipeg, Y was described as so jaundiced that she was literally green in colour, with florid cirrhosis and portal hypertension. The pediatric gastroenterologist made a provisional diagnosis of biliary artresia, for which bile duct surgery (Kasai procedure) by 2-3 months of age is the recommended treatment. However, Y was so ill that she was immediately transferred to Toronto where she was listed for life-saving liver transplantation.

21. In Dr. Elves' response to concerns about his care of Y, he acknowledged that an ultrasound has limited sensitivity in this type of case. Dr. Elves further acknowledged that his follow-up plan should have been more explicit rather than relying upon the parents to monitor Y. Dr. Elves stated that since this case he has had a lower threshold for investigating jaundice in infancy, including an earlier consultation to gastroenterology and other diagnostic modalities (such as HIDA scans, which are more sensitive for biliary atresia).
22. Timely diagnosis of biliary atresia may have avoided the necessity of Y's liver transplant.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. ELVES' CONDUCT IN not meeting his professional responsibility to recognize his limitations and the competence of others and, given his limited experience with intestinal malrotation with volvulus and with biliary atresia, not promptly consulting colleagues for assistance and/or referring X and Y for care.

Dr. Elves paid the costs of the investigation in the amount of $2,472.50.

Moving? Retiring?

If you are leaving the province or retiring from practice, By-law #1 requires that you advise the College where your records will be stored. This is so we can make note of it on your file to advise interested parties.

Need Assistance?

PHYSICIANS AT RISK

Phone 204-237-8320 (24 hours)

Practice Address

It is important that if you are changing your practice location you must notify the College immediately so your Physician Profile can be updated and current. You can email your change of location to cpsm@cpsm.mb.ca.