Citation: Dhalla v College of Physicians and Surgeons of Manitoba, 2022 MBCA 7
Date: 20220125
Docket: AI20-30-09520

IN THE COURT OF APPEAL OF MANITOBA

Coram: Madam Justice Diana M. Cameron
Madam Justice Jennifer A. Pfuetzner
Madam Justice Lori T. Spivak

BETWEEN:

DR. SONNY SUREJ DHALLA	)	***D. G. Hill***
	)	*for the Appellant*
Appellant	)	
	)	***J. D. de Jong***
- and -	)	*for the Respondent*
	)	
THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA	)	*Appeal heard:* ***August 25, 2021***
	)	
Respondent	)	*Judgment delivered:* ***January 25, 2022***

CAMERON JA

Introduction

[1] Following a hearing, a panel (the panel) of the Inquiry Committee of the respondent (the College), found that the appellant had committed acts of professional misconduct and contravened article 9 of the Code of Conduct, Schedule G to By-Law 1 of the College (the Code) by failing to ensure continuity of care for a patient (the patient) and by failing to provide appropriate assistance in circumstances where he remained responsible for the patient (charge 1(c)). In addition, the appellant pled guilty to a charge of contravening article 24.1 of By-Law 1 of the College by failing to adequately

document his involvement in the care and management of the patient in the medical record (charge 2) (together, the merits decision).

[2] After conducting a hearing regarding the orders to be issued by the panel pursuant to section 59.6(1) of *The Medical Act*, CCSM c M90 (the *Act*), as repealed by *The Regulated Health Professions Act*, SM 2009, c 15, section 261 on January 1, 2019, the panel ordered that the appellant be reprimanded and his licence to practice medicine be suspended for two months (the penalty decision).

[3] A further hearing to determine costs resulted in the panel ordering that the appellant pay costs in the amount of $85,000 as a contribution to the costs of the investigation and hearing of the charges pursuant to section 59.7 of the *Act* (the costs decision).

[4] Pursuant to his statutory right to appeal provided for in section 59.10 of the *Act*, the appellant appeals the portion of the penalty decision which suspended his licence, as well as the costs decision.

[5] The sections of the *Act* referred to herein are appended to these reasons.

[6] For the reasons that follow, I would dismiss the appellant's appeal with respect to both the penalty and costs decisions.

Background

[7] In the merits decision, the panel provided a detailed description of the evidence, diagnosis and medical procedures involved in the treatment of

the patient. The following is a brief summary of those findings that are necessary to understand the panel's subsequent decisions.

[8] The appellant was the physician on call at the Brandon Regional Health Centre's Emergency Department in Brandon, Manitoba on November 5, 2015 when the patient was admitted to the hospital. He was the physician most responsible for the patient's care from November 5, 2015 until November 12, 2015, during which time the events that formed the basis for the notice of inquiry against him occurred. All future references to dates herein refer to the year 2015.

[9] At the time of admission, the appellant diagnosed the patient with a gastric volvulus. The treatment plan included an endoscopy procedure to reduce the volvulus, which he performed on November 9. As expected, it was not successful in completely reducing the volvulus.

[10] Following the endoscopy procedure, the appellant's plan was for the patient to be stabilized and then to perform a surgical reduction of the volvulus. However, after having been contacted to return to care for the patient shortly after the endoscopy due to complications, he diagnosed the patient with further conditions, a number of which he treated. The appellant also called in Dr. X, the Intensive Care Unit (ICU) attending physician, who determined that the patient needed to be intubated emergently. Dr. X agreed to have the patient admitted to the ICU.

[11] Over the course of the night, the patient's condition deteriorated and, at 1:30 a.m. on November 10, the appellant performed surgery on the patient to repair a previously diagnosed perforation of the stomach and to untwist the gastric volvulus. However, in view of the severe instability of the patient, the

appellant decided not to close the abdominal wound. Instead, he used VAC ABThera (VAC) dressing to manage the open incision.

[12] The panel noted that, during the above surgical procedure, a swab was taken which was "positive for various microbes capable of establishing infection." It stated that it relied on this fact in asserting that the patient "had likely experienced a significant spillage of gastric contents."

[13] After the surgery, the patient remained unstable. He was returned to the ICU where Dr. X described him as being in a state of "extremis" and profound Systemic Inflammatory Response Syndrome and likely septic shock.

[14] Of import, the patient experienced significant continued bleeding after the surgery and required ongoing blood transfusions during the remainder of that day.

[15] Later in the day, the appellant assessed the patient and decided that it was neither necessary nor advisable to return him to the operating room.

[16] At approximately 10:45 p.m. on November 10, Dr. X called Dr. Mohamed, who was covering for the appellant on November 11, to express concern about the patient's ongoing blood loss. In the morning of November 11, Dr. Mohamed conducted a gastroscopy and recommended continuing with medical treatment.

[17] At 7:30 p.m. on November 11, Dr. X contacted the appellant regarding concerns about the ongoing blood loss. In reply, the appellant provided Dr. X advice with respect to VAC pressure monitoring.

[18] In response to concerns about the continued massive bleeding, in the early morning hours of November 12, Dr. Mohamed performed a further exploratory procedure wherein he noted that there was bleeding coming from the abdomen. After that procedure, he reattached the VAC dressing. His expectation was that the appellant would conduct a follow-up surgery to address the bleeding.

[19] The patient continued to bleed, requiring transfusion of one unit of blood per hour. Blood product availability was becoming a concern.

[20] When the appellant arrived in the ICU at 8:30 a.m. on November 12, he declined Dr. X's request that he defer another patient's Whipple procedure, which he had scheduled for that day, and attend to the patient. Instead, he provided Dr. X with advice regarding pressure monitoring and manipulation of the VAC dressing.

[21] According to the panel, a Whipple procedure is usually elective, but is also complex and takes a significant amount of time, usually about six hours.

[22] Dr. X spoke to Dr. Chaudry, who determined that the patient required surgery for the ongoing bleeding. Dr. Chaudry went to the operating room where the appellant was performing the Whipple procedure and told the appellant that the patient required immediate surgery for the ongoing bleeding. The appellant told him to contact Dr. Goossen to perform the surgery. Dr. Goossen, assisted by another doctor, performed the surgery. The operative report indicated that adequate control of the intra-abdominal bleeding was achieved.

[23] Unfortunately, the patient continued to experience the grave effects of multi-organ failure and died on November 20.

The Merits Decision

[24] While the appellant does not appeal the merits decision, I will review it as it formed the basis for the panel's subsequent decisions regarding penalty and costs.

[25] The notice of inquiry against the appellant contained two charges. As previously explained, the appellant pled guilty to charge 2. He contested charge 1. Charge 1 consisted of a general allegation that the appellant, in his overall treatment and management of the patient, displayed a lack of knowledge, skill and judgment in the practice of medicine and contravened specific articles in the Code. In particular, charge 1 alleged three specific acts of professional misconduct described in charges 1(a)-1(c).

[26] The panel found that charges 1(a) and 1(b) had not been proven. It found the appellant guilty of charge 1(c).

[27] In reaching its conclusion, the panel found that the appellant did not properly address the significant bleeding, which occurred immediately after the November 10 surgery and continued throughout November 10 and 11.

[28] It further held that the massive continuous bleeding, even after Dr. Mohamed's interventions on November 12, required "an immediate re-exploration to identify, and if possible, control any surgically correctable bleeding source."

[29] The panel held that the appellant's advice to Dr. X at 8:30 a.m. on November 12 to reduce the pressure on the VAC dressing was "inappropriate and ineffectual" and that the application of the VAC dressing in the presence of active bleeding was "contra-indicated." Furthermore, it stated that his advice to reduce the VAC pressure was "more indicative of a reluctance to operate without valid reason, rather than a genuine attempt to care for a seriously ill patient."

[30] The panel concluded that the surgery performed by Dr. Goossen should have been undertaken much sooner. It stated that, by the early morning of November 12, there was "no doubt that immediate surgical intervention was required." It added that it was "very arguable that immediate surgical intervention was required from late in the morning on November 10 . . . and continuously thereafter."

[31] After making the above findings, the panel stated that the appellant's decision to proceed with an elective Whipple procedure on a different patient was "deeply troubling" as it made him effectively unavailable to attend to the patient or assist other physicians who were doing so for a significant period of time. It noted that he did not take any active steps to have another surgeon operate on the patient until confronted in the operating room by Dr. Chaudry. The panel further stated that, if the appellant was not intending to operate on the patient, "he should have made much more detailed and thorough arrangements for another surgeon to be available to do so, and those arrangements should have been made far earlier than occurred in this case."

[32] After considering all of the evidence, the panel concluded that the appellant had contravened article 9 of the Code in that he failed to provide

appropriate assistance to the patient who was in urgent need of medical care. It also held that, when assessed against the "standard of other surgeons possessing a reasonable level of knowledge, competence and skill expected of surgeons in this jurisdiction", the appellant's conduct and behaviour fell significantly short of that standard. The panel found him guilty of professional misconduct as outlined in charge 1(c).

The Penalty Decision

[33] At the hearing for the determination of which order(s) should be issued pursuant to section 59.6(1) of the *Act*, the panel had the benefit of an impact statement from the patient's family, additional evidence from the appellant and written and oral submissions from the parties.

[34] As well, the appellant entered into an undertaking, which imposed conditions on his practice, that was filed at the hearing and endorsed by the panel.

[35] The College submitted that the panel should reprimand the appellant and suspend his licence to practice medicine for a period of not less than five months. The appellant submitted that the only order necessary was a reprimand.

[36] The panel imposed a reprimand and a two-month suspension. It stated that the order was required to "punish [the appellant], to achieve the objectives of specific and general deterrence, to maintain the standards of the profession and to preserve the public's faith in the medical profession's ability to govern itself". It also stated that the penalty was consistent with the principles of proportionality and consistency.

The Costs Decision

[37] The panel held an additional hearing pursuant to section 59.7 of the *Act* to determine costs after it had made its penalty decision.

[38] The appellant submitted that he should pay only $17,000 in costs, which was the approximate cost of the investigation. Alternatively, he argued that he should pay less than $50,500 in costs representing less than 30% of the College's total costs. The College submitted that the appellant should pay $134,699 in costs representing 80% of the total costs of the proceedings.

[39] The panel ordered costs in the amount of $85,000.

Grounds of Appeal

[40] The appellant argues that the panel erred in ordering that he serve a two-month suspension in addition to the reprimand. In this regard, he asserts that the panel placed too much weight on the principles of specific and general deterrence and that it failed to give the appropriate weight to the severity of a reprimand and authorities where censure had been deemed appropriate.

[41] Regarding costs, the appellant originally alleged that the panel erred when it refused his request to admit into evidence, at the costs hearing, documents concerning settlement communications that he had engaged in with the College prior to the hearing of the misconduct charges. However, at the appeal hearing, he indicated that he was no longer pursuing this ground, and I need not address it further.

[42] Thus, his sole ground of appeal regarding the costs order of $85,000 is that the quantum was disproportionate or unfit.

Did the Panel Err in Suspending the Appellant's Licence to Practice Medicine for Two Months?

Standard of Review

The Positions of the Parties

[43] The appellant notes that, in *Canada (Minister of Citizenship and Immigration) v Vavilov*, 2019 SCC 65, the Supreme Court of Canada held that, where a legislature has provided for an appeal from an administrative decision to a court, the appellate standards of review are applied and the applicable standard is to be determined by the nature of the question (see paras 36-37).

[44] Adopting the standards set out in *Housen v Nikolaisen*, 2002 SCC 33, he submits that the alleged errors are questions of mixed fact and law to be reviewed on the standard of palpable and overriding error.

[45] The College states that the issues of whether the panel erred in placing too much weight on the principles of specific and general deterrence and in failing to give the appropriate weight to the severity of a reprimand in determining the penalty are questions of mixed fact and law.

[46] Nonetheless, it argues that the standard of review for a sentence in a criminal matter—whether an error in principle had occurred or the sentence is demonstrably unfit—applies to the review of penalty in the professional regulatory context. In this regard, the College asserts that the criminal

standard, which allows for appellate intervention only where a sentence is demonstrably unfit is, in substance, a pragmatic reformulation of the standard of palpable and overriding error.

Analysis

The Civil Standards of Review

[47] This is a statutory appeal pursuant to section 59.10 of the *Act*. In *Vavilov*, the Supreme Court specified (at para 37):

> It should therefore be recognized that, where the legislature has provided for an appeal from an administrative decision to a court, a court hearing such an appeal is to apply appellate standards of review to the decision. This means that the applicable standard is to be determined with reference to the nature of the question and to this Court's jurisprudence on appellate standards of review. Where, for example, a court is hearing an appeal from an administrative decision, it would, in considering questions of law, including questions of statutory interpretation and those concerning the scope of a decision maker's authority, apply the standard of correctness in accordance with [*Housen*] at para. 8. Where the scope of the statutory appeal includes questions of fact, the appellate standard of review for those questions is palpable and overriding error (as it is for questions of mixed fact and law where the legal principle is not readily extricable): see *Housen*, at paras. 10, 19 and 26-37. . . .

[48] Recently, in *Hydro-Québec v Matta*, 2020 SCC 37, the Supreme Court explained (at para 33):

> . . . An error is *palpable* if it is plainly seen and if all the evidence need not be reconsidered in order to identify it, and is *overriding* if it has affected the result: *H.L. v. Canada (Attorney General)*, 2005 SCC 25, [2005] 1 S.C.R. 401, at paras. 55-56 and 69-70;

> *Salomon v. Matte-Thompson*, 2019 SCC 14, [2019] 1 S.C.R. 729, at para. 33. . . .

[49] Aside from the civil standards described in *Housen*, there are decisions that are discretionary in nature. These decisions often involve questions of law, of mixed fact and law and/or of fact, the review of which will engage several standards. The various factors are then weighed and balanced and judicial experience and expertise are applied to them in reaching a conclusion. In *Perth Services Ltd v Quinton et al*, 2009 MBCA 81 (*Perth Services*), Freedman JA explained (at para 28):

> The standard for intervention in a discretionary decision is very high. It is not enough that the appellate judges think the trial (or motions) judge simply reached a wrong result; there rarely is, in truly discretionary matters, a "right" or "wrong" result. It is not enough that the appellate judges would have decided differently; they are to respect, and not replicate, the unique role of trial judges. . . .
>
> [emphasis added]

[50] As recently reaffirmed by this Court in *CIBC v Ahmed*, 2021 MBCA 25 (*Ahmed*), "Appellate review of a discretionary decision calls for deference absent error in principle or palpable and overriding error of fact, or unless the decision is so clearly wrong as to yield an unjust result" (at para 4) (the deferential standard).

Penalty Standards of Review

[51] Pre-*Vavilov*, penalty decisions of professional disciplinary bodies were reviewed on the standard of reasonableness. That is, the question was

whether the penalty imposed fell within "a range of possible and acceptable outcomes" (*Kuny v College of Registered Nurses of Manitoba*, 2018 MBCA 21 at para 6; see also *Dunsmuir v New Brunswick*, 2008 SCC 9 at para 47).

[52] In *Law Society of New Brunswick v Ryan*, 2003 SCC 20, the Supreme Court explained that the foundations for the choice of the reasonableness standard for the review of disciplinary penalties rest, in part, on the basis that "the Discipline Committee has a broad discretion in respect of the sanctions it may apply" (at para 38), and because the penalty decision involves "a balancing exercise [that] require[s] the Discipline Committee to choose among a range of remedial choices" (at para 39), and is "a question of mixed fact and law since it involves the application of general principles of the Act [*Law Society Act*, 1996, SNB 1996, c 89] to specific circumstances." (at para 41)

[53] Also see *Hunter v College of Physicians & Surgeons of Alberta*, 2014 ABCA 262 at para 5; *Fashoranti v College of Physicians and Surgeons of Nova Scotia*, 2015 NSCA 25 at para 31; *The Law Society of Manitoba v Alghoul*, 2018 MBCA 23 at para 21; and *College of Physicians and Surgeons of Ontario v Peirovy*, 2018 ONCA 420 at paras 55, 74 (*Peirovy*), regarding the broad discretion of a disciplinary body over decisions regarding penalty.

[54] Post-*Vavilov*, some courts have continued to apply the reasonableness standard to decisions involving both penalty and costs. See, for example, *Zuk v Alberta Dental Association and College*, 2020 ABCA 162 at para 15; and *Essa v APEGA*, 2021 ABCA 116 at para 22. On other occasions, the question of penalty has been reviewed on the *Housen* standard of palpable and overriding error (see *Zuk* at para 44).

[55] In Manitoba, the reasonableness standard was applied to a penalty decision in the professional disciplinary context in *Hancock v College of Registered Nurses of Manitoba*, 2021 MBCA 20 at paras 28 and 60. However, the substance of that case was not about the standard of review of penalty decisions and, therefore, it applied the pre-*Vavilov* standard of review, set out in *Kuny*, without consideration of the impact of *Vavilov* on the standard of review of penalty decisions.

[56] In Ontario, pre-*Vavilov*, penalties imposed by professional disciplinary bodies were reviewed on the standard of reasonableness. However, in describing that standard, courts in Ontario have used terms such as "error in principle" and "demonstrably unfit" or "clearly unfit", thus importing the language from the standard of review of sentences in the criminal context (see, for example, *Reid v College of Chiropractors of Ontario*, 2016 ONSC 1041 at para 99; and *Peirovy* at para 56). A demonstrably unfit sentence has been described as one that is "clearly unreasonable" (*R v Lacasse*, 2015 SCC 64 at para 40).

[57] The use of the above language has continued in a number of post-*Vavilov* cases in Ontario (see, for example, *Mitelman v College of Veterinarians of Ontario*, 2020 ONSC 6171 at para 35; *Shah v College of Physiotherapists of Ontario*, 2020 ONSC 6240 at para 4; and *Dr Jonathan Mitelman v College of Veterinarians of Ontario*, 2020 ONSC 3039 at para 18).

[58] In Manitoba, pre-*Vavilov*, this Court, unlike in Ontario, did not adopt the language of the criminal standard of review for sentences when

applying the standard of reasonableness in the realm of professional disciplinary matters.

[59] As earlier stated, historically, decisions concerning penalty have been considered to be discretionary decisions. That is, they involve a number of considerations, including issues of law, fact and mixed fact and law. The final decision involves a balancing exercise requiring the College to choose among a range of remedial choices. Thus, the civil deferential standard would apply post-*Vavilov*.

Are the Standards of Review Equivalent?

[60] The College argues that the standards of "palpable and overriding error", "demonstrably unfit", "clearly unreasonable" and "so clearly wrong as to amount to an injustice" are all pragmatic reformulations of the same test. I agree that, in some cases, the language describing standards of review appears to be used interchangeably. For example, in *HL v Canada (Attorney General)*, 2005 SCC 25, Fish J described a palpable and overriding error (at para 55):

> "Palpable and overriding error" is at once an elegant and expressive description of the entrenched and generally applicable standard of appellate review of the findings of fact at trial. But it should not be thought to displace alternative formulations of the governing standard. In *Housen*, for example, the majority (at para. 22) and the minority (at para. 103) agreed that inferences of fact at trial may be set aside on appeal if they are "clearly wrong". Both expressions encapsulate the same principle: an appellate court will not interfere with the trial judge's findings of fact unless it can plainly identify the imputed error, and that error is shown to have affected the result.
>
> [emphasis added]

[61] In addition, he stated that, "clearly wrong" and "unreasonable" are the "functional equivalents" of palpable and overriding error (at para 110).

[62] Despite being seemingly interchangeable, the above language does not indicate that the standard of palpable and overriding error and the deferential standard are no longer distinct. In my view, Fish J was simply using the above language to demonstrate the principle that appellate intervention in a finding of fact at trial is only justified where an obvious error is found that affected the result.

[63] The application of the palpable and overriding standard to a decision that traditionally would attract the deferential standard was considered in the post-*Housen*, but pre-*Vavilov* case of *Hospira Healthcare Corporation v Kennedy Institute of Rheumatology*, 2016 FCA 215 (*Hospira*). In that case, the Federal Court of Appeal, sitting as a panel of five, considered the deferential standard and whether there was any reason to distinguish that standard when discretionary decisions were made by prothonotaries (some of which were reviewed *de novo*) as opposed to motions judges. Overruling its previous jurisprudence, the Court determined that the standard of palpable and overriding error in *Housen* should now apply to all discretionary decisions made by both prothonotaries and judges (see paras 69, 72).

[64] In reaching the above conclusion, the Court stated that it was "entirely satisfied" (at para 67) that, in *Housen,* the Supreme Court did not intend to apply the standard of palpable and overriding error to discretionary decisions. Nonetheless, while recognizing that the Supreme Court continued to apply the deferential standard to discretionary decisions, the Court held

that, "notwithstanding the different language used to convey the ideas behind the standards, [they are], in effect, the same" (at para 68).

[65] As earlier stated, the Federal Court of Appeal sat as a panel of five in that case, as it was considering overturning its previous jurisprudence. Although *Hospira* has been applied by other courts, the issues involved in those cases did not concern the application of the palpable and overriding error standard of review to discretionary decisions (see, for example *Reid v McLennan et al*, 2017 MBQB 200 at para 35; and *Sparks v Holland*, 2019 NSCA 3 at para 10). Otherwise, I am unaware of any courts, other than Federal Courts, that have adopted the determination in *Hospira* that the standard of palpable and overriding error should be applied to all discretionary decisions, nor am I aware of the issue having been considered by the Supreme Court.

[66] In my view, it is important to recall that *Vavilov* is about administrative standards of review. The reasons in *Vavilov* only devote one paragraph to civil standards of review. After stating that civil standards are to be applied in cases where there is a legislated right of appeal, the majority referred to the *Housen* standards as an example of them. *Vavilov* was not intended to constitute an examination or variation of the law governing civil standards of review. Had the Supreme Court intended such a result, it would have clearly stated so. In addition, one would expect that it would have referred to *Hospira*.

[67] In Manitoba, this Court continues to apply the deferential standard described by Freedman JA in *Perth Services* in the review of discretionary decisions made in the civil law context (see, for example, *Ahmed* at para 4;

6486976 Manitoba Ltd v 7344989 Manitoba Ltd, 2021 MBCA 61 at para 6; *Wolfe et al v Taylor et al*, 2021 MBCA 72 at para 26; and *Sagkeeng v Government of Manitoba et al*, 2021 MBCA 88 at para 29).

[68] In the recent professional disciplinary decision in *Histed v Law Society of Manitoba*, 2021 MBCA 70, this Court endorsed the deferential standard of review for discretionary decisions made by an administrative tribunal in the context of a statutory appeal made pursuant to *The Legal Profession Act*, CCSM c L107, of a finding of professional misconduct (see para 38).

[69] Thus, absent direction from the Supreme Court or a duly constituted panel of five members of this Court reconsidering the decision in *Perth Services*, the deferential standard applicable to discretionary decisions made in the civil context should continue to be applied by this Court.

[70] Considering the above, I would decline the College's invitation to introduce the criminal law standard of review on sentencing into civil law matters. Put another way, I am of the view that the distinction should be maintained.

[71] In conclusion, I would apply the civil deferential standard of review to the discretionary decision regarding penalty. That is, absent a misdirection in law or on the facts, an appellate court will not intervene unless the decision on penalty is so wrong as to amount to an injustice.

Analysis on Penalty

[72] The appellant submits that, in ordering that he serve a two-month suspension in addition to a reprimand, the panel erred by (i) giving undue weight to the principles of specific and general deterrence, and (ii) failing to give the appropriate weight to the severity of a reprimand and the authorities that he had provided where censure had been deemed appropriate.

[73] Regarding specific deterrence, he argues that there was no need to emphasize specific deterrence given his unblemished prior history as a competent general surgeon with no record of discipline in the 26 years that he had been practicing.

[74] Regarding general deterrence, he argues that there was no evidence of any prevailing or ongoing issue in the medical community that required deterrence.

[75] In my view, the appellant has not demonstrated that the panel committed either of the above errors.

[76] I agree that a lack of prior discipline history is relevant to the consideration of specific deterrence. However, it is not the only factor to be considered. Here, while the panel considered the appellant's lack of prior disciplinary history, it also relied on the serious and deliberate nature of the conduct in determining the issue of specific deterrence.

[77] As for general deterrence, there is no need for the panel to find an ongoing concern with the conduct in question in order to emphasize this factor.

[78] In considering penalty, the panel reviewed the objectives and purposes of the various orders that it could make. It stated that these include (a) the primary purpose of the protection of the public, (b) the punishment of the physician involved, (c) specific deterrence, (d) general deterrence, (e) preservation of the public trust, (f) the rehabilitation of the physician involved, (g) proportionality of the penalty in light of the specific misconduct, and (h) consistency in sentencing achieved through the imposition of similar penalties for similar conduct.

[79] It also considered (a) the nature of the misconduct and the circumstances in which it occurred, (b) the impact of the misconduct on those affected by it, (c) whether or not the appellant had acknowledged the seriousness of what had occurred, and (d) the presence or absence of mitigating or aggravating circumstances.

[80] In reaching its decision, the panel did consider the mitigating factors applicable to the appellant. Nonetheless, it made substantial findings regarding his misconduct describing it as "deeply troubling" in a number of respects. This included his failure to address the patient's significant bleeding throughout November 10 and 11 and that there was no justification for the delays in returning the patient to the operating room after the surgical intervention on November 12. It found that the appellant's advice on how to deal with the continued bleeding on November 12 was "inappropriate and ineffectual" and was "indicative of a reluctance to operate without valid reason, rather than a genuine attempt to care for a seriously ill patient." Finally, it found his decision to proceed with the elective operation on November 12 was also "deeply troubling", as well as the fact that he had taken

no steps to ensure another surgeon was available to operate on the patient while he was in the elective surgery.

[81] The panel also found that the appellant's decisions were deliberate and conscious, and not the result of a flawed exercise of professional discretion.

[82] Furthermore, in imposing the penalty, the panel considered the authorities filed by both the College and those of the appellant, including the censure cases on which he relied. It found that caution must be used when considering censures, as they are not decisions made by inquiry panels after a full hearing of the evidence. It also found that none of the cases filed by the parties were particularly helpful in the determination of proportionality and consistency.

[83] In light of the above, the panel found that a reprimand would not represent adequate punishment or achieve the objectives of specific and general deterrence. To achieve those goals, as well as to maintain the standards and preserve the public's faith in the medical profession, it held that a suspension was also required. It imposed a penalty approximately mid-range of that suggested by the parties.

[84] To summarize, the panel considered and balanced the objectives of imposing the penalty decision, the mitigating factors, the serious nature of the facts of this case and the authorities submitted by the parties. I have not been persuaded that the panel committed an error in principle or that its decision is so clearly wrong as to yield an unjust result, and I would dismiss this ground of appeal.

Did the Panel Err in Imposing the Costs Decision?

[85] Section 59.7(1)(a) of the *Act* provided the authority for the panel to order "all or part of the costs of the investigation and hearing".

[86] As earlier stated, before the panel, the College argued that the appellant should pay $134,699 in costs. The appellant argued that he should only pay $17,000 representing the costs of the investigation. Alternatively, he argued that he should pay no more than $50,500 representing less than 30% of the College's total costs.

[87] The appellant argues that the costs decision of $85,000 was disproportionate. In support of his position, he asserts that costs should not be punitive in nature.

[88] Consistent with my reasoning that the appropriate standard of review for a discretionary decision made by an administrative body is the traditional civil standard, I would apply the civil standard of review to the panel's costs decision. This standard is highly deferential. In *Hamilton v Open Window Bakery Ltd*, 2004 SCC 9, the Supreme Court stated, "A court should set aside a costs award on appeal only if the trial judge has made an error in principle or if the costs award is plainly wrong" (at para 27). Also see *The Law Society of Manitoba v Kalo*, 2020 MBCA 37 at para 6; and *Carlson v Dunn et al*, 2020 MBCA 85 at para 13.

[89] In reaching its conclusion, the panel noted that the appellant had successfully defended two of the allegations contained in charge 1. It also stated that costs in the amount that the College requested could be regarded as punitive.

[90] On the other hand, it stated that it was fair and reasonable that the appellant pay $85,000, as such an order reflected (a) his responsibility for the inadequate documentation which adversely impacted the investigation of the matters and the conduct of the hearing itself, (b) his responsibility for the $17,000 investigation costs, and (c) the nature and extent of the proven versus unproven allegations. Regarding the last point, the panel noted that, in order to assess the successful charge against the appellant, the panel required evidence in relation to the entire period between November 9 and 12.

[91] In my view, the panel carefully considered and weighed the issue of costs. I am not persuaded that it committed a reviewable error, and I would dismiss this ground of appeal.

[92] In the result, the appeal is dismissed with costs.

_____ JA

I agree: _____ JA

I agree: _____ JA

APPENDIX

Relevant provisions of *The Medical Act*, CCSM c M90, as repealed by *The Regulated Health Professions Act*, SM 2009, c15, section 261:

Orders of panel

59.6(1) If the panel makes any of the findings described in section 59.5, it may make one or more of the following orders:

(a) reprimand the member

(b) suspend the member's licence for a period of time that the panel determines appropriate;

(c) suspend the member's licence until he or she has completed a specified course of studies or obtained supervised clinical experience, or both, to the satisfaction of any person or committee that the panel may determine;

(d) suspend the member's licence until the member has obtained treatment or counselling and has demonstrated that any disability, addiction or problem can be or has been overcome to the satisfaction of any person or committee that the panel may determine;

(e) impose conditions on the member's entitlement to practice medicine, including conditions that the member

(i) limit his or her practice,

(ii) practise under supervision,

(iii) not engage in sole practice,

(iv) permit periodic inspections of his or her practice,

(v) permit periodic audit of records,

(vi) report to the investigation committee, the registrar or the executive committee on a specific matter,

(vii) complete a particular course of studies or obtain supervised clinical experience, or both, to the satisfaction of any person or committee that the panel may determine,

(viii) obtain treatment for a disability or addiction or undertake counselling until such time as the person can demonstrate that a disability, addiction or problem can be or has been overcome to the satisfaction of any person or committee that the panel may determine;

(f) direct the member to waive money owed, or refund money paid, to him or her that, in the opinion of the panel, was unjustified for any reason; or

(g) cancel one or both of the member's registration and licence.

Costs and fines
59.7(1) A panel may, in addition to or instead of dealing with the conduct of the member in accordance with section 59.6, order that the member pay to the college

(a) all or part of the costs of the investigation and hearing;

(b) a fine not exceeding $10,000.; or

(c) both the costs under clause (a) and a fine under clause (b);

within the time set by the order.

Nature of costs
59.7(2) The costs referred to in subsection (1) may include, but are not limited to,

(a) all disbursements incurred by the college, including

(i) fees and expenses for experts, investigators and auditors whose reports or attendances were reasonably necessary for the investigation or hearing,

(ii) travel costs and reasonable expenses of any witnesses required to appear at the hearing,

(iii) fees for retaining a reporter and preparing transcripts of proceedings,

(iv) costs of service of documents, long distance telephone and facsimile charges, courier delivery charges and similar miscellaneous expenses;

(b) payments made to members of the panel or the investigation committee; and

(c) costs incurred by the college in providing counsel for the college and the panel, whether or not counsel is employed by the college.

Failure to pay costs and fines by time ordered
59.7(3) If the member is ordered to pay a fine or costs or both under subsection (1) and fails to pay within the time ordered, the registrar may immediately suspend the member's licence until the fine or costs are paid.

Filing of order to pay costs
59.7(4) The college may file an order under subsection (1) in the court, and on the order being filed it may be enforced in the same manner as a judgment of the court.

APPEAL TO COURT OF APPEAL

Appeal to Court of Appeal
59.10(1) A member in respect of whom a finding or order is made by a panel under section 59.5, 59.6 or 59.7 may appeal the finding or order to The Court of Appeal.

Commencement of appeal
59.10(2) An appeal shall be commenced

(a) by filing a notice of appeal; and

(b) by serving a copy of the notice of appeal on the college;

within 30 days after the date on which the decision and any order of the panel is served on the member.

Appeal on record
59.10(3) An appeal shall be founded on the record of the hearing before the panel and any exhibits.