IN THE MATTER OF:	THE MEDICAL ACT, C.C.S.M. c**.** M90
AND IN THE MATTER OF:	Dr. SONNY SUREJ DHALLA**,** a member of the College of Physicians and Surgeons of Manitoba
AND IN THE MATTER OF:	A Notice of Inquiry dated December 7, 2018

INQUIRY PANEL:

Dr. Alex Vajcner, Chairperson

Dr. Brent Anderson

Sandra Benavidez, Public Representative

REASONS FOR DECISION OF AN INQUIRY PANEL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA RE ORDERS UNDER S. 59.6 OF THE MEDICAL ACT

COUNSEL FOR THE INVESTIGATION COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

Jeremy de Jong

Lynne Arnason

COUNSEL FOR THE MEMBER, DR. SONNY SUREJ DHALLA

Nicole Watson

Todd Campbell

COUNSEL FOR THE INQUIRY PANEL

Blair Graham, Q.C.

REASONS FOR DECISION OF THE INQUIRY PANEL

INTRODUCTION

On May 6th, 2020, following a hearing which took place over a seven day period in September 2019 (and the subsequent receipt of extensive written and oral submissions from the parties), this Inquiry Panel (the "Panel") issued a Resolution and Order and Reasons for Decision in these proceedings. Pursuant to that Resolution and Order, Dr. Dhalla was found guilty of committing acts of professional misconduct and of contravening Article 9 of the Code of Conduct of the College, relating to his treatment and management of a patient (Patient Y) for a gastric volvulus and subsequent complications between November 10th and November 12th, 2015. During that period, Patient Y required urgent surgical intervention and Dr. Dhalla failed to ensure continuity of care for Patient Y and failed to provide appropriate assistance in circumstances in which he remained responsible for Patient Y.

Dr. Dhalla was also found guilty of professional misconduct and 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 Patient Y in the medical record.

On August 24th, 2020, a further hearing was convened before the Panel to receive the parties' submissions with respect to the order or orders which should be issued by the Panel pursuant to s. 59.6(1) of *The Medical Act* (the "Act"). Prior to the hearing of August 24th, 2020, the Panel had received and read an impact statement from members of the family of Patient Y, a written submission on behalf of the Investigation Committee of the College (the "Investigation Committee"), supported by various legal authorities, some additional evidence from Dr. Dhalla, a written submission on behalf of Dr. Dhalla, supported by various legal authorities and a reply submission on behalf of the Investigation Committee, also supported by additional legal authorities. On August 24th, 2020, the Panel received oral submissions from counsel for the Investigation Committee and counsel for Dr. Dhalla, which supplemented their written submissions. All of the

written and oral submissions addressed the issue of the order or orders which ought to be issued by the Panel pursuant to section 59.6 of the Act.

The Inquiry Panel's Reasons and Resolution and Order dated May 6th, 2020, made findings pursuant to s. 59.5 of the Act, namely that Dr. Dhalla had been guilty of professional misconduct and had contravened a provision of the College's Code of Conduct, and a by-law of the College. Once a finding or findings are made pursuant to s. 59.5 of the Act, s. 59.6 outlines the orders which an inquiry panel may make. Those orders include, but are not limited to, an order reprimanding the member, an order suspending the member's licence for a period of time, an order imposing conditions on the member's entitlement to practice medicine, and an order cancelling one or both of the member's registration and licence.

It is the position of the Investigation Committee that the following orders should be issued by the Panel under s. 59.6 of the Act:

(i) a reprimand of Dr. Dhalla (s. 59.6(1)(a)); and

(ii) a suspension of Dr. Dhalla's licence to practice medicine for a fixed period of five months, to commence on the date of the Panel's order (s. 59.6(1)(b)).

It had been the position of the Investigation Committee in its initial written submission that orders under s. 59.6 of the Act should also include the imposition of conditions requiring Dr. Dhalla to practice under supervision in accordance with specified conditions, and that he cooperate with one or more chart audits as deemed necessary by the Chair of the Investigation Committee. However, in view of the terms of an undertaking provided by Dr. Dhalla to the College (a copy of which was included with the additional evidence submitted on behalf of Dr. Dhalla prior to the August 24th, 2020 hearing), the Investigation Committee agreed that it would not be necessary to impose conditions on Dr. Dhalla's Certificate of Practice. However, the Investigation Committee requested that the Panel endorse the necessity for such conditions to ensure publication of those matters, thereby promoting public confidence in the medical profession's ability to self-regulate.

It is the position of Dr. Dhalla that, subject to the issue of costs, the only order required under s. 59.6 of the Act, is a reprimand.

The Investigation Committee and Dr. Dhalla agree that the issue of the costs of these proceedings remains to be determined. They intend to make their submissions respecting costs under s. 59.7 of the Act after the Panel has rendered its decision on the orders to be made under s. 59.6 of the Act.

THE OBJECTIVE OF S. 59.6 ORDERS

Before commenting on the positions of the parties with respect to the order or orders which would be appropriate in this case, it is useful to consider the objectives and purposes of such orders. Those objectives include:

(a) the protection of the public. This is the primary purpose of orders under s. 59.6 of the Act. They are not simply intended to protect the particular patients of the physician involved, or those who are likely to come into contact with the physician, 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) preserving 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) proportionality between the conduct of the physician and the orders granted under subsection 59.6 of the Act, meaning that the penalty must be proportionate to the specific misconduct involved in the case in question; and

(h) consistency in sentencing, meaning the imposition of similar penalties for similar misconduct. However, it also must be recognized that each case must be decided on the basis of its own unique facts.

The above-noted objectives do not constitute an exhaustive list. Numerous authorities have referred to other factors which should also be considered or which may be particularly applicable in specific cases. Additional factors which may be relevant in this case are:

(a) the nature of the misconduct and the circumstances in which the misconduct occurred;

(b) the impact of the misconduct on those affected by it;

(c) whether or not Dr. Dhalla has acknowledged the seriousness of what occurred; and

(d) the presence or absence of mitigating or aggravating circumstances.

THE POSITIONS OF THE PARTIES

The Investigation Committee and Dr. Dhalla both provided detailed written and oral submissions in support of their respective positions. It is not necessary to outline

all of the arguments which were presented. However, a brief summary of the primary arguments of both parties will provide a context for the analysis which follows.

The Submissions of the Investigation Committee

The primary submissions of the Investigation Committee are summarized below:

1. The protection of the public is the paramount consideration in determining what orders are required. In this case, a suspension of not less than five months is required to maintain standards of competence and professional integrity.

2. A reprimand would be totally inadequate to address the misconduct which occurred in this case and to fulfill the objectives of s. 59.6 of the Act.

3. There were two significant components to Dr. Dhalla's deficiencies in this case, namely his misconduct in relation to his treatment of Patient Y and his failure to ensure continuity of care for Patient Y, and his failure to adequately document his involvement in the care and management of Patient Y in the medical record. The order to be issued by the Panel must reflect the seriousness of both of those components, with appropriate weight being given to the inadequacy of the documentation in the medical record. Proper documentation is an essential element of patient care; inadequate or non-existent documentation is not a trivial or inconsequential breach of a technical standard, but an inherently serious deficiency which is deserving of serious sanction.

4. The patient in this case died on November 20th, 2015. The multiple impacts of this tragic outcome on Patient Y and his family, and extended family, are

factors to be considered in determining the orders to be granted under s. 59.6 of the Act.

5. Dr. Dhalla's conduct on November 12th, 2015, in deciding to proceed with a Whipple procedure on another patient and his other failures to provide continuity of care to Patient Y as particularized in the Reasons for Decision dated May 6th, 2020, were not the result of a flawed exercise of professional discretion, but were rather the result of conscious decisions which resulted in Patient Y not receiving appropriate assistance on a timely basis when he was in urgent need of medical care.

6. Dr. Dhalla's attitude as demonstrated by portions of his testimony reflected a refusal or unwillingness to accept responsibility for his own actions and to acknowledge the seriousness of his misconduct. This attitude is similar to that which was described in *Houghton v. Association of Ontario Land Surveyors, 2020 ONSC 863*, in which the member maintained that he had done little wrong and denied that he had harmed his clients. The penalty imposed should, therefore, be significant to send a clear message of denunciation and deterrence to Dr. Dhalla.

7. To the extent that poor documentation in medical records is a general or widespread problem in Brandon, as implied by Dr. Dhalla, such a problem reinforces the necessity for general deterrence, which should be reflected in any order issued under s. 59.6 of the Act.

8. In order to protect the public, maintain professional standards, and fulfill the objectives of denunciation, punishment and specific and general deterrence, a reprimand and a suspension of Dr. Dhalla's licence for at least five months is required. Such a disposition would be proportionate to Dr. Dhalla's misconduct and consistent with past decisions of the College and with decisions of colleges in other jurisdictions. Indeed, counsel for the Investigation Committee suggested that other cases, in Manitoba and

elsewhere, involving less serious misconduct, had resulted in more significant penalties.

The Submissions of Dr. Dhalla

The primary submissions of Dr. Dhalla are summarized below.

1. Dr. Dhalla is a competent surgeon, who has served the community of Brandon very well for many years;

2. A suspension of Dr. Dhalla's licence to practice medication is not required to satisfy the principles of sentencing or to fulfill the objectives of orders under s. 59.6 of the Act.

3. The sentence imposed should be the "least onerous sanction appropriate to the circumstances of both the offence and the offender", as outlined in various judicial authorities including *McKee v. College of Psychologists (British Columbia) 1992 CanLII 12841 (BCSC)*.

4. It is inappropriate to conclude that Dr. Dhalla is unwilling to accept responsibility for his own actions, or to acknowledge the seriousness of his misconduct based on his evidence at the September 2019 hearing. That evidence was given in the context of Dr. Dhalla vigorously defending the charges against him which he had the right to do, and prior to the Panel finding him guilty of misconduct and of contravening Article 9 of the Code of Conduct and Article 24.1 of By-Law 1 of the College.

5. A close examination of the authorities relied upon by the Investigation Committee indicates that the misconduct in those cases was more serious than the misconduct of Dr. Dhalla because, in most cases, the physicians involved had either provided false or misleading information to the investigators, withheld or attempted to cover up relevant evidence, or had committed serious breaches of standards over an extended period of time. Counsel for Dr. Dhalla also argued that the cases which were the most

factually analogous to the present case, were cases in which the College had issued censures. Counsel for Dr. Dhalla argued those cases are significant because they demonstrate that the College was satisfied that its mandate to protect the public was adequately fulfilled by the issuance of a censure, and that a finding of guilt with additional sanctions was not required.

6. There are mitigating circumstances in this case. Dr. Dhalla has been practising general surgery in Manitoba since 1989 and, prior to the events in question, had no record of discipline. In addition, Dr. Dhalla pled guilty to the charge that between November 5th and 12th, 2015, he had failed to adequately document his care and management of Patient Y in the medical record.

7. A reprimand is a harsh penalty and its significance should not be downplayed. A reprimand would constitute a formal denunciation of Dr. Dhalla's conduct as outlined in detail in the Panel's Reasons for Decision dated May 6th, 2020, and would be a powerful expression of the Panel's disapproval of his conduct.

8. Cases in Manitoba involving suspensions typically involve a repetitive pattern of conduct, a progression of discipline, or circumstances in which the member had been guilty of dishonesty, or of misleading the College. In contrast, this case involves a single instance of a failure to provide adequate medical care. Notwithstanding the seriousness of Dr. Dhalla's failure, the principles of sentencing, including specific and general deterrence, and the maintenance of the public's confidence in the ability of the College to regulate the medical profession, can be achieved by way of a reprimand.

ANALYSIS

There were three issues which arose during the course of the submissions with respect to s. 59.6 on which there was substantial disagreement between the Investigation Committee and Dr. Dhalla.

The first was whether it would be proper for the Panel to consider evidence given by Dr. Dhalla at the September 2019 hearing as proof that he was not accepting responsibility for his own actions and not acknowledging the seriousness of his misconduct.

The second was whether or not it was a principle of sentencing in professional misconduct matters that the sanction imposed should be the “least onerous” sanction appropriate to the circumstances.

The third was whether this Panel should consider censures which have been issued by the College in prior cases when considering the issues of proportionality and consistency.

With respect to whether Dr. Dhalla’s testimony at the September 2019 hearing demonstrated that he has not accepted responsibility or acknowledged the seriousness of his actions, the Panel is unwilling to rely on that evidence to reach such a conclusion. Dr. Dhalla’s comments were made in the context of a not guilty plea to charge 1, and in response to questions under cross-examination by an able and experienced counsel. The Panel does not find Dr. Dhalla’s testimony to be analogous to that of the member in the *Houghton v. Association of Ontario Land Surveyors* case relied upon by the Investigation Committee.

On the second issue, the Panel acknowledges and respects the Investigation Committee’s rebuttal remarks relating to the arguments of Dr. Dhalla’s counsel relating to the “least onerous” sanction appropriate to the circumstances. The Investigation Committee observed that such a concept is likely derived from criminal law, and that it is not well established that such a concept applies in the administrative

law/professional regulation context. The Panel has concluded, that while it should have due regard to all of the various objectives of s. 59.6 orders, including proportionality and consistency, it is not necessary or helpful to apply the “least onerous” sanction concept in determining what orders are appropriate in this case.

Finally, the Panel understands that censures are not decisions made by inquiry panels after a full hearing based on extensive evidence. Censures should therefore be used with caution, when determining what sanctions are appropriate. It is also true that each case is unique and must be decided on the basis of its own facts. Nonetheless, censures may be useful to particular inquiry panels in considering issues of proportionality and consistency and, in certain cases, may be useful for comparative purposes.

In terms of reaching its decision relating to the sanctions to be imposed in this case, the Panel has considered the objectives of orders under s. 59.6 of the Act, with a particular emphasis on the protection of the public.

The Panel is acutely aware of the profound loss sustained by the family of Patient Y and is appreciative of the impact statements submitted by the family. The impact on the family has been considered by the Panel in reaching its decision. At the same time, the Panel recognizes that the protection of the public is a broader consideration than simply responding to the expectations of the people directly impacted by Dr. Dhalla’s misconduct.

The Panel has considered the type of sanctions which are necessary to maintain standards of competence and integrity, to punish Dr. Dhalla, to achieve specific and general deterrence and to preserve the public’s faith in the medical profession’s ability to regulate itself. The Panel has also considered what measures may be required

to rehabilitate Dr. Dhalla and to ensure that the penalty is proportionate to Dr. Dhalla's misconduct and consistent with penalties in prior cases.

There are factors present in this case which suggest that the sanctions sought by the Investigation Committee may not be necessary to achieve the purposes of s. 59.6. Those factors include:

(i) Dr. Dhalla's lengthy unblemished record as a general surgeon;

(ii) Notwithstanding the seriousness of the findings in this case, there was no evidence presented to indicate Dr. Dhalla is not a competent general surgeon. Indeed, the Investigation Committee acknowledged in its opening statement that Dr. Dhalla is a competent general surgeon;

(iii) Dr. Dhalla is taking active steps (as evidenced by his Undertaking dated December 2019) to substantially improve his medical recordkeeping.

The above-noted three factors indicate that any rehabilitation required of Dr. Dhalla is reasonably achievable and that Dr. Dhalla is taking steps to improve his practice;

(iv) Patient Y's case was unique and difficult and presented several challenges between November 9th and 12th, 2015. Some of the allegations against Dr. Dhalla, as particularized in the Notice of Inquiry were dismissed, because the Panel concluded that Dr. Dhalla's actions in relation to those allegations met applicable professional standards; and

(v) In terms of proportionality and consistency, none of the cases referred to by either of the parties were particularly similar in terms of their background facts. Many of the cases relied upon by the Investigation Committee involved repetitive patterns of misconduct, or a lack of cooperation with the

College's investigation, or active attempts to mislead the College's investigators. Those factors are not present in this case.

Conversely, there are features of Dr. Dhalla's conduct which were deeply troubling to the Panel. The most significant findings of the Panel against Dr. Dhalla were that:

- The significant bleeding which occurred immediately after the November 10th surgery performed by Dr. Dhalla and which continued thereafter throughout November 10th and 11th, was not properly addressed by Dr. Dhalla.

- Dr. Dhalla acknowledged at the hearing that he was the physician most responsible for the care and treatment of Patient Y.

- Notwithstanding Surgeon 1's surgical intervention early on November 12th, including the evacuation of six litres of blood and the packing of the right upper quadrant of Patient Y's abdomen, significant bleeding continued. Such massive, continuous bleeding, even after Surgeon 1's interventions early on November 12th required an immediate re-exploration to identify and, if possible, control any surgically correctible bleeding source.

- Whatever concerns Dr. Dhalla or Dr. X may have had with respect to DIC, did not justify the delays in returning Patient Y to the operating room, after Surgeon 1's intervention.

- Dr. Dhalla's advice at 8:30 on November 12th to reduce the pressure on the VAC dressing 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.

- Further surgery on Patient Y should have been undertaken much sooner than the afternoon of November 12th, 2015. Immediate surgical intervention was required.

- In such circumstances, Dr. Dhalla's decision to proceed with an elective Whipple procedure was deeply troubling. His decision effectively made him unavailable to Patient Y or to assist other physicians who were doing so for a significant period of time.

- No steps were taken by Dr. Dhalla prior to commencing the Whipple procedure to ensure another surgeon was available, if needed.

The Panel felt strongly that Dr. Dhalla, recognizing that he would be unavailable for the next six to eight hours due to the Whipple procedure to perform any surgery on Patient Y, should have made detailed and thorough arrangements for another surgeon to be available to do so.

Given the seriousness of the above-noted findings, a sanction which is more punitive than a reprimand is required. The Panel recognizes that a reprimand is a formal and serious denunciation of Dr. Dhalla's misconduct. However, a reprimand by itself does not represent adequate punishment and does not achieve the specific and general deterrence required in this case.

The Panel agrees with the Investigation Committee that Dr. Dhalla's failures were not the result of a flawed exercise of professional discretion, but were the result of deliberate conscious decisions made by him, including his decision to undertake the Whipple procedure. Those decisions resulted in Patient Y not receiving the medical assistance which he urgently required.

To punish Dr. Dhalla, 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, the Panel has decided that a reprimand and a suspension Dr. Dhalla's licence to practice medicine for a period of two months from November 1st, 2020 up to and including December 31st, 2020, are required. A reprimand and a two month suspension is also consistent with the principles of proportionality and consistency.

In view of the Undertaking already provided by Dr. Dhalla, the Panel agrees with the Investigation Committee and with Dr. Dhalla, that the imposition of conditions pursuant to s. 59.6 of the Act, requiring Dr. Dhalla to practice under supervision in accordance with specific conditions, and to cooperate with chart audits as required by the Chair of the Investigation Committee (the "Chair"), is not required. However, in order to preserve public confidence in the medical profession's ability to self-regulate, it is important to make specific note of some of the important terms of the Undertaking dated December 18th, 2019, which has been provided by Dr. Dhalla to the College. The Undertaking reflects the terms of the order which the Investigation Committee would have been seeking if Dr. Dhalla had not provided the Undertaking.

Pursuant to the Undertaking, Dr. Dhalla has undertaken and agreed to:

1. Create complete, accurate and timely records for each patient in accordance with:

    (a) the expected professional standard of care and the requirements of the College's Standards of Practice of Medicine; and

    (b) the by-laws and policies of the Regional Health Authority and/or Hospital.

2. To comply with and fully cooperate in all aspects of a Monitoring Plan established for Dr. Dhalla's practice which includes the following components:

    (a) the designation of a Practice Monitor by the Chair who will be expected to complete the chart reviews for at least ten patients

admitted in hospital under Dr. Dhalla's care once every two weeks, and to provide monitoring reports to the Chair, pursuant to a specific schedule;

(b) the Chair will review the Undertaking every three months after the initiation of the Monitoring Plan and, upon review, may vary the number of charts to be reviewed and/or the scheduling of the monitoring reports. Written notice of any amendment by the Chair to the number of charts that are expected to be reviewed and/or the schedule for providing monitoring reports will be provided to both Dr. Dhalla and the Practice Monitor;

(c) if any significant deficiencies are identified by the Practice Monitor or the Chair, Dr. Dhalla will be advised of those deficiencies and will respond to them in writing to the Chair in a timely way; and

(d) serious deficiencies may be referred to the Registrar of the College for possible further action.

The Undertaking given by Dr. Dhalla contains a number of other specific details which are not necessary to summarize herein, including terms relating to the duration of the Undertaking and the process to be followed with respect to any changes to the Undertaking. The Undertaking also contains specific terms obliging Dr. Dhalla to give notice of the Undertaking to the Chief Medical Officer of any Regional Health Authority to which Dr. Dhalla applies for privileges, to the supervisor or chief executive officer at any facility where Dr. Dhalla obtains employment or acts as an independent contractor, and to any physician with whom Dr. Dhalla proposes to enter a practice arrangement.

DECISION AND ORDER

Based on all of the foregoing, the Panel hereby orders that:

1. Pursuant to s. 59.6(1)(a) of *The Medial Act*, Dr. Dhalla is hereby reprimanded for committing acts of professional misconduct and for contravening Article 9 of the Code of Conduct of the College, and for committing acts of professional misconduct and contravening Article 24.1 of By-Law 1 of the College, as more particularly set forth in the Reasons for Decision of this Inquiry Panel dated May 6th, 2020.

2. Pursuant to s. 59.6(1)(b) of *The Medical Act*, Dr. Dhalla's licence to practice medicine is suspended for a period of two months from November 1st, 2020 up to and including December 31st, 2020.

3. There will be publication in the usual course as set out in *The Medical Act*, including Dr. Dhalla's name, as determined by the College.

4. The Panel hereby retains jurisdiction with respect to the issue of costs pursuant to s. 59.7 of the Act and will convene a further hearing to deal with that issue at the request of the parties or either of them.

DATED this 21st day of September 2020.