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IN THE MATTER OF AN APPEAL
TO THE HOSPITAL APPEAL BOARD

BETWEEN:

DR. Y

APPELLANT

AND:

Z, A HEALTH AUTHORITY

RESPONDENT

DECISION

BEFORE THE	)	
	)	**Hearing: April 10-13**
	)	**and May 25, 2007**
HOSPITAL APPEAL BOARD	)	

Appearing for the Appellant: Peter M. Willcock and Mandeep Gill

Appearing for the Respondent: Penny A. Washington and Sara Harbottle

A. INTRODUCTION

This is an appeal from the decision of the Board of a Health Authority (the "Z Board") on July 18, 2006 to accept the recommendation of a Medical Advisory Committee (the "MAC") to refuse the granting of privileges at a Hospital (the "Hospital") to Dr. Y.

The application that gives rise to this appeal is an application for appointment as a surgical assistant in the Hospital, which was filed by Dr. Y on December 14, 2005.

The Appeal is brought pursuant to s. 46 of the *Hospital Act*, R.S.B.C. 1996, c. 200, which provides:

> 46(1) The Hospital Appeal Board, consisting of the members appointed under subsection (4) is continued for the purpose of providing practitioners appeals from:
>
> (a) A decision of a board of management that modifies, refuses, suspends, revokes or fails to renew a practitioner's permit to practice in a hospital, ...
>
> (2) The Hospital Appeal Board may affirm, vary, reverse or substitute its own decision for that of a board of management on the terms and conditions it considers appropriate.
>
> (2.1) A practitioner may appeal to the Hospital Appeal Board if:
>
> (a) the practitioner is dissatisfied with the decision of a Hospital Board, ...
>
> (2.3) An appeal to the Hospital Appeal Board is a new hearing.

Section 46(3) of the *Hospital Act* establishes the jurisdiction of the Hospital Appeal Board ("Appeal Board"):

> 46(3) The Hospital Appeal Board has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law and discretion arising or required to be determined in an appeal under this section and to make any order permitted to be made.

The Appeal Board's mandate is to balance fairly and responsibly the conflicting interests between practitioners who wish to obtain maximum access to public hospitals and hospitals which need to exercise control over the number of practitioners, their practice standards and the public interest in an efficient and high quality health care service. The Appeal

Board described its role in *Schlagintweit v. Maple Ridge* (Medical Appeal Board, May 15, 1979) as follows:

> In exercising its jurisdiction, this Board is primarily concerned with what is in the interest of the public who are admitted as patients in the hospital – what is commonly referred to as a high level of patient care. At the same time, this Board is also concerned with the rights of the individual physician. Hospitals, through their medical staffs, exercise a power of professional life or death over their medical staff members. It is the responsibility of this board to ensure that power is exercised fairly and reasonably.

This is a *de novo* hearing in which this Panel sits in the place of the board of management: *Ng v. Richmond Hospital Society* (Hospital Appeal Board, February 6, 2003)

B. BACKGROUND

Dr. Y obtained his medical training at the University of Alberta and practiced at a number of positions in the Canadian military, prior and subsequent to obtaining his Fellowship qualifications in anesthesia at McGill University. At age 40, Dr. Y left the military and moved to a community where he received full, active medical staff privileges at the Hospital.

Dr. Y first obtained privileges on the medical staff of the Hospital in 1984 as an anesthetist. He has acted as Head of the Department of Anesthesia on more than one occasion and the Hospital and all the witnesses on both sides acknowledge that he has provided many years of excellent service as an anesthetist.

From 1984 to 1993 Dr. Y was a busy and successful member of the medical staff and one of a small group of anesthetists at the Hospital. In 1993 nurses at the Hospital expressed concern that Dr. Y was abusing alcohol. Although Dr. Y admits that he is an alcoholic he believes he was a "functional alcoholic" and that he continued to work well for many years despite his drinking. Dr. Y also gave evidence that when he tried to cut back on alcohol; he began to use another drug, the intravenous anesthetic drug Propofol, as a mood elevator while working. After the nurses expressed their concern about his behavior, he was required to withdraw from practice in order to deal with his substance abuse on April 27, 1993 and the College of Physicians and Surgeons of B.C. (the "College") was notified.

After withdrawing from practice in 1993, Dr. Y was referred to a rehabilitation service in Guelph, Ontario, known as Homewood, for treatment for one month. He returned to practice as an anesthetist at the Hospital on September 13, 1993. His evidence before the Panel was that unfortunately he was "not in recovery" at that time because he was also suffering from depression, although this condition had not yet been diagnosed or treated.

In March 1994 in the midst of heavy use of alcohol and Propofol and while feeling very depressed, Dr. Y attempted suicide with an overdose of stockpiled medications. This suicide attempt was interrupted and he was admitted to a community hospital for two weeks. Shortly thereafter he was treated at the Springbrook facility in Oregon, USA in the addiction program.

During his stay at Springbrook his depression was diagnosed and he was placed on Zoloft. He was discharged from the Springbrook addiction program in August 1994. He returned to practice as an anesthetist at the Hospital on November 1, 1994, where he worked successfully for 10 years until 2004. During this period, Dr. Y lectured at various anti-addiction and addiction help organizations about his personal experiences and campaigned against drug addiction. Although he remained abstinent, towards the end of the period he let up on his program. He had lost contact with his sponsor and was attending fewer meetings.

In early 2004 Dr. Y fractured several ribs in a fall. He continued to work due to a staffing shortage. In August 2004 he relapsed in the context of fractured ribs, increased work hours, sleep deprivation and symptoms of depression. At this time, he began to self-medicate with a sedative antiemetic drug, Gravol, taken intravenously.

In August 2004, an operating room ("OR") nurse noticed that Dr. Y was exhibiting signs of impairment. The explanation given by Dr. Y was that his behavior was related to stress and the pressures of work. He went on vacation and also saw his general practitioner.

On September 20, 2004, Dr. Y returned from vacation and returned to work.

November 17, 2004, another OR nurse reported that Dr. Y was acting strangely. An anesthetist, Dr. A investigated and reported that he did not find anything wrong with Dr. Y.

On November 19, 2004, two OR nurses reported that Dr. Y had, contrary to the usual practice, taken the monitors off of a patient and left him unattended without writing orders. In addition, Dr. A had to assist Dr. Y in inserting an IV into a patient.

On November 20, 2004, Dr. Y again withdrew from practice. Nurses at the Hospital expressed anger to hospital management at the time because they felt that the concerns they had expressed earlier in August had not been listened to or sufficiently investigated by physicians. Dr. Y now admits he was abusing drugs at that time, and had been doing so since fracturing his ribs in the spring of 2004.

From the perspective of the Hospital and the nurses, this is an important period because they say it demonstrates that even though the nurses noticed Dr. Y exhibiting unusual behavior and expressed concerns that there was a risk of harm to patients, there was either insufficient or no action in response.

Dr. Y returned to practice on April 1, 2005 on a part-time basis, again on the basis of clearance by the College confirming his fitness to return to practice. The MAC recommended a return to practice on conditions to the Z Board. The Z Board approved the reinstatement of Dr. Y's privileges in 2005 on conditions including regular monitoring and urine testing. Although Dr. Y saw his family doctor after his withdrawal in November 2004 there was no evidence of any other assessments or further treatment prior to his return part-time in April 2005.

This is also an important stage in the history of this matter from the perspective of the Hospital. A review of the notes of a meeting that the OR manager held with the nursing staff on March 31, 2005 to update them on Dr. Y's return to work demonstrates concerns on the part of nurses very similar to those they expressed at this hearing. The Hospital nonetheless facilitated Dr. Y's return and the Z Board accepted the recommended conditions for his return. Reassurances were provided to the nurses by the OR manager that protocols were in place and that two physicians with Z would be monitoring his health and return to work. There was also discussion about tightening controls on narcotics and other drugs, such as locking the anesthetic and narcotic carts. Although, at the time, a system was in place pursuant to which unused narcotics were returned to a locked cupboard the anesthetic carts in the OR were not locked because the anesthetists, for practical reasons, wanted quick access to these carts in the OR.

Despite the conditions imposed by the Z Board and the College, and despite the opinions of his treating physicians that he was fit to return, Dr. Y again began abusing intravenous Gravol and, on a number of occasions, the sedative Propofol, some time shortly after his return to practice in April 2005. An OR nurse gave evidence that on June 3, 2005 Dr. Y showed signs of impairment and had difficulty starting an IV. Another OR nurse described the same episode.

Dr. Y once again withdrew from practice on June 3, 2005 and re-entered the Springbrook residential treatment program the same month. He was discharged from this program at the end of August, 2005 and has not worked at the Hospital since this withdrawal.

Initially, Dr. Y wanted to return to practice at the Hospital as an anesthetist. Dr. B, the Hospital's Chief of Staff, advised him that that would be very difficult. After discussions with Dr. B and his colleagues, as well as with Dr. C, his addiction specialist, Dr. Y decided to revise his plan to return and to apply instead to come back as a surgical assistant. Dr. B described this as a route the physicians considered "a reasonable compromise".

The College provided a letter dated December 7, 2005 to the effect that Dr. Y could return to practice in B.C. as a surgical assistant.

Dr. Y filed an application for privileges to act as a surgical assistant at the Hospital on December 14, 2005. On December 15, 2005 the MAC recommended to the Z Board that Dr. Y be reinstated with provisional staff privileges at the Hospital limited to surgical assists, subject to a number of conditions.

The MAC's December 15, 2005 recommendation was made based on the assumption that the nursing staff would have no problems with Dr. Y's return as a surgical assist. Following the MAC's December 15, 2005 recommendation, additional information was received from the OR manager who advised that in her view there was considerable concern from the OR and post anesthetic recovery ("PAR") nurses about Dr. Y returning. As a result, in January 2006, the MAC advised the Z Board that it may not have had all of the information it should have when it made its December 15th recommendation that Dr. Y be reinstated and requested advice as to whether in the circumstances the Z Board wanted the MAC to reconsider Dr. Y's application.

On January 18, 2006, the Z Board directed the MAC to reconsider Dr. Y's application in light of additional information received and instructed Dr. B to interview and seek the opinions of a wide spectrum of staff in the areas of the OR and PAR where Dr. Y would be working.

On January 12, 2006 Dr. B and Dr. D, a general surgeon, met with twenty-three of the peri-operative nurses at the Hospital to discuss Dr. Y's planned return to work as a surgical assistant. The nurses expressed concern that it was not safe to permit him to return to an environment where there were any drugs at all. Their main stated concern was patient safety. They also told Drs. B and D that in the past signs of Dr. Y's impairment were not seen, followed up on or responded to by the surgeons in the operating room. As a result they had no confidence that the situation would be any different this time. Dr. B gave evidence that he had had no idea how strongly the nurses felt about the possibility of Dr. Y returning to work at the Hospital. This Panel received similar evidence from the nurses and administrators who testified before us, including six OR nurses.

On February 9, 2006 the Hospital's medical advisory committee met to consider Dr. Y's request for privileges. Dr. B advised that he had met with the anesthetists, general surgeons and OR staff, and that while the general surgeons were willing to have Dr. Y come back to do assists, the anesthetists had mixed feelings and the OR nursing staff were very much against Dr. Y's return. Concern was also expressed that Dr. C had in his November 5, 2005 letter supporting Dr. Y's return as a surgical assistant stated: "relapse to the use of any drugs is, in part, related to access. As a surgical assistant, I assume Dr. Y would have no access to the narcotic cupboard or any potentially abusive medications at the hospital". As was pointed out at the meeting, and in the evidence before this Panel, this was an assumption that could not be made given the fact that the anesthetic carts are not locked.

At the request of Dr. Y's counsel the matter, which was to come before the Z Board again in mid-March 2006, was tabled until the Z Board's next meeting in May 2006 so that he could address the concerns about Dr. C's letter.

Dr. C provided a subsequent letter dated April 6, 2006 purporting to address the concerns arising from the assumptions made in his November 5, 2005 letter. However, he still premised his support for the return of Dr. Y to medical practice in the OR on the assumption that, in his experience, medications are kept in designated areas such as the PAR or a designated OR medication room and would be essentially "off limits" to

anyone other than the health care providers intimately involved in their administration and distribution. This was an assumption that could not be made based on the evidence before us.

Ultimately, the MAC meeting was scheduled for June 15, 2006 to consider the new report from Dr. C. Dr. Y and his counsel attended and made submissions in support of Dr. Y. The MAC passed a resolution indicating that the Committee did not support granting Dr. Y privileges at the Hospital. The motion was unanimous.

On July 18, 2006 the Z Board accepted the recommendation of the MAC to not support the granting of privileges to Dr. Y at the Hospital.

The evidence indicates that the Z Board's decision was made based on the nurses' opposition to Dr. Y's return. There is no evidence as to whether or not the question of need for an additional surgical assistant was considered.

Since this matter first came to the Z Board, the College has re-instated Dr. Y's license to practice anesthesia. As a result, Dr. Y is free to seek privileges as an anesthetist at any hospital. Dr. Y's evidence was that he has secured anesthesia locums at other hospitals and has registered with the Physician Locum Program.

C. POSITIONS OF THE PARTIES

The position of the Hospital with respect to this appeal is that:

a) There is no need for Dr. Y's services at the Hospital as an assistant;

b) His return to the Hospital at this time would be too disruptive;

c) The evidence of the experts supporting Dr. Y's return to practice is premised on the false assumption that access to the drugs is controlled or limited in such a way as to minimize the risk; and

d) There will be adverse publicity if Dr. Y returns to the Hospital and a potential loss of confidence in the Hospital by the community.

Dr. Y's position is that:

a) He is fit to return to practice;

b) He would add value to the community as a surgical assistant;

c) His reinstatement is important to the current medical staff;

d) His reinstatement is important to future recruitment at the Hospital;

e) The opposition to his reinstatement is ill founded; and

f) The hospital has an obligation to accommodate him under the *Human Rights Code* R.S.B.C. 1996, c. 210 (the "Code").

D. ISSUES

The issues to be determined in this appeal are:

1. Dr. Y's fitness to practice.

2. Whether it is in the public interest to grant Dr. Y privileges as a surgical assistant at the Hospital.

3. Whether and to what extent the Hospital Appeal Board has the jurisdiction, and ought to, apply the provisions of the *Code* in determining whether Dr. Y should be granted privileges at the Hospital.

E. DISCUSSION AND ANALYSIS

1. Dr. Y's fitness to practice.

The unchallenged evidence of the experts before the Board is that Dr. Y is fit to return to work in medicine. They say that Dr. Y is fit to return to work in anesthesia.

It is the mandate of the College to evaluate the competence and conduct of physicians in British Columbia.

Based on the expert reports, the decision of the College and the evidence presented with respect to Dr. Y's current health status this Board accepts Dr. Y's fitness to practice.

2. Whether it is in the public interest to grant Dr. Y privileges as a surgical assistant at the Hospital.

The nature of hospital privileges and the factors that are considered in granting privileges have been described by previous Appeal Board panels. Although hospitals are public facilities, practitioners are not entitled to make use of them without a permit to practice granted by a hospital board, commonly referred to as "privileges". This is reflected in section 7(1)(b) of the Regulations to the *Hospital Act*:

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

It is clear that a permit to practice within a hospital facility is a privilege and not a right. The fact that a physician is duly licensed by a provincial college or licensing authority to practice medicine is not determinative in that there may be many other qualifications requisite for appointment to a medical staff beyond competence in a professional field. The following passage from Lorne E. Rozovsky in *Canadian Hospital Law*, (Toronto: Canadian Hospital Association, 1974) at p. 78 has been frequently referred to and adopted by the Appeal Board:

> This license is merely recognition that a physician has received certain basic medical education as the licensing authority recognizes as acceptable to enable him to practice medicine within the scope of his license in the province. It establishes basic medical standards. It does not imply the physician is of any particular merit or that he actually practices good medicine. It does not imply that the licensed physician will be suitable as a member of the medical staff of every hospital.

The Appeal Board has adopted the "whole person" approach to the selection of medical staff. This approach was explained by the Appeal Board in the decision of *Hicks v. West Coast General Hospital*, (Medical Appeal Board, May 25, 1991) at pp. 21-22:

> . . . . a hospital board's duty, in selecting doctors for its medical staff, is to have regard to the whole person, not merely that person's qualifications and

> skills but the applicant's character and personality as well. Every hospital has a duty imposed on it by the Hospital Act RSBC 1979, ch.176, to provide a high level of patient care. That duty is owed to the community which, in this country, supplies through taxes, the greater portion of the costs of operating the public hospitals. The onerous task faced by a hospital board is to ensure that the institution is run competently and efficiently. It is a delicate mechanism. If the total trust, cooperation and general team work of any of its constituent parts breaks down the result can be unfortunate for the hospital and community.

In making a decision with respect to privileges, the board of a hospital (and therefore this Panel) must consider amongst other factors whether there exists a demonstrated need within the community served by the hospital for the services of the particular practitioner. If a board of management of a hospital is empowered with the duty to establish a medical staff to serve the community in which it operates, that board must also have the right to determine the makeup of its particular medical staff and must therefore take into consideration the needs of that community.

It is the view of this Panel that Dr. Y has not demonstrated any need for a surgical assistant at the Hospital. While the surgeons who testified on behalf of Dr. Y said they would always "like" more assistants, the manager of the OR gave evidence that the Hospital already has access to 10 physicians that they can call on as surgical assistants which was adequate to meet the Hospital's needs, as well as the names of another four to five general practitioners who would like to be on the list. In addition, two hospital administrators, Dr. B and Dr. E, a medical director with the health authority, testified that they were not aware of any demonstrated need for more surgical assistants.

Because there is no demonstrated need for an additional surgical assistant this appeal must fail. It is not in the public interest to add unnecessary staff. Had the issue of need been considered, or given more weight by the MAC and the Z Board when they initially refused Dr. Y's application for privileges as a surgical assistant this appeal may not have been necessary. Nevertheless because this is a *de novo* hearing this is evidence which we are obliged to hear and consider.

In addition to the absence of need, the hospital also opposes the reintroduction of Dr. Y because it says his re-introduction will cause unnecessary disruption and contribute to poor morale in the nursing staff. In this regard a number of nurses gave evidence that if Dr. Y were to return to the Hospital in any capacity, they would not work with him. Some went so far as to say they would quit or retire should he return. We also heard evidence that the OR nursing team is already short-staffed.

The nurses' opposition to Dr. Y's reinstatement is based, in part, on their fear that further relapses are likely and that Dr. Y's physician colleagues will be no more attentive in observing Dr. Y for changes in his behavior this time than they were in the past. As a result they fear that the obligation of watching out for Dr. Y will once again rest with them.

The Panel also heard evidence from Dr. E that in his view of the situation there was no reasonable prospect of reintegrating Dr. Y given his history of relapses, and the nurses' concerns and lack of faith or confidence that any effective system to monitor Dr. Y could either be put in place or enforced.

This Panel was troubled by this climate of mistrust, and by the intensity of the nursing staff's opposition to Dr. Y's reinstatement given that in many cases it was not founded upon any particular knowledge of his illness, the treatment that he has received since he last withdrew or the possibility that he has been successfully treated. Four OR Nurses all gave evidence that they would refuse to work with Dr. Y if he were to return even though they knew nothing of these matters. The Panel encourages the Hospital to address the underlying communication issues.

We are of the view that a hospital should not refuse to grant privileges to an individual solely because of a diagnosis of addiction, without regard to whether a physician is effectively treated or is in recovery. Nor should any group or individual be able to dictate who will or will not be granted privileges by threatening to refuse to work with an individual because they have been diagnosed as suffering from an addiction.

We want to be clear that our decision is based on the lack of demonstrated need, and not on the refusal of the nurses to work with Dr. Y or their threats of resignation.

The Hospital also argued that it would not be in the public interest to allow Dr. Y to return to the Hospital because of the potential loss of

confidence in the Hospital by the community. There was, however, insufficient evidence put forward to support that position.

3. Whether and to what extent the Hospital Appeal Board has the jurisdiction, and ought to, apply the provisions of *Code* in determining whether Dr. Y should be granted privileges at the Hospital.

Dr. Y submits that based on s.8 of the *Code,* the Z Board must not deny him access to a service or facility that is customarily available to the public because of physical disability. Dr. Y submits his addiction is a physical disability.

The position of the Hospital is either that the *Code* does not apply in the circumstances of an application for privileges, or alternatively if it does Dr. Y has been accommodated to the point of undue hardship for the Hospital.

Having reached the decision that there is no demonstrated need for an additional surgical assistant at the Hospital, it is not necessary to deal with Dr. Y's arguments raised based on the *Code.*

F. DECISION

The appeal is dismissed and Dr. Y's application to act as a surgical assistant at the Hospital rejected. It would not, in our view, be in the public interest to grant Dr. Y privileges in light of the evidence that there is no need for another surgical assistant at the Hospital, and particularly so given the potential adverse impact on the nursing staff's morale his reintroduction may cause.

Dated the 28th day of September, 2007.

William G. Hopkins, Panel Chair

Elisabeth J. Riley, Panel Member

Dr. Bakul I. Dalal, Panel Member