IN THE MATTER OF AN APPEAL BEFORE THE HOSPITAL APPEAL BOARD

Between:

DR. TRACY HICKS

Appellant

And:

FRASER HEALTH AUTHORITY, operating as
PEACE ARCH HOSPITAL

Respondent

DECISION

Dr. Tracy Eugene Hicks, Orthopaedic Surgeon, brings this Appeal from a decision of the Board of Directors of the Fraser Health Authority (the "FHA") made on August 12, 2010 approving the recommendation of the Board Quality Performance Committee of the FHA that the decision of the Local Medical Advisory Committee (the "LMAC") of the Peace Arch Hospital (the "PAH") not to recommend his reinstatement to the regular emergency on-call schedule of the PAH Department of Orthopaedics "as local call groups are responsible to determine their call schedules".

In October, 2009 Dr. Hicks, a Consulting member of the medical staff at the PAH, was removed from the orthopaedic on-call rota of the PAH. He unsuccessfully sought reinstatement, giving rise to this Appeal to the Hospital Appeal Board. Dr. Hicks' stated grounds of appeal are that the PAH administration coerced and intimidated the members of the Department of Orthopaedics at the PAH in order to compel them to discontinue his participation in the emergency on-call rota and that, together with the FHA, they interfered with those orthopaedists in arranging their own emergency on-call schedule. Dr. Hicks raised the further ground of appeal that the FHA Board of Directors erred in its decision in that the recommendation of the Medical Advisory Committee ignored his services as an orthopaedic surgeon at the PAH in granting Active staff privileges to two other orthopaedic surgeons without considering that those appointments would result in his being removed from the orthopaedic on-call rota at the PAH.

On this Appeal, Dr. Hicks seeks an Order that he be reinstated to the PAH orthopaedic emergency on-call rota, with the Division of Orthopaedic Surgery to determine the extent of his participation therein without interference or influence by the FHA or, alternatively, that the matter of his participation in the on-call schedule be remitted back to the Division of Orthopaedic Surgery for a decision as to whether or not he will be "utilized on the orthopaedic emergency on-call rota without interference or influence by the FHA". The FHA has joined issue on the substantive merits of this Appeal.

At the conclusion of the hearing of this Appeal, the Dr. Hicks enlarged his claim for relief to seek an Order that there should be no impediment to his undertaking treatment of patients seen at the Emergency Department of the PAH and requiring urgent surgery, that there should be no impediment to his obtaining time to do follow up and secondary operations arising from the consequences of a patient's initial surgery, and further, that as a Consulting staff member, he is not a *locum tenens* or Temporary staff member when he is involved in the on-call schedule of the Orthopaedic Division at the PAH and insofar as he does not require *locum tenens* or Temporary staff privileges in doing so, the FHA's Guidelines for *Locum Tenens* or Temporary Staff of the FHA does not apply to him.

Prior to the hearing of the Appeal, the FHA raised an issue as to the Board's jurisdiction to entertain the Appeal, arguing that the decision appealed from was not a decision which modified, refused, suspended or revoked Dr. Hicks' privileges and that accordingly, the Hospital Appeal Board was without "jurisdiction" to entertain the within Appeal. The FHA's position was, and remains, that its decision, sought to be appealed, does not fall within the scope of s.46 of the *Hospital Act*, RSBC 1996, c.200 (the "*Hospital Act*").

The FHA sought a preliminary decision on the "jurisdictional" question prior to an evidentiary hearing before this Board. Following receipt of written submissions, we declined to deal with the "jurisdictional" objection in advance of the hearing of the substantive merits of this Appeal. See, *Hicks v. Fraser Health Authority,* Decision on Procedure for Determining Jurisdiction, May 11, 2011.

The Appeal proceedings spanned a lengthy period of time. Following the evidentiary hearing, written submissions of the parties were received by the Board, the latest of which were received on February 1, 2013. Decision on the Appeal was reserved.

I The Preliminary Issue

This Appeal requires the Board to address a preliminary question of statutory interpretation. That question is whether the decision to remove Dr. Hicks from the orthopaedic on-call rota, given the nature of the Consulting staff privileges he holds under the FHA Medical Staff *Bylaw*s (the "*Bylaw*s"), constitutes a modification, refusal, suspension or revocation of his permit to practice in the PAH, within the purview of s.46(1) of the *Hospital Act*:

> 46 (1) The Hospital Appeal Board, consisting of members appointed under subsection (4), is continued for the purpose of providing practitioners appeals from
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> > (a) a decision of a board of management that modifies, refuses, suspends, revokes or fails to renew a practitioner's permit to practice in a hospital,...
> >
> > (underlining added)

If the answer is “yes”, Dr. Hicks has a right to appeal to this Board. If the answer is “no”, Dr. Hicks has no such right. Since the right of appeal lies only from a change to a permit to practice, one of the key issues on this branch of the within Appeal concerns the fundamental nature of that particular permit to practice which confers consulting privileges. Central to this preliminary issue is the proper interpretation of *Bylaw* 6.5.5, which governs Consulting staff. The *Bylaws* are promulgated by the Board of Directors of the FHA pursuant to the authority and requirements of the *Hospital Act* and its

Regulations. They describe the relationship and the responsibilities of the Board of Directors and individual members of the medical staff within the FHA. They also set out the conditions under which members of the medical staff serve the facilities and programs operated by the FHA and provide patient care. The *Bylaws* are approved by the British Columbia Minister responsible for Health Services. Medical staff *Rules* established pursuant to the *Bylaws* outline medical staff and FHA's obligations respecting patient care.

Bylaw 6.5.5 provides:

> 6.5.5 Unless specifically exempted by the Health Authority, members of the consulting staff may be required to participate in fulfilling the organizational and service responsibilities, including on-call responsibilities, of the Regional Department to which the member is assigned, as determined by the Health Authority and described in the Medical Staff *Rules*.
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> (underlining added)

The *Bylaws* define “Consultant" as:

> A Member of the Medical Staff who has been asked to evaluate a patient and provide recommendations for care (consultation only), write orders for care and follow up (consultation with ongoing care) or assume the entire care of the patient and become the Most Responsible Practitioner (consultation with transfer of care).

Dr. Hicks submits that providing on-call coverage is part of the legal scope of his permitted practice as a member of the Consulting medical staff, and that a complete denial of on-call time, as occurred here, therefore constitutes a revocation or modification of his privileges and can be appealed pursuant to s.46 (1) (a) of the *Hospital Act*: *Tsang v. Delta Hospital*, 2000 BCSC 232 ("*Tsang").*

Dr. Hicks advances several submissions in support of his position, but to bring the issue into focus it is useful at the outset to reproduce here his submissions with regard to the language of *Bylaw* 6.5.5:

> On a plain reading of *Bylaw* 6.5.5, the FHA is given the authority to compel consultants to fulfill on-call responsibilities “as determined by the Health Authority”…. *Bylaw* 6.5.5 does not grant the converse authority and does not give the FHA the authority to exclude a practitioner from call. *Bylaw* 6.5.5 does not mention excluding consultants from the on-call schedule.
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> [Emphasis in original]

In its response, the FHA submits that *Bylaw* 6.5.5 makes clear that Consulting staff privileges do not include any on-call rights. It submits that participation in the on-call schedule is not one of the legal incidents of Consulting staff privileges to begin with, and that any grant or limitation in on-call participation engages a purely operational decision within the discretion of the FHA:

> It is the position of the FHA that the words “may be required” and “as determined by the Authority” do not import a “right” but rather a discretion, a discretion that lies with the Health Authority.

If the FHA's interpretation is correct – that Dr. Hicks' Consulting privileges do not in their nature, terms or conditions confer any entitlement to participate in the on-call rota – no appeal would lie to the Board.

We conclude that s.46(1)(a) of the *Hospital Act* makes clear that the Board's mandate is to hear appeals from decisions that adversely affect the *permit* itself. Dr. Hicks is therefore correct in asserting that "the fundamental issue on this Appeal is the nature of Consulting privileges". If the nature of Consulting privileges does not include the legal incidents relied on by Dr. Hicks, it would follow that no appeal would lie under s.46(1)(a) of the *Hospital Act*: *Paulus v. Surrey Memorial Hospital*, 2000 BCCA 342 ("*Paulus*"). For the reasons that follow, it is our view that the FHA's position on this issue is the correct one, and that no appeal lies to the Board from the FHA's decision in this instance.

At the outset, we observe that both the Board and the parties have over the course of these proceedings described this question as being "jurisdictional" in nature. However, recent judicial authority has called into question whether this type of legal issue is properly described as being truly "jurisdictional", or whether it is more properly characterized as pertaining to the interpretation of the "home statute" within the exclusive jurisdiction of the tribunal even though it speaks to whether an appeal properly lies to the tribunal: *Alberta (Information and Privacy Commissioner) v. Alberta Teachers' Association*, [2011] 2 S.C.R. 654 (S.C.C.); *Canada (Canadian Human Rights Tribunal) v. Canada (Attorney General)*, [2011] 3 S.C.R. 471 (S.C.C.); and see *Prairie North Regional Health Authority v. Kutzner*, 2010 SKCA 650. While that question is obviously one for a reviewing Court and not this Board, the point is raised here simply to acknowledge that given recent developments in the larger body of administrative law, we seek to avoid using the term "jurisdiction" except where necessary to do so with reference to a quotation from a judicial authority or the submissions of the parties.

The FHA *Bylaws* define the term "Privileges" as follows:

> Privileges: Permission to practice medicine, dentistry, midwifery or as a nurse practitioner in the facilities and Programs operated by FHA and granted by FHA to a Member of the Medical Staff. Privileges describe the extent of clinical practice of an individual Member based on the member's credentials, competence, performance and professional suitability. Privileges are based on the needs of the programs and communities supported by FHA and capacity of the facilities and Programs to support the member's scope of clinical practice. Privileges describe and define the extent and scope of the permitted clinical practice of a Member in the facilities and Programs of FHA.

While Dr. Hicks has correctly stated that the fundamental issue in this Appeal is the nature of Consulting privileges, the answer to this question must be found with reference to the *Bylaws* and related *Rules*. While this Board has broad appellate jurisdiction, we cannot rewrite the *Bylaws* themselves. The question is not what the panel thinks the *Bylaws* ought to provide, but what they do provide: *Paulus* (at paras. 24-25).

Dr. Hicks submits that *Bylaw* 6.5.5 "does not mention excluding consultants from the on-call schedule". However, that position begs the question as to whether there is such a right to begin with. Dr. Hicks has not pointed to any support in the text of *Bylaw* 6.5.5 for the existence of such a right. Indeed, on its face, *Bylaw* 6.5.5 is not couched as a provision which contemplates that "on-call" is a necessary incident of Consulting staff

status. Rather, it is framed as something that Consulting staff "may" be required to do by the FHA.

Considerable light is shed as to the proper interpretation of *Bylaw* 6.5.5 when it is read together
with related *Bylaw*s governing Active and Provisional staff:

> Active Staff
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> 6.3.6 Unless specifically exempted by the Health Authority, members of the active staff are required to participate in fulfilling the organizational and service responsibilities, including on-call responsibilities, of the Regional Department to which the member is assigned, as determined by the Health Authority and described in the Medical Staff *Rules*.
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> Provisional Staff
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> 6.2.6 Unless specifically exempted by the Health Authority, members of the provisional staff are required to participate in fulfilling the organizational and service responsibilities, including on-call responsibilities, of the Regional Department to which the member is assigned, as determined by the Health Authority and described in the Medical Staff *Rules*.
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> (underlining added)

We consider that a comparison of these provisions indicates the intention of the drafter of the *Bylaw*s that, unlike Active and Provisional staff for whom on-call responsibilities is a compulsory incident of their privileges (unless specifically exempted), the on-call participation of Consulting staff is purely at the discretion of hospital management – a reality consistent with the categorical definition of "Consultant" staff as someone whose role is to undertake responsibilities if *asked* to do so.

It is of course correct that *Bylaw* 6.5.5 is drafted so that if management requires a Consultant staff member to fulfill "organizational and service responsibilities, including on-call responsibilities", that member must comply. But the duty to fulfill on-call duties at the behest of a third person is not, in our view, the foundation of a positive right to be placed on the on-call schedule, or that participation to any extent on the on-call schedule is inherent in Consulting staff status. Even less can it be successfully asserted that such a right exists merely because Dr. Hicks has, in the past, participated *de facto* in on-call coverage. In our view, the assertion of such a right is inconsistent with the *Bylaws*, the intention of which is that participation of the Consultant staff member is for the discretion of management. In our view, the language and structure of the *Bylaws* do not support the distinction Dr. Hicks seeks to have the Board draw between "the distribution of on-call shifts and the entitlement to undertake on-call".

It can be asked whether this result, which flows from a consideration of the language of *Bylaw* 6.5.5, considered within the context of related *Bylaw*s, is consistent with the overarching nature of hospital privileges. In our view, it is. Permits to practice are referred to as "privileges" because they are just that. This does not mean that the nature of some classes of permits do not have specific legal rights attached which, if modified or suspended, can be appealed – they do. But there is nothing inherently contrary to the legislative purpose if a *Bylaw* established a class of permit created primarily as a means to facilitate the exercise of effective hospital management, without corresponding legal rights, and whose purpose is to have available specialized or other services given the complex array of interests and responsibilities engaged in operating a

hospital: see generally, *Ng v. Richmond Health Services Society* (February 6, 2003, Hospital Appeal Board).

The larger purposes of the governing legislation are not undermined by the existence of a permit class that does not carry with it a necessary expectation, entitlement or right to participation in the on-call schedule. As noted in *Paulus* a legal problem would arise if members of Consulting staff had privileges "appertaining only to members" of the Active staff (at para 17). Turning a purely "discretionary" permit into a "rights-based" permit would both confuse permit classes and hamstring hospital management and administration in the exercise of their difficult and complex responsibilities to the public.

This is not to say that a formal revocation or termination of consultant staff privileges are not subject to appeal under s.46(1)(a) of the *Hospital Act*. This is precisely what took place leading up to the Medical Appeal Board's decision in *Hicks v. Peace Arch Hospital*, (January 5, 1996, Medical Appeal Board). Nor do we rule out the possibility of "constructive revocation" occurring in a case where an appellant could establish that in all of the circumstances, the hospital had resolved in advance never to use him or her for any purpose notwithstanding his or her consultant staff status and an objective demonstration of need.

In the latter regard, we have considered the helpful reasons of the Saskatchewan Court of Appeal in *Prairie North Regional Health Centre v. Kutzner*, 2010 SKCA 132 ("*Prairie North*"). In that case, which concerned the question of whether a reduction in the operating room time of an ophthalmologist was amenable to appeal under the Saskatchewan statute, the Court held that "a grant of privileges contemplates that a physician will have some access to the facilities and services needed to perform those procedures in relation to which he or she has been granted privileges" (at para. 61). The Court proposed the following analytical approach to determining whether and in what circumstances a reduction in access to facilities and services would give rise to a right of appeal (paras 61-66):

> **...** In considering whether a change in operating room allocations amounts to a constructive amendment, suspension or revocation of privileges, the Tribunal will want to consider the combined effect of all relevant factors. One of these factors will certainly be the significance of the change in question. For example, a reduction in operating room time from six days a month to five-and-a-half days a month is presumably something materially different than a reduction from six days a month to one day a year. The closer a change comes to wholly denying a physician the right to perform a specific procedure or specific procedures, the more it will tend to assume the character of an amendment, suspension or revocation of his or her privileges.
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> A second factor the Tribunal will want to consider is the duration of the change. For instance, a reduction in operating room times which is in place for a week is not the same thing as a reduction which is permanent. The longer a change extends, the easier it will be to see it as involving a *de facto* amendment, suspension or revocation of privileges.
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> A third factor to be considered might be the reach of the change in issue. A reduction in access to facilities or services that reflects a broad attempt on the part of a health district to reduce expenditures will generally tend to have less of the flavour of a suspension, revocation or amendment of privileges than will a change targeted at a particular physician. By way of a concrete illustration of this idea, a decision that cuts global operating room time by a specific percentage, and which affects all surgeons in the same way, typically will have less of the character of

> amendment, suspension or revocation of privileges than will a decision which cuts only one physician's operating room allocation.
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> There might well be other factors that should inform the Tribunal's decision-making on issues of this sort. The considerations noted above are merely indicators of whether the actions of a health district have, in effect, amended, changed or modified a physician's privileges given the reality that the term "privileges" does not involve any specific allocation of facilities or services but that it does contemplate, subject to the normal realities of matters like resource availability and patient demand, the allocation of some services and facilities. The three factors discussed here are not intended to represent a closed list and, obviously, they might be subject to qualification in some cases.
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> I appreciate that this approach to s.45(1)(c) does not involve a test which will neatly and clearly indicate at the outset, in all cases, whether a change to operating room time allocations is something the Tribunal can review by way of a physician appeal. However, it is not possible, in the abstract, to draw a bright line precisely separating the sorts of changes which will engage s.45 of the *Act* from those which will not. The Tribunal will need to address and consider the relevant issues in the context of the facts of specific appeals as they arise, always bearing in mind that s.45 should not become something that draws it into the ongoing detail of the ordinary day-to-day administration of hospitals or health districts. As the Tribunal's decisions accumulate, both physicians and health authorities will develop a clearer working sense of the sorts of situations which might be expected to come within the scope of s.45(1)(c).

We would endorse this analytical approach as a general proposition, and while we observe the same nomenclature of “consulting privileges” was at issue in *Prairie North* it must be recognized that that case did not involve, as here, a particular permit class the very nature of which does not, as we have found, carry as an incident or “entitlement” any necessary participation on the on-call list.

In our view, *Prairie North* is distinguishable because it arose under a different regulatory scheme and did not deal with the unique class of permit under consideration here. *Prairie North* would have application in a “consulting privileges” case where an appellant could establish that in all the circumstances the hospital had resolved in advance, without formally cancelling the permit, never to use him or her for any purpose consistent with Consulting staff privileges notwithstanding his or her consultant status and an objective demonstration of need. Such a situation could arguably constitute a “constructive revocation” of a permit class. However, that is not the case before us. Dr. Hicks has not suggested that the PAH has determined never to utilize his services for any purpose for which he could be so utilized as a Consulting staff member. The specific question raised by Dr. Hicks is whether being on the on-call schedule is an “entitlement” for a physician with consulting privileges. As we have concluded above, the assertion of on-call entitlement, or of necessary participation on the on-call list, is incompatible with the nature of “Consulting staff” status. As such, removal by the PAH of Dr. Hicks' participation from an on-call list does not constitute a “constructive revocation” or modification of his permit to practice.

We recognize that Dr. Hicks argues that his Consulting staff privileges have “no value” if he cannot assert at least some degree of participation on the orthopaedic on-call schedule. Two points arise from this submission. First, to the extent that Dr. Hicks is asserting that Consultant staff status is essentially hollow and meaningless without being able to participate on the on-call list, it seems to us that Dr. Hicks is really seeking to redefine the privilege. It is clear from the status itself that Consulting staff privileges

permit one to be “consulted” by other physicians, for example because of some special expertise, or to be used for any of the services listed in the definition at the discretion of the hospital administration.

As the FHA points out in its submissions, a Consulting staff member “can also be used as a *locum tenens* by his colleagues” in which case “he will not have to apply anew for privileges, as a physician without any permit to practice in a hospital would have to do”. Second, Dr. Hicks does not dispute, nor could he, that the FHA's position that his removal from the on-call list places him in the same position as other consultant staff physicians. While Dr. Hicks emphasizes that the 1996 decision of the Medical Appeal Board allowed his appeal “in order to allow Dr. Hicks to provide on-call coverage”, the Medical Appeal Board did not decide, in our view, that Dr. Hicks' Consulting status carried a right to on-call participation, let alone a right that would apply in perpetuity.

Dr. Hicks has emphasized that under the *Bylaws*, Consulting staff, *locum tenens* and Temporary staff are separate and distinct, and that the *Bylaw*s “say nothing about consultants doing call as a *locum tenens* or Temporary staff member”. He says that “one of the fundamental issues for consideration on this Appeal is whether he is a Consultant, *locum tenens* or Temporary staff member when he provides on-call coverage at Peace Arch Hospital”.

We agree with Dr. Hicks that the fundamental question is whether, as a matter of law, on-call rights are a necessary incident of Consulting privileges. While it may be desirable for Dr. Hicks to ask the FHA to clarify whether any future on-call work he is asked to undertake is being undertaken as “overflow” in his capacity as a Consulting staff member, or whether it arises as a necessary incident to a Temporary appointment (*Bylaw* 6.6) or *locum tenens* appointment (*Bylaw* 6.7), none of that changes the legal reality that on-call work undertaken *qua* Consulting staff is not an “entitlement”, but arises solely at the discretion of the FHA. Removal of a Consulting staff member from the on-call list is an operational decision, and not a decision that in our view falls within the purview of an appeal under s.46(1)(a) of the *Hospital Act*.

Dr. Hicks relies on the British Columbia Supreme Court decision in *Tsang*, and particularly the statement that “a complete denial” of a physician’s rota time would arguably amount to a revocation or suspension of privileges (at para. 16). Just as we have found that *Prairie North* does not assist Dr. Hicks, neither, in our view, does *Tsang*. First, the Court’s statement above referencing a “complete denial” was made in the context of a physician who held “courtesy staff” privileges and for whom, like active status, participation on the on-call roster was a necessary incident of his permit to practice and therefore, was properly described as an entitlement under the permit. In our view, this factor also acts to distinguish the Alberta and Saskatchewan decisions relied on by Dr. Hicks: *Macdonald v. Mineral Springs Hospital,* 2008 ABCA 273, per Berger J.A., dissenting, and *Prairie North*. Second, the background to *Tsang* involved a physician's original and erroneous application for Consulting privileges – the “error” obviously arising from his recognition that “on-call” time would not be a necessary incident to Consulting staff privileges, but was a feature of Courtesy staff privileges (at paras. 8-9). While the term “consulting staff privilege" was not in that case defined as precisely as it is here, it is noteworthy that the *Tsang* case arose in the same health authority, the FHA, and the fundamental nature of the privilege as conferring no entitlement in the decision in that case is consistent with our conclusions here.

Dr. Hicks has also placed reliance on *Bylaws* 5.8.2 (duty to ensure orthopaedic surgeon available 24 hours per day), 5.8.3 (duty to create call schedule) and 5.8.5, which provides:

> 5.8.5 All Members of the medical staff shall participate equitably in the Regional Departmental on-call rosters, including weekend call rosters, except in special circumstances as approval by the Regional Department Head and HAMAC.

In our view, *Bylaw* 5.8.5, properly viewed, does not serve to create a right that it is contrary to the very nature of the class of privileges otherwise in issue. Clearly, the equitable participation principle in *Bylaw* 5.8.5 must be read in context of the permit classes otherwise created in the FHA *Bylaws*.

Having arrived at the conclusion on the preliminary issue that the decision appealed from does not fall within the purview of s.46(1)(a) of the *Hospital Act*, since this Appeal was fully presented and argued on the merits, we have nevertheless considered whether we ought to address the merits of this Appeal in the alternative, should we be found at some future date to have committed a reviewable error on the preliminary issue. In our view, it is just and appropriate to do so.

Fragmenting legal proceedings rarely advances justice and efficiency. The parties and the public should not be put to the expense of conducting further proceedings if our decision on the preliminary question was to be set aside at some future date, which expense potentially includes arguing the merits of this Appeal months or years later should the present Panel for some reason no longer be available. We consider it appropriate to ensure that any reviewing Court has the benefit of the totality of our reasons on the grounds of appeal so that the Court can undertake its review function recognizing that the final Order, rather than particular reasons on particular issues, is what is fundamentally at issue on judicial review.

II **The Merits**

1. The Evidence

It is common ground that the FHA is a relatively new regional health authority and is an amalgam of what were previously three health authorities – Fraser North, Fraser South and Fraser East. The FHA catchment includes 12 acute care hospitals. The PAH and the Langley Memorial Hospital ("LMH") fall under its management and responsibilities. On January 13, 2010, the FHA promulgated new Medical Staff *Bylaw*s and Medical Staff *Rules* reflecting a revised governance model within the FHA's regional organizational structures. The general purpose of the *Bylaw*s is variously to provide a structure for the organization, governance, management and administration of the medical staff within the FHA, to promote the provision of quality health care in the programs within the FHA, to govern the procedures for the appointment, reappointment, suspension and termination of appointment of medical staff, and to provide a means of granting privileges to members of the medical staff, including the amendment, suspension or revocation thereof (*Bylaw* 2). The subordinate FHA Medical Staff *Rules* more particularly outline the obligations of the FHA and its medical staff with respect to patient care and are applicable to all members of the medical staff practicing within the FHA's hospital facilities. This Appeal was argued by the Parties on the basis, *inter alia*, of the *Bylaws* on a hearing *de novo*.

The Board of Directors of the FHA is ultimately accountable for the quality of care and provision of appropriate resources in the medical facilities and programs operated by it. The *Bylaw*s are approved by the British Columbia Minister of Health Services and the FHA Medical Staff *Rules* are approved by the FHA Board of Directors.

Dr. Hicks is certified in the medical speciality of orthopaedics. He received his medical degree at the University of Saskatchewan in 1971 and became a Fellow of the Royal College of Physicians and Surgeons of Canada in orthopaedics in 1977. He received a diploma in orthopaedic hand surgery in Colorado. In 1980, he obtained an American Board Certification in orthopaedics. From approximately 1978, Dr. Hicks was a member of the Visiting (now Consulting) staff category at the PAH, within the Department of Orthopaedics. He has made a valuable contribution to the hospital over the years. Dr. Hicks was an active participant in the orthopaedic on-call coverage rota until the mid 1990's, and following a relatively brief interlude, thereafter until 2009 and the events giving rise to this Appeal.

Dr. Hicks currently holds privileges as an Active member of the medical staff at the LMH, where he is entitled to admit and discharge patients, has an elective surgery slate and participates in the orthopaedic surgery on-call rota at that hospital. By contrast, as a member of the Consulting staff at the PAH, Dr. Hicks may not admit or discharge patients, but may write orders and treat patients in a consulting capacity. He has no elective surgery slate at the PAH.

In 1994, the PAH declined to renew Dr. Hicks' privileges as a Visiting staff member, giving rise to proceedings before the Medical Appeal Board in 1996. In that case, Dr. Hicks was successful in his appeal for re-appointment as a Visiting Consultant at the PAH. The 1996 decision turned on the Board's determination of the need to ensure appropriate orthopaedic on-call emergency coverage:

> …we suggest that the hospital should consider appointment of a third orthopaedic surgeon to its active staff if the need is clear, if support of local physicians and local patients is obvious and if a truly committed surgeon of such quality that the needs of the community will be well served becomes available. Meanwhile the hospital needs help in its coverage of orthopaedic emergencies, since, despite the promise of the two Active Consultants in the Division to alternate call, no one should be expected to take call every second night. Appointment of a Visiting Consultant to service this function does not preclude appointing a third surgeon to an Associate Consultant position and, should such an appointment be made, there is no obligation on the part of the hospital to give emergency calls to a Visiting Consultant whose services had been needed previously. The fact that the Visiting Consultant was no longer needed by the hospital would be made clear by the actions of the hospital without precipitating the difficulties which might result from failure to the renew an appointment.

> The Appellant has shown his commitment to the institution, despite the complaints which have been levelled and about which there has been conflicting evidence. At the same time, this Panel cannot support the Appellant's attempts to obtain elective operating privileges. There must be no impediment to him undertaking treatment of patients seen in the Emergency Department and requiring urgent surgery. Similarly there should be no impediment to his obtaining time to do secondary operations arising from consequences of their initial surgery. But there should be no attempt on his part to increase his surgical activities in the hospital otherwise. The rules are clear, they are widely accepted in Hospitals throughout the Province and, we believe, they are fair.
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> For these reasons, this Board grants the Appellant Visiting Consultant Privileges without elective operating privileges at the Peace Arch Hospital.
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> (underlining added)

Following the 1996 Medical Appeal Board decision, Dr. Hicks provided orthopaedic on-call emergency coverage at the PAH, initially sharing the rota with two other Active orthopaedic staff members. On the evidence before us, the events giving rise to the decision of the FHA Board of Directors appealed from here occurred in 2008 and 2009. A number of related problems associated with operating room resources and functioning, orthopaedic on-call coverage and Dr. Hicks' behaviour within the PAH converged. Some of the witnesses who testified on this Appeal attributed greater or lesser weight to those problems and their causes.

Dr. H, PAH Medical Director from November 2006 to February 2009, testified on behalf of the FHA. She gave evidence that in 2008, there had been resignations of operating room nursing staff due to over-time work requirements associated with after-hours surgery. It became apparent to her that there was an inordinate recourse by Dr. Hicks to after-hours and late-night operating room time for surgery involving patients admitted during his emergency on-call service time. In the absence of elective surgery time during regular operating room hours, which elective time was not available to Dr. Hicks as a Consulting staff member, he chose to schedule surgery in the evenings and on weekends, outside of the normal elective slate time, and tended to characterize operations as "emergency" surgeries when they would otherwise be treated by an Active staff member as elective procedures during regular operating room times.

Dr. H explained that this resulted in an increased volume of orthopaedic surgeries, particularly after-hours, with resulting stress on operating room nursing staff and operating room resources. It became apparent to Dr. H that whereas an Active orthopaedic staff member with elective operating room time was able to use that elective time for surgeries, Dr. Hicks often performed his operative procedures on an emergency basis after regular daytime operating room times.

Dr. H also registered concerns with an apparent lack of coordination between the members of the Active orthopaedic staff in arranging for adequate on-call coverage. It appeared to her that there did not seem to be good communication within the Orthopaedic Department itself. There were times when two or three Active orthopaedic staff members were concurrently on extended holidays and unable to provide adequate on-call coverage. She considered that there was over-reliance by the Active orthopaedic staff upon Dr. Hicks to "step into the gap" in providing on-call services which otherwise the Active orthopaedic staff members ought to have arranged between themselves.

In the result, Dr. H initiated an active dialogue with the members of the PAH Orthopaedic Department in 2008. She discussed with them the over-utilization of Dr. Hicks for on-call coverage, the reallocation of operating room resources for emergency orthopaedic surgery time and the desirability of recruiting a new Active member of the Orthopaedic Department in the spring or summer of 2009. She summarized her view of these and other issues in her memorandum entitled "Summary of PAH Orthopaedic Issues December 20, 2008". In it she referred to Dr. Hicks variously as the "non-active staff member":

> "The current contract has not yet been signed by all parties. The contract contains 4 names, one of which is not on the active staff at PAH and who generates high intensity of work when on call.
>
> The non active staff member on the MOCAP list has generated multiple complaints due to behavioural issues as well as lack of compliance with PAH booking and admission policies and procedures. The behavioural issues are in the process of being addressed through respectful workplace policy process, but even through the course of this, there have been additional issues brought forth and significant problems are ongoing. (details can be provided as needed). These dynamics have added profound stress to an already stressed OR program. There has been a high rate of burnout of RN staff with some resignations occurring which have been due to the use to a large part (*sic.*) to the involvement of this medical staff member.
>
> The ortho group has been asked informally on several occasions to discontinue involvement of this staff member. Over the early summer of 2008 several meetings and conversations took place, primarily with Dr. S as spokesperson for the division, where a plan was laid out to gradually decrease the involvement of this staff member over the fall with the expectation that as of 2009 his services would no longer be required. To enable this transition, the agreement was made that orthopaedic trauma time would be made available during the daylight hours, to decrease ortho after hours surgery requirements. With this in place, it would be possible for the group to be self sufficient in providing call coverage, at least for a few months with the plan being to recruit for a new member of the group by spring/summer 2009.
>
> … In follow up with Dr. S by phone he expressed his displeasure and disappointment in the slow progress of administration in instituting this trauma time or in any additional ortho resources, and indicated therefore that it would not be viable for the division to institute or maintain a 1/3 roster. He was asked to continue to support limited involvement of non active staff while we continued to work on infrastructure issues."

. . . . . .

> A recent meeting was held with the division of orthopedics and head of anesthesia and surgery at PAH. One of the main issues discussed was the significant disruption to the surgical services by ongoing extensive use of this non active staff member. At this meeting the orthopaedic surgeons indicated that they would be willing to stop using non active staff only with written directive from administration.
>
> The MOCAP schedule to the end of March has already been published on the FHA website, therefore the earliest target date for removing this surgeon from the schedule would be April 2009.

> The orthopaedic surgeons verbally agreed not to make further changes to the schedule by giving away more shifts to non active staff".

One of the resulting initiatives implemented at the PAH was a program of Dedicated Orthopaedic Trauma Time ("D.O.T.T."). Dr. L, the local head of the Department of Surgery at the PAH in 2008 and 2009, and now FHA's Regional Head of Surgery, described the origins of the D.O.T.T. program. He testified that this program, in which a daily time slot of 3:00 p.m. to 5:30 p.m. was exclusively reserved for orthopaedic trauma surgery, was developed, in part, as a result of the resignation of operating room nurses who were being overwhelmed by the number of orthopaedic and other surgeries required to be undertaken after normal operating room hours, in the evenings, at night and over the weekend. He gave evidence that due to a small operating room capacity and relatively small number of operating room nurses at the PAH, it was necessary to develop the program to ensure that operating room nursing staff were not overworked. Dr. L testified that following the implementation of the D.O.T.T. program, nursing morale improved significantly with the result that there were no further resignations. He also said that some of the nursing staff resignations related to respectful workplace issues involving Dr. Hicks. In his view, the D.O.T.T. program had no effect on the amount of on-call time otherwise available to Dr. Hicks at that time and was implemented merely to alleviate the pressure on operating room staff.

Dr. C, PAH Medical Director from March 2009 - 2010, and Dr. H's successor, testified that upon her assuming her position at the PAH, the hospital administration was concerned overall with the performance of the Orthopaedic Department. She acknowledged that there were challenges confronting the PAH in February 2009, in that there were only three Active member orthopaedic surgeons, a complement which was insufficient to cover the on-call roster consistently or a comprehensive orthopaedic service capability within the PAH. She came to the view that the PAH required additional orthopaedic staff after her consultations with the members of the Orthopaedic Department. A decision was then made by the FHA to recruit a fourth orthopaedic surgeon to the Active medical staff, enabling a one-in-four coverage rotation of Active staff members in emergency on-call.

In 2009, Dr. C consulted with members of the PAH Orthopaedic Department on the question of Dr. Hicks ceasing on-call services, and understood them to be supportive of a decision that Dr. Hicks not continue on the on-call rota. Initially, there was a search conducted by the FHA for one additional orthopaedic surgeon. Dr. B was considered the strongest candidate for this new appointment. At a meeting with the Orthopaedic Department, Dr. Y raised a concern that Dr. KK was reducing his clinical time and might soon be retiring. If that occurred, the full-time Active staff would, even with the addition of Dr. B, revert to the existing one in three on-call coverage. She was told by members of the Orthopaedic Department that they had become familiar with Dr. JK, Dr. KK's son, and were impressed with his clinical services. Accordingly, a decision was made by Dr. C to authorize the hiring of a fifth orthopaedic surgeon, Dr. JK, in addition to Dr. B. Dr. JK would be brought onto the Active provisional staff with a view to him ultimately replacing his father. In the interim there would be five Active staff orthopaedic surgeons capable of providing on-call coverage.

Dr. C testified that in February 2009, she became aware of two other matters respecting Dr. Hicks. First, she became aware of complaints about Dr. Hicks' professional behaviour, which were being addressed through a mediation process within the FHA. An investigation by the FHA was carried out pursuant to its Respectful Work Place Policy into

allegations that, if substantiated, would constitute violations of those policies by Dr. Hicks. Arising out of this, on May 14, 2009, Dr. Hicks entered into a "Behavioural Contract" as part of an FHA complaint resolution process, a condition of which included his enrolling in the Physicians Universal Leadership Skills Education ("P.U.L.S.E.") Program. Second, Dr. C became aware of Dr. Hicks providing on-call services at both the PAH and the LMH to such an extent that, in her view, it would not allow Dr. Hicks to provide satisfactory patient care. She considered that there was a need for Dr. Hicks to reduce his overall level of emergency on-call participation.

In response to a letter from the FHA dated February 23, 2009, advising Dr. Hicks that his excessive level of on-call participation was "an unsafe practice" and that he would no longer be scheduled for on-call at the PAH, Dr. Hicks ceased providing emergency on-call services there as of April 1, 2009. Following "negotiations", involving legal counsel for Dr. Hicks and the FHA, Dr. Hicks was reinstated to the PAH emergency on-call rota in May 2009 on the condition that he agree to reduce his combined on-call shifts to twelve per month at the two hospitals.

Prior to April 1, 2009, Dr. S, a member of the Active medical staff in the PAH Division of Orthopaedics, raised with Dr. C the concerns of the Active orthopaedic staff and sought an appropriate assurance from the FHA that proper process had been followed and that the FHA would take responsibility for any fallout from the apparent direction that Dr. Hicks cease on-call coverage at the PAH. More specifically, Dr. S requested the FHA's assurance that "any action brought against us as a result of these proposed changes will be handled by the FHA, including legal fees, and compensation for time and income lost, as well as any other losses and damages, including loss of reputation (related to media exposure and other similar mechanism)". The concerns raised by Dr. S on behalf of the Active staff of the Orthopaedic Department were acknowledged by Dr. C, who advised that she would take the issue of possible litigation and its consequences forward to Dr. W, the then acting Executive Medical Director of the FHA.

By April 15, 2009, three candidates for the new orthopaedic positions at the PAH were selected for interviews. Following this, on June 3, 2009, Dr. W, who had authored the earlier letter to Dr. Hicks dated February 23, 2009, wrote to Dr. Hicks and advised him that two new orthopaedic surgeons had been selected to join the Active staff at the PAH, bringing the total complement of the hospital's Orthopaedic Department to five. He advised that as a result of the additional numbers of orthopaedic Active staff, Dr. Hicks' participation in the on-call rota for the PAH would no longer be required as of October 1, 2009. In a follow up letter on June 29, 2009, Dr. W gave Dr. Hicks the contractually required ninety-day written notice of the termination of his MOCAP agreement, effective October 1, 2009. The MOCAP Agreement provided for payment at established rates for participating physicians in the provision of orthopaedic on-call coverage services.

On August 5, 2009, Dr. C confirmed in writing to the Active staff members of the PAH's Orthopaedic Department that Dr. Hicks had been formally notified that as of October 1, 2009, his MOCAP agreement would be terminated and his on-call services at the PAH would no longer be required. She informed the orthopaedic Active staff members that, with five orthopaedic surgeons on staff after the two new appointments, she considered that the decision to remove Dr. Hicks from the orthopaedic on-call rota was consistent with the 1996 decision of the Medical Appeal Board.

On September 11, 2009, an additional four to six weeks of cast clinic time was allocated to Dr. Hicks so that he could continue to access the clinic until all his patients had

completed their care with him. At the same time, Dr. C wrote to Dr. W, advising that she thought it unlikely that Dr. Hicks would do any *locum tenens* work for other orthopaedic surgeons at the PAH, but that she had no issue with him doing so. It was subsequently confirmed with Dr. Hicks that should he participate in the orthopaedic on-call rota at the PAH, in his capacity as a *locum tenens*, he would have access to MOCAP funds and the cast clinic for those patients under his care. On October 19, 2009, Dr. C wrote to Dr. Hicks confirming that if, at any time in the future, he were to be requested to participate in the orthopaedic on-call roster at the PAH, he would be assured clinical time once again. We take this to be an intended reference to Dr. Hicks' participation in the on-call rota in his capacity as a *locum tenens* or Temporary staff member.

Dr. S, who remains a member of the PAH Active orthopaedic staff, gave evidence on behalf of Dr. Hicks. He recalled being asked on a number of occasions by others in 2008 to either reduce, or preferably remove, Dr. Hicks from the on-call schedule. He testified that these requests came from Dr. H and Dr. F, as well as from either Dr. SS or Dr. L. He testified that, in response, he requested that the Orthopaedic Department be provided with a written directive by the PAH administration to that effect. At that time, the three Active staff members in the Orthopaedic Department at the PAH considered that in order to maintain a full complement of orthopaedic on-call services, a fourth orthopaedic surgeon would be required to be added to the medical staff. In the absence of a fourth orthopaedic appointment, it was his department's view that it could only provide full-time on-call coverage with Dr. Hicks participating in the rota. It was his belief at the time that, as a part of the FHA, the PAH's Orthopaedic Department could not independently do what it wished in excluding Dr. Hicks from the on-call rota and accordingly, he sought a proper written directive from the FHA administration to that effect.

When he requested direction from the FHA regarding Dr. Hicks' removal from on-call coverage, Dr. S was aware of the 1996 decision of the Medical Appeal Board and that, as a result of that decision Dr. Hicks had been given an opportunity to continue to provide on-call coverage. Dr. S testified that he was not sure in 2008 and 2009 whether Dr. Hicks had the right to on-call participation, but that he knew it was likely that Dr. Hicks would obtain legal advice and bring proceedings in the event his participation was terminated. For this reason, he requested the FHA's agreement that it take responsibility for legal costs in such event. He was also concerned about media attention flowing from any decision to terminate Dr. Hicks' on-call coverage participation and was concerned about damage to reputations, presumably of the members of the Orthopaedic Department at the PAH, in the fallout from such a decision.

Dr. F, Head of the Department of Anesthesiology at the PAH, testified of his observations during the 2008 – 2009 period. It was apparent to him as well that there was a major problem in the Operating Room Department at the PAH. He considered that there was no real organizational structure utilized to determine how the operating room time was allotted. He described it as "a bit of a free-for-all". Dr. F accordingly implemented the Slate Coordinating Committee and a multi-disciplinary approach in addressing problems in the use and functioning of the operating room facilities at the PAH. It was apparent to him that operating room nursing staff considered that there was an excessive work load being placed upon them. Covering three operating rooms with twenty nursing staff was challenging and many of the operating room nursing staff were being required to perform evening work. They were suffering from "burn-out" upon being called back for a lot of after-hours and nighttime support for orthopaedic and obstetric surgeries.

Dr. F considered that some of the problems associated with the overtime use of the operating rooms were attributable to Dr. Hicks, who required evening surgery time in the absence of any daytime elective slate time. It was his impression that the absence of an elective slate lead to the tendency by Dr. Hicks to designate surgery as "emergency" in order to obtain evening and nighttime operating room access and use. He felt that since Dr. Hicks had no capacity to do surgery during the elective slate time during the day, those surgeries ended up on the emergency board for evening surgeries.

Dr. F also testified that he became aware that members of the Orthopaedic Department were unwilling to participate fully in the on-call program. He referred to one orthopaedist as being away for significant periods of time, during which he was not available to do on-call. In response to the problems associated with operating room nurse morale and the use of evening and nighttime surgery times for emergency orthopaedic surgery, he implemented steps through the Slate Coordinating Committee to reduce evening and nighttime operating room use.

One of the steps taken was to implement the D.O.T.T. program, which involved the dedication of a half day of regular elective orthopaedic operating room time, to ensure that emergency cases were handled during the day and not after-hours. He testified that, in spite of instituting a number of changes, including the D.O.T.T. program, there were still significant pressures for evening and nighttime surgery placed on the system by Dr. Hicks. If Dr. Hicks was unable to perform surgeries during the D.O.T.T., he would retain and schedule patients for evening and nighttime surgery instead of turning over those surgeries to other physicians to perform in normal operating room hours. It was his view that Dr. Hicks' inability or incapacity to schedule elective surgery meant that he constantly added patients to the emergency lists for evening and nighttime surgeries and that this "kept recurring in the system", leading to conflict between Dr. Hicks, the nurses and the operating room booking staff.

Dr. F testified that there was no plan by the PAH that was aimed simply at removing Dr. Hicks from the on-call schedule, but that the overall objective in recruiting additional Active orthopaedic staff in 2009 was to increase the number of Active staff to enable adequate on-call coverage and that the Active staff, having elective privileges, would reduce the evening and nighttime emergency surgery demands that Dr. Hicks continued to place on the system. It was the combined effect of certain members of the Orthopaedic Department taking long absences without appropriate on-call coverage and their over-reliance upon Dr. Hicks' provision of on-call coverage that contributed to increased requirements for evening and nighttime access to the operating room resources. It was anticipated by Dr. F that once the complement of Active orthopaedic staff was increased in 2009, and the D.O.T.T. program became fully functioning, the PAH's Orthopaedic Department could adequately fulfill its on-call coverage requirements without resort to the participation of Dr. Hicks. This would, in turn, reduce the problems associated with excessive evening and nighttime operating room demands.

Dr. SS testified on behalf of the FHA that he did not support the idea of having on-call surgeons without Active privileges. Dr. SS was the local Head of the PAH Department of Surgery when, as late as May 10, 2012, Dr. B suggested that Dr. Hicks help cover on-call due to inadequate manpower to provide on-call coverage for the month of August 2012. Dr. SS was not in favour. In his view, the then five Active staff orthopaedic surgeons should not be "trying to get out of covering their summer vacation call" and they should utilize Active staff members of the Orthopaedic Department for that purpose.

Dr. Y gave evidence as a member of the orthopaedic staff at the PAH. Dr. Y has been a member of the orthopaedic staff of the PAH since 1987 when he was initially responsible for organizing the orthopaedic on-call schedule. When Dr. Y started working in the PAH's Orthopaedic Department there were only three practicing orthopaedic surgeons at the PAH: Dr. KK, Dr. Hicks and himself. Only he and Dr. KK were members of the Active staff at that time, and Dr. Hicks was then a Visiting Consultant. Dr. S joined the Active staff later.

Dr. Y generally recalled that in 2008 there was a request from the PAH medical director to remove Dr. Hicks from the orthopaedic on-call schedule. He was unsure at the time whether there would be any legal ramifications if the Orthopaedic Department unilaterally removed Dr. Hicks from the on-call schedule. Accordingly, a letter of direction to that effect was requested by the members of the Orthopaedic Department from the FHA. Dr. Y recalls that the Orthopaedic Department sent a letter to the FHA requesting assurance that any legal issues arising out of the termination of Dr. Hicks' on-call participation would be handled by the FHA. He testified that he would not have removed Dr. Hicks from the on-call rota if he had not been directed to do so in writing by Dr. C on August 5, 2009. It was his understanding in March 2009 that the reasons for Dr. Hicks being sought to be removed from on-call coverage was that there were conflicts between Dr. Hicks and the PAH's staff members, including anesthetists and nursing staff, as well as a problem with Dr. Hicks scheduling cases without going through the "proper protocol". He agreed that the FHA's reasons for bringing on additional Active orthopaedists in 2009 was related to an increase in patient needs in the White Rock area.

Dr. Y gave evidence that, with the current complement of Active orthopaedic staff at the PAH at the time of the hearing of this Appeal, there was no need to include Dr. Hicks in regular on-call coverage. He testified that the Orthopaedic Department was satisfied that it had the manpower to cover on-call at this time and that they could resort to the use of a *locum tenens* if need be. In summary, as far as Dr. Y was concerned, there was no need to have Dr. Hicks reinstated to the regular on-call roster at this time.

Doctors KK and JK both gave evidence. Dr. KK became an Active member of the orthopaedic staff at the PAH in approximately 1982. It was apparent that his knowledge was somewhat limited as to the discussions between the PAH administration and the Orthopaedic Department regarding the use of Dr. Hicks' services in 2008. He testified that the Orthopaedic Department would have liked to have continued to use Dr. Hicks on the on-call schedule in 2008. In his view, had the Orthopaedic Department not received a letter from the PAH administration directing the removal of Dr. Hicks from the on-call schedule, Dr. Hicks would not have been taken off the rota by the Orthopaedic Department. He testified that he could not recall any other occasion in which the PAH administration specifically directed the orthopaedic group as to who was to be put on the on-call schedule.

Dr. KK acknowledged that, notwithstanding the FHA directive, he had nevertheless asked for and obtained Dr. Hicks' relief and on-call coverage on October 17 and 18, 2009. Surprisingly he did not believe that meant that Dr. Hicks was effectively being placed back on the on-call roster. Instead, he considered that Dr. Hicks was merely "covering" for him when he was away. Dr. KK's evidence on this point was rather equivocal. He was informed by Dr. C that Dr. Hicks should not be put on the on-call roster and after that time, Dr. KK has not utilized Dr. Hicks to replace him in providing on-call coverage

Dr. KK did not participate in the on-call schedule from November 2010 to November 2011. In December 2011, he started taking either one or two days of on-call coverage and said that this may increase to four or five days per month in the future. He agreed with Dr. Y's stated view that the Orthopaedic Department at the PAH is satisfied that, with the present complement of Active staff members, it can fulfill its on-call obligations. He agreed that, at this time, there is no need for any new or different persons, other than the current compliment of Active orthopaedic staff members to participate in the regular on-call roster at this time.

On cross-examination, Dr. KK agreed that in 2008 there were "real problems" concerning the PAH and its operating room services, which were under stress due to growth in community health needs and the limited number of operating rooms available. The problems that the Surgical Slate Coordinating Committee were grappling with at the time were, in his view, not specifically related to Dr. Hicks or the Orthopaedic Department. He recalls that there were a number of resignations of operating room nurses complaining that they were being required to perform too much overtime work. He also recalled that there were problems dealing with absences from on-call coverage and in establishing an equitable allocation of on-call responsibilities within the Orthopaedic Department. These issues were confronting the PAH administration, which was endeavoring to handle them in the interests of the hospital. In his view, the issue "wasn't just Dr. Hicks".

Dr. KK has never used the services of Dr. Hicks as a *locum tenens*, but he is not aware of any reason why Dr. Hicks could not take on-call time as a *locum tenens* at the PAH. He concluded that, at present, with the compliment of five orthopaedic surgeons at the PAH, there is no actual need to place Dr. Hicks on the on-call schedule, but when Active staff members are away, there might be such a need.

Dr. JK commenced his practice at the PAH in September 2009. At the time of the hearing of this Appeal, he was responsible for setting the on-call schedule within the PAH's Department of Orthopaedics and had held that role since August 2010. He testified that establishing the on-call coverage schedule is essentially a group decision based on input from the Active members of the orthopaedic staff. In the normal course of events, it is reasonable for all Active members of the Orthopaedic Department to cover on-call on a "fairly equitable basis". In instances of illness, unexpected family absences, vacations, conferences and the like, other Active staff members will normally cover absences, and when that is not possible, a *locum tenens* can be used by the absent Active member. Dr. JK recalled that in one instance in the summer of 2011, Dr. WW was used as a *locum tenens* on the orthopaedic on-call rota.

Dr. JK testified that he considers that the members of the Orthopaedic Department are currently satisfied that there is adequate on-call coverage to meet the needs of those seeking medical treatment at the PAH through the current on-call coverage allocations among Active staff orthopaedists. He agreed that the on-call system currently in place at the time of the hearing of this Appeal is "working adequately to serve the needs of the community".

Dr. JK recalled a brief discussion with Dr. F in the spring of 2011 during which Dr. F expressed his view that it would be a poor idea to put Dr. Hicks on the on-call rota because members of the Department of Anaesthetics felt negatively about Dr. Hicks' return. He also recalled one discussion he had with Dr. SS during which the latter expressed the view that the decision about whether to obtain a *locum tenens* was up to

the Orthopaedic Department, but that it was not a good choice for Dr. Hicks to be utilized based on his somewhat disruptive past record.

As to the significance of access to on-call time, particularly for the development of the practices of newer orthopaedists, Dr. JK confirmed that he and Dr. B had been keen upon joining the PAH's Active staff to build up their practices and increase their patient referrals by being present at the PAH as much as possible and assuming on-call coverage responsibilities. He confirmed that in order to build up a practice, it is desirable for an orthopaedist to take on-call coverage as well as to provide services as a *locum tenens.*

Dr. W gave evidence as the current Executive Medical Director of the FHA. He has a lengthy and relevant background. Trained as a pediatrician, he became president of St. Paul's Hospital and then Deputy Minister of Health for the Province of Nova Scotia, prior to taking a position as Executive Medical Director for Interior Health in British Columbia and acting Vice President of Medicine for the FHA. In October 2008, he assumed his position as the FHA's Executive Medical Director.

As incoming Executive Director of the FHA, Dr. W came to the view in February 2009 that Dr. Hicks was working an excessive number of days on-call between the LMH and the PAH. Following his review of the matter, Dr. W wrote to Dr. Hicks on February 23, 2009, advising him that the FHA considered that Dr. Hicks' participation in the provision of on-call coverage for a total of 16 days in the month of January was "an unsafe practice for both you and our patients". For that reason, Dr. W advised Dr. Hicks that as of March 31, 2009, he would no longer be scheduled on the roster of on-call orthopaedic surgeons at the PAH. In cross-examination, Dr. W conceded an error in his calculations and that Dr. Hicks' on-call total time for the month of January 2008 was actually 13, and not 16 days; however, we do not find that this error is material to our alternative decision on the merits.

When he wrote his letter of February 23, 2009 to Dr. Hicks, Dr. W testified that he was unaware of any plans by the PAH to remove Dr. Hicks from the emergency on-call rota as of April 1, 2009 and denied that this played any role in his decision to write to Dr. Hicks. He said it was his decision to remove Dr. Hicks from the on-call schedule, and that it was based primarily on the fact that Dr. Hicks had Active staff privileges at the LMH and the PAH, and that the combined days of on-call coverage undertaken by Dr. Hicks was "profoundly unsafe for patients". Even Dr. Hicks agreed during his own testimony that his level of on-call coverage prior to being reduced, pursuant to Dr. W's letter was "too much".

Upon his initial appointment as Executive Medical Director, Dr. W assumed many of the duties of the then vacant position of the Vice-President of Medicine. Those duties included overseeing medical staff and medical staff structure, dealing with issues relating to quality of patient care, medical staff behaviour and the recruitment of medical staff for the FHA's hospital sites. Upon taking up duties at the FHA, he embarked upon a process of developing and implementing a program management system across the twelve acute care hospitals within the FHA. That program engaged issues of patient access to medical services, quality of care, the setting of standards and best practices, and the allocation of resources, including hospital operating room facilities. One of these initiatives resulted in the development of the current *Bylaws* and *Rules* which were adopted by the FHA in January 2010 and remain in effect at this time.

Dr. W generally described the way in which the FHA interprets and implements the *Bylaws* and *Rules* of the FHA in relation to categories of medical staff, including ensuring the provision of adequate emergency on-call services and the use of *locum tenens*, provisional and Temporary staff categories to fulfill the requirements of the FHA's hospitals and the communities they serve.

He gave evidence that the practice and role of Consulting staff is to consult as specialists or sub-specialists upon the request of Active medical staff members. Consultants are permitted to write orders and direct the treatments of those patients in respect of whom they are asked to provide consulting services but that they do not generally assume the role of most responsible physician with overall patient care responsibilities. Members of the Consulting staff category do not have the right, as such, to admit patients or to perform elective surgery. It is expected that members of the Active medical staff will provide continuous on-call coverage for emergencies and treatment within their respective medical divisions. Active staff members are required under the FHA *Bylaws* to participate in on-call coverage as an incident of their Active medical staff category.

Dr. W described a *locum tenens* as a physician who is brought in to cover a member of the Active medical staff's practice within a hospital when the Active staff member is absent from the hospital for a period of time. As a matter of practice, during that time the *locum tenens* is entitled to admit patients under the name of the absent referring physician and the *locum tenens* services are billed to the Medical Services Plan under the name of the former by the *locum tenens*. Physicians acting as a *locum tenens* may or may not, depending on an agreement with the physician being replaced, take over the offices and overall practice of the absent referring physician. As a matter of practice *locum tenens* are appointed for a prescribed period of time and it is the FHA's expectation that when the replacement period ends, the returning physician will assume responsibility for those patients handled in his or her absence by the *locum tenens*.

Dr. W described the Temporary medical staff category as one to which a physician may be appointed by the FHA to meet certain specific service needs within a department for a defined period. These appointments may be made in circumstances of a shortage of Active medical staff or for temporary needs pending appointments to additional medical staff. At the conclusion of the term of the temporary appointment, the relevant medical department or division will assume responsibilities for ongoing care and treatment of the patients managed by the departing Temporary staff member.

Dr. W testified to the expectation within the FHA that medical staff members holding Active privileges provide on-call emergency coverage on a continuous basis for emergency room and in-patient care. It is expected that the relevant hospital department's Active members will arrange the on-call schedule to afford adequate coverage, failing which it is possible to arrange for a Temporary staff appointment, as may be required. Normally the emergency on-call roster includes members of the provisional and Active staff of the relevant medical department.

According to Dr. W, as a matter of practice, members of the Consulting staff may be requested by the FHA to participate in on-call coverage duties. The involvement of the FHA in the decision to approve the participation of Consultants in on-call duties is considered important to address any major concerns and ensure that appointments are compatible with the safe operations of hospitals and optimal utilization of hospital resources. The FHA allocates resources at various hospital sites with the expectation that, within those sites, members of the Active medical staff will participate in decisions

about how hospital resources are to be used within the scope of the FHA's *Bylaw*s, *Rules* and other policies or procedures implemented by the FHA's Board of Directors. Dr. W considers the role of the FHA in this process as critically important having regard to the increasing challenges surrounding resource allocation and the overall use of hospital resources. The FHA considers that the defined medical staff categories are established with a view to managing the allocation of hospital resources.

It was the testimony of Dr. W that, as a matter of practice, if a member of the Consulting staff was requested by the Department of Orthopaedics to participate in an on-call schedule in light of a need for the same, permission would first have to be granted by the FHA. It is also standard practice within the FHA that where an Active member seeks to utilize a *locum tenens*, the former must first obtain the approval for the appointment from the FHA Regional Department Head. He said that the FHA had relegated the organizing of the on-call schedule to local hospital departments. If a local Orthopaedics Department asked for a member with Consulting staff privileges to participate in the on-call schedule, it was nevertheless open to that Consultant to refuse. If, however, it was necessary for a Consultant to participate in the on-call schedule to meet hospital requirements and the Consultant refused, he or she would not be in compliance with the *Bylaws*.

The FHA does provide medical departments with the discretion to establish the content of on-call schedules for Active staff members. The FHA does not, however, cede authority to its medical staff to unilaterally determine who may be eligible to participate in on-call coverage. This remains the jurisdiction of the FHA through its implementation of the *Bylaws, Rules*, guidelines and policies. If there is a requirement to bring a non-Active staff member onto the on-call schedule, Dr. W testified that it was the FHA's expectation that the non-Active staff member would participate in on-call either as a *locum tenens* or Temporary staff member and, further, that the FHA's Regional Department Heads would be required to be consulted in order to determine whether to approve that participation having regard to the FHA's overall objective of ensuring the preservation and continuity of patient care. It is the FHA's expectation that the *locum tenens* or Temporary staff member will transfer ongoing patient care to the referring physician and the department, respectively, upon the termination of the coverage period.

Dr. W was referred to proposed appendices to the *Bylaw*s and *Rules* entitled "Parameters for Locums and Temporary Staff" (the "Guidelines"). The Guidelines have been accepted by the FHA's Board of Directors and Dr. W testified that the FHA is in the process of incorporating them into the *Bylaws*. The Guidelines, at the time of the hearing of this Appeal have, according to Dr. W, been adopted by the FHA as an operational policy.

Dr. W considers that it was necessary to develop the Guidelines in the first instance to augment and clarify the FHA's practices and expectations with respect to the *locum tenens* and the Temporary medical staff categories. We were informed by Dr. W that the Guidelines that were adopted are currently undergoing further revision by the FHA. We do not understand the FHA *Bylaws* and *Rules* to be exhaustive in their scope as it relates to the operation of the FHA's hospitals; the development of policies and practices not inconsistent with the FHA *Bylaws* or *Rules* are both necessary and permitted. They provide that before a *locum tenens* or Temporary staff may practice within the FHA, he or she must be "appropriately credentialed and privileged", and "subsequently appointed by the Board". The Guidelines provide that "individuals may practice as a *locum tenens* or Temporary staff member" if they have been granted "*locum* or Temporary status by the Regional Department Head or delegate". The Guidelines state the following:

> As per the *Bylaws* – Members of the *locum tenens* staff are appointed for a specified period not to exceed twelve months for the purpose of replacing an absent member of the active, provisional, or consulting staff or for the purpose of replacing the duties of a vacant medical staff position.
>
> 1. All *locums* must be properly credentialed and privileged as is required by the Medical Staff *Bylaws*;
>
> 2. *Locums* are engaged for the purpose of fulfilling the responsibilities of a medical staff member who was absent and unable to meet their responsibilities. The *locum* appointment is for a clearly defined period of time;
>
> 3. The member must be absent and cannot be performing other medical duties elsewhere in Fraser Health; and
>
> 4. *Locums* assume all the responsibilities of the absent physician for the duration of the absence, and upon return, the absent member must assume all responsibilities of their practice and they will also assume the care and on-going management of all the patients that the *locum* admitted during the time the *locum* was covering the absent physician's practice.

Similarly, with respect to the appointment of Temporary staff, the Guidelines provide:

> As per the *Bylaws* – members of the Temporary staff are appointed for a specified period not to exceed twelve months for the purpose of filling a temporary service need.
>
> 1. All Temporary staff must be properly credentialed and privileged as is required by the Medical Staff *Bylaws*;
>
> 2. Temporary staff will be engaged for the purpose of fulfilling the service needs of a clinical department unable to meet their responsibilities for short time periods. The appointment is for a clearly defined period of time; and
>
> 3. The Department will assume all the care and on-going management for all of the patients that the Temporary staff admitted during the time that staff worked in Fraser Health.

Dr. W testified that the FHA's expectation is that Active and provisional staff members of a local hospital department will develop an on-call schedule which affords 24/7 coverage for the emergency room and the care of in-patients. As a matter of practice, if an Active or provisional staff member anticipated that they may become, or they became, unavailable to provide medical services at a hospital, including on-call coverage, it is expected that he or she will canvass the other Active and provisional staff members to determine if they can provide substitutional on-call coverage services, failing which he or she will attempt to obtain a *locum tenens* to perform those services. If a *locum tenens* is not available and the relevant hospital department is unable to provide continuous on-call coverage, that department is expected to seek a Temporary staff appointment to meet its service needs. In each case, the appointment and approval of Temporary staff and *locum tenens* appointment rests with the FHA, insofar as the FHA is ultimately responsible for the safe operation of the hospitals and for the optimal utilization of its available resources.

According to Dr. W, if a member of the Consulting staff was asked to participate in an on-call schedule pursuant to *Bylaw* 6.5.5, then, as a matter of practice, the approval of the FHA would first be required to enable on-call participation. This is so because the

participation in on-call coverage would require the physician to obtain a *locum tenens* or Temporary staff position. He testified that, unless specifically asked by the FHA to provide on-call coverage, a physician holding Consulting privileges would be required to obtain a *locum tenens* or Temporary staff appointment in order to provide on-call coverage. Dr. W gave evidence that, as a matter of practice, the FHA's Regional Department Heads are required to approve a *locum tenens* or Temporary staff physician on behalf of the FHA to enable a Consulting staff member to provide on-call coverage for an Active or provisional staff member. Once that approval is obtained, it would fall to the local hospital department to establish the schedule for participation in on-call coverage.

Dr. W reiterated that the Guidelines, which are current policy and may be adopted as formal *Rules*, were instituted to address a significant abuse of the concept of *locum tenens* and Temporary staff appointments with resulting risk to patients. It was his view that physicians were "disobeying the rules", and there was concern that the *Rules* were not clear enough with respect to the appointment and role of *locum tenens* and Temporary positions. The Guidelines address the transfer of patient care at the end of the period of *locum tenens* or Temporary staff coverage. In Dr. W's view, the transfer of patient care requirements are necessary and desirable to ensure that hospital resources, including operating room, in-patient ongoing care and cast room access, can be coordinated in such a manner as to optimize the use of hospital assets and resources. Dr. W summarized in his testimony the practices which are contemplated in the Guidelines, as follows:

> We've basically taken twelve small hospitals and tried to move them into regional programs, and part of that ongoing ability for us to operate and provide reasonable and safe care of the patients will continue to be a re-working of the *Bylaws,* policies and procedures, until such time we get to a level that we are comfortable with.
>
> Again, in terms of departmental -- departments setting the call schedule, we do allow some discretion at that level for the Active staff member. But if a requirement is to bring somebody else in on a temporary or short-term basis then, in fact, those Guidelines are -- our expectation is that they would either be *locums* or Temporary Staff, and when their period of time is completed, that somebody has to assume the responsibility of those patients. In the case of a *locum*, it is whoever that individual has replaced, and in the case of a temporary service need, when the service need is over, the department has the responsibility to assume the care of the patient, and whether the department assigns those patients to one individual or they share the patients, we let the departments manage that.
>
> But the expectation is that they will have a member of the Active staff manage them on the long-term basis.

Dr. W agreed that it was open for Dr. Hicks to become a *locum tenens* at the PAH and also to apply for Active staff privileges at the PAH. However, if Dr. Hicks applied for and obtained an Active staff position at the PAH, it was probable, in his view, that the FHA would not allow him to maintain concurrent Active staff privileges at both the PAH and the LMH. In Dr. W's view, from the FHA regional administrative standpoint, the current *Bylaws* do not contemplate the status that Dr. Hicks appears to be seeking on this Appeal, namely, that he be entitled to participate as a Consultant in the PAH on-call emergency rota "without interference" from the FHA.

In cross-examination, Dr. W agreed that the existing *Bylaws* do not expressly provide that a Consultant seeking participation in the on-call emergency rota is required to ask for permission from the FHA to do so. The *Bylaws* simply provides that a member of the Consulting staff can be required by the FHA to provide emergency on-call services. Dr. W reiterated that, as a matter of practice, the *Bylaws* are interpreted by the FHA in such a manner that if a Consulting staff member refused to participate in the on-call schedule without an exemption from the FHA, he or she could be held in breach of the *Bylaws*. He acknowledged that the FHA *Bylaws* are silent in dealing with the situation in which a Consulting member must have *locum tenens* privileges to undertake emergency on-call. He said that the *Bylaws* were not specifically written to address the special status sought by Dr. Hicks.

In Dr. W's view, if Dr. Hicks were to seek a *locum tenens* status, there would be no impediment to his doing so from the standpoint of the FHA. He did, however, express a concern that Dr. Hicks' history of patient retention after initial admission during his on-call coverage time might again seek after-hours operating time at the PAH.

We have considered Dr. W's evidence and the Guidelines in the context of the *Rules*. When a patient attends the Emergency Department at the PAH, he or she may be admitted by the attending emergency room physician, who is deemed to be the Most Responsible Physician ("MRP") in that instance pending a clear transfer of care to another medical staff member. The MRP is accountable and assumes responsibility for the overall care provided to the patient. The MRP is integral to the provision of quality health care, to the promotion of continuity of care and to the delivery of appropriate medical services for the patient. Every patient admitted for care and treatment in the FHA acute care facility must have an MRP who holds appropriate FHA credentials and privileges: *Rule* 5.1.2.1. The admitting member is deemed to be the MRP until a clear transfer of care occurs: *Rule* 5.1.2.5. The MRP can be designated as a service rather than an individual, and in some cases, the MRP's responsibilities may be shared by a group of physicians.

It is common ground that good communication between the transferring physician and the receiving physician is essential to ensure proper continuity of patient care. Where a patient is admitted from the Emergency Department to an in-patient unit at the PAH, the emergency physician will be identified as the admitting physician, and the MRP will be identified as the attending physician. The attending physician assumes MRP responsibility for the patient as soon as the transfer of care has been arranged with the admitting emergency physician: *Rule* 5.1.7.3. Only the MRP or a designate may authorize the discharge of patients from the facility: *Rule* 5.1.9.1.

Where a Consultant has participated in the care of an in-patient, that Consultant must continue to be available to respond to the care needs arising for that patient or must specify another qualified and privileged Consultant to be available for any period that they themselves are not available: *Rule* 5.8.3.3. In the case of post-operative or post-procedural care, this responsibility falls to the medical staff member who performed the operative procedure, unless an alternate responsible member is identified on the order sheet and on the information sheet provided to the patient at the time of discharge: *Rule* 5.9.1.

The foregoing *Rules* suggest that any surgeon, whether a Consultant or Active staff member, who performs orthopaedic surgery at an FHA hospital has an ongoing responsibility to ensure post-operative care pending a clear transfer of responsibility. In our view, the Guidelines are compatible with the *Rules* in this respect.

On questioning by this Board, Dr. W was referred to his briefing note to the Health Authority Medical Advisory Committee ("HAMAC") dated June 2, 2010 in which he stated "we did not change his privileges and we said that he can do locums if asked by a member of the orthopaedic group". He testified that he considered that participation in the on-call roster is not a "privilege"; instead it is an operational expectation. We conclude from Dr. W's evidence that it is his view as the FHA's Medical Director that "privileges" encompass the extent and scope of a permitted clinical practice at a particular hospital site; that is, the grant of a right to participate in the provision of a particular category of medical care and treatment utilizing the hospital's resources, but that the FHA interprets and implements its *Bylaws* such that the ability to participate in on-call emergency scheduling is neither a right nor an incident of privileges appertaining to membership in the Consulting staff category.

When asked what he considered the impact on the FHA would be if the relief sought by Dr. Hicks on this Appeal was granted, Dr. W responded that Dr. Hicks would, in the result, enjoy a "special" or "unique" position not shared by others with a Consulting staff appointment, in that the PAH Department of Orthopaedics would be free to unilaterally, and without any FHA oversight or direction, include Dr. Hicks in on-call emergency coverage. In his view, such a practice could lead to the Orthopaedic Department using Consultants for on-call coverage to an excessive degree. It could lead to a situation in which an "itinerant" surgeon could drop in and out of emergency on-call schedules, adversely impacting follow-up and continuity of patient care. He testified that it is possible that, given Dr. Hicks' past reluctance to relinquish continuing care of patients seen by him on an emergency on-call basis to the Orthopaedic Department, their continuous care could be adversely affected by Dr. Hicks' absence from the PAH while performing his duties as an Active staff member at the LMH.

Lastly, Dr. W agreed that he had no information on the basis of which to conclude that Dr. Hicks would be unable to coordinate his schedule at both the LMH and the PAH. In his view, Dr. Hicks still retains his full privileges as a Consultant.

It was suggested on behalf of Dr. Hicks that neither HAMAC nor the Board of Directors of the FHA was informed by Dr. W that the premise underlying the HAMAC recommendation – that the Department of Orthopaedics had decided not to include Dr. Hicks in the on-call schedule – was as a result of a direction to that effect by the PAH administration. It was suggested to Dr. W that the HAMAC was not made aware that the decision to remove Dr. Hicks from the on-call orthopaedic schedule was a decision, in effect, that was caused by a direction by the PAH administration and that the HAMAC had misapprehended matters. In our view, this approach belies somewhat the procedural history leading to the recommendations of the LMAC and the HAMAC. It is apparent from the documents in evidence that the impetus behind the progressive elevation of the complaint process through the LMAC, HAMAC and Board of Directors of the FHA, was Dr. Hicks.

On October 28, 2009, counsel for Dr. Hicks wrote to Dr. SS asking that the LMAC consider and decide to reinstate Dr. Hicks to the on-call coverage rota. A request was made that the letter be placed before the LMAC and that counsel for Dr. Hicks be permitted to make submissions at the meeting of the LMAC to consider the matter. The letter made it clear that Dr. Hicks considered that the decision to remove him from the on-call schedule was a decision made by the PAH's administration and the FHA, not the members of the PAH Orthopaedics Department. The "direction" was contrasted with what was described in the letter as a "tradition" whereby the setting of participation in the on-call schedule was made by a physician in the relevant department and that

hospital administration did not interfere with that selection unless patient safety may be compromised. In his written "Outline of Submission to the LMAC at the PAH, November 17, 2009", counsel for Dr. Hicks made it clear that the complaint was that the decision not to continue Dr. Hicks on the orthopaedic on-call rota was made at the instance of the PAH administration and the FHA, and was not a decision of the Department of Orthopaedics.

At the meeting of the LMAC on November 17, 2009, submissions were made on behalf of Dr. Hicks and the FHA. Following those submissions, Dr. SS, Chair of the LMAC, advised that at the next meeting of the LMAC on December 8, 2009, the following motion would be considered and voted on:

> "Having heard from Dr. Hicks and his counsel, Mr. Robertson, and Dr. C and Ms. Washington, counsel for Fraser Health, the Local Medical Advisory Committee of Peace Arch Hospital does not recommend that Dr. Hicks be reinstated to the regular emergency call schedule".

On December 8, 2009, the LMAC met and subsequently passed the foregoing resolution. On April 16, 2010, counsel for Dr. Hicks wrote directly to the Chair of the FHA Board of Directors requesting that the Board of Directors consider the LMAC motion or, alternatively, direct the HAMAC to make a recommendation to the Board of Directors "so that the matter can be properly placed before the Hospital Appeal Board where it belongs". Subsequently, Dr. Hicks was advised that the LMAC motion would be discussed at the next HAMAC meeting on June 9, 2010.

On June 2, 2010, counsel for Dr. Hicks forwarded counsel for the FHA an "Outline of Submission to the Fraser Health Authority Medical Advisory Committee" dated June 1, 2010, which was subsequently put before the HAMAC. It is clear from these submissions that Dr. Hicks maintained that the decision to remove him from on-call coverage had emanated with the PAH administration and the FHA, as opposed to with the members of the PAH's Department of Orthopaedics. We infer from correspondence in evidence between counsel for Dr. Hicks and the FHA that a further "Supplemental Submission to the Fraser Health Authority Medical Advisory Committee" dated June 4, 2010 was presented on behalf of Dr. Hicks to the HAMAC.

At its meeting on June 9, 2010, the HAMAC resolved that it be recommended to the Board of Directors of the FHA that the LMAC decision not to recommend that Dr. Hicks be reinstated to the regular emergency on-call schedule be upheld, "as local call groups are responsible to determine their call schedules". This motion was brought forward to the Board of Directors of the FHA at its meeting on August 12, 2010 by the Board Quality Performance Committee of the FHA and, upon its recommendation, the Board of Directors resolved unanimously:

> That upon the recommendation of the Board Quality Performance Committee of the Peace Arch Hospital LMAC decision not to recommend Dr. Hicks be reinstated to the regular emergency call schedule be upheld; as local call groups are responsible to determine their call schedules.

Dr. Hicks gave evidence on his own behalf. He testified that he is an orthopaedic surgeon and Fellow of the Royal College in Orthopaedics. He holds an American Board Certification in Orthopaedics, having obtained this certification in 1980. His best recollection is that he obtained Active staff privileges at the LMH in 1986, where he

retained an elective slate. He applied for Active staff privileges at the PAH at the same time that Dr. S did in 1999. At that time, Dr. Hicks was not selected and Dr. S was.

Dr. Hicks said that he worked at the PAH from 1978 until 1996, when his Visiting staff privileges were removed. Subsequent to the 1996 decision of the Medical Appeal Board, when his Consulting privileges were reinstated, he remained on the regular on-call rota at the PAH until October 1, 2009. He confirmed that the last time he practiced in the PAH was December 24 and 25, 2009, on a brief substitution on-call for Dr. S.

In 1996, his Visiting staff privileges, now referred to as Consulting privileges, were not renewed, and Dr. Hicks appealed that decision to the Medical Appeal Board. Throughout that time, he has remained on the Active staff at the LMH and has retained throughout two elective surgical days per month at that site. Dr. Hicks is currently a member of the on-call schedule at the LMH, upon which he shares a one-in-five rotation with other Active staff members.

Historically, upon providing on-call coverage at the PAH Dr. Hicks participated on the rota with two others. When Dr. S joined, on-call coverage became shared with three other orthopaedists. In the past, he was the only orthopaedist at the PAH that did hand surgery. In 2008, he was on-call an average of six to seven times per month in the PAH and seven or eight times per month in the LMH. The preponderance of his practice was at the LMH.

In direct examination, Dr. Hicks said that he first became aware that the FHA considered that he was doing excessive call was when he received the letter from Dr. W dated February 23, 2009. Had he previously been made aware that it was FHA's view that he was doing too much emergency on-call and he testified that he would have voluntarily cut back his on-call time as he was "somewhat too busy".

As a result of Dr. W's letter to him dated June 3, 2009 and upon being advised that as at October 1, 2009 two additional orthopaedic surgeons would be joining the staff at the PAH, Dr. Hicks ceased providing regular on-call services at the PAH on October 1, 2009. He acknowledges receiving ninety days' notice of the termination of his MOCAP agreement at the PAH in Dr. W's letter dated June 29, 2009. He estimates that he has suffered a thirty-five percent (35%) decrease in his income as a result of being removed from the PAH on-call rota.

Currently at the LMH, a regular on-call schedule is in place whereby Dr. Hicks provides on-call services from 8:00 a.m. on Wednesday to 8:00 p.m. on Thursday, two times per month and on one weekend per month. Occasionally, he may participate on the Monday or Tuesday on-call schedule. His current schedule at the LMH is such that he has fifteen non-consecutive days open where he would be available at the PAH for a maximum of ten days in total. In aggregate he participates on six days per month of on-call participation at the LMH. When he was doing on-call at the PAH, in addition to working Fridays and weekends, his general on-call day was Wednesday. During that time there were four orthopaedic surgeons at the PAH and a one in four rotation on the weekends.

Dr. Hicks is aware of the D.O.T.T. program, which is regional in scope. He is aware that at the PAH the program runs between 3:30 a.m. to 5:00 p.m. each day and at the LMH between 2:00 p.m. to 5:00 a.m. daily. The D.O.T.T. times overlap between the PAH and the LMH.

Dr. Hicks lives proximate to both the LMH and the PAH, and he believes he could travel effectively between the hospitals and his office when required to do so. He says that he would not accept an on-call schedule at the PAH if it created a conflict with his duties at the LMH. In the event of a potential conflict, he would expect that the LMH would free him up so that he could attend at the PAH.

After being removed from on-call at the PAH, Dr. Hicks testified that he provided on-call services at the request of Dr. KK on October 17 and 18, 2009, and for Dr. S on December 24, 2009. He testified that in neither instance was he required to apply for *locum tenens* or Temporary privileges, or required to obtain a permission or authorization from the FHA when relieving Dr. S on-call on December 24, 2009. He says he "just plugged in".

Dr. Hicks testified that he met with Dr. S in July 2011 and that Dr. S told him that the Department of Orthopaedics at the PAH really needed him back on the on-call schedule, but that the Orthopaedics Slate Committee did not want to put Dr. Hicks on definite on-call days. Dr. S reportedly told Dr. Hicks that he wanted to use Dr. Hicks for on-call replacement coverage. Dr. S is said to have alluded to "all kinds of plans for you for July and August and September". Dr. Hicks testified that this initiative waned and that "the administration quashed it", but he provided no further details. He said that Dr. S alluded to a hospital administration conspiracy to remove Dr. Hicks from the PAH.

Dr. Hicks says he met with the PAH's orthopaedic surgeons group, except Drs. B and JK, in Victoria in the summer of 2012. He said he did not attend on-call "as a result of those discussions", but did not elaborate on the content of those discussions.

Dr. Hicks' attention was drawn to an on-call schedule for the PAH for July and August 2011, where Dr. WW was scheduled for seven on-call days commencing July 22, 2011. During the month of August, Dr. WW was scheduled for fifteen days of on-call. Presumably this evidence was introduced to demonstrate that there was a continuing need for on-call holiday coverage during the summers at the PAH and that Dr. WW was being utilized for this purpose.

It was Dr. Hicks' stated view that the D.O.T.T. program, which was in place for a short time during his period of on-call service, helped relieve the need for after-hours emergency surgery. In this regard, his evidence is consistent with that of Dr. W and others. He said that the Department of Obstetrics and General Surgery put the most pressure on emergency surgical services at the PAH, followed by orthopaedics. He characterized the D.O.T.T. program as "sufficient and useful". He explained that prior to the start of the D.O.T.T. program, the general rule for after-hours surgery was that obstetrics and general surgery would go first, and orthopaedics would be last. This, he said, pushed orthopaedic emergency surgery time into the late evenings.

Dr. Hicks commented on the Guidelines relating to the "hand-off" or transfer of care of patients admitted during a physician's on-call attendance at the conclusion of the on-call period to a succeeding member of the Active staff. He discussed at length his concerns about continuity of medical care and in his view, the problems, with the hand-off of patients in this manner. He considered it preferable to retain continuity of patient care by him in lieu of handing off a patient seen by him, after his on-call period ended. His stated concerns were that, in patient transfers, patient communications and the possibility of miscommunication or non-communication between the on-call member and the successor Active staff member were problematic on a transfer of care. He described the

potential for miscommunication and adverted to the extra work required to ensure an appropriate communication and continuity of patient care between the two physicians involved in the hand-off of a patient. He described it as a process of "phone calls and confusion and…schizophrenia".

With respect to the implementation of the Guidelines, Dr. Hicks was asked to comment on whether he first saw any problems with respect to patient follow-ups as a result of the Guidelines. His response was there would be problems and confusion. As he put it, he would anticipate "slips between the cup and the lip". He foresaw that "if you looked at a year of that carnage, there would be lawsuits and confusion and risks and disruption, and worse than itinerant surgery, I think. I really, honestly think it would be worse". Dr. Hicks further opined that, as a practical matter, Active members of staff would be unlikely to use a *locum tenens* when the Guidelines required them to receive the patient from the *locum tenens* immediately after the surgery. He viewed that physicians would be unhappy, and "it's just asking for a disaster".

Dr. Hicks was questioned on a written undertaking that he had provided as a result of a practice review by the College of Physicians and Surgeons. Apparently, certain complaints were made with respect to his patient care which resulted in the College undertaking a practice review. Flowing out of that review, Dr. Hicks was requested by the College to, and did, enter into a formal undertaking with the College that, *inter alia*, he would limit his on-call schedule to ten days per month.

Overall, Dr. Hicks appeared to be somewhat dismissive of complaints reportedly made with respect to his excessive on-call service and its implications for patient care. However, he did acknowledge that he had agreed previously to limit his on-call time at the PAH and that his reducing on-call time to ten days was "probably a good idea" given the amount of on-call he was otherwise providing. He testified that limiting his total on-call to ten days between the LMH and the PAH would result in him performing approximately four days a month on-call at the PAH.

In cross-examination, Dr. Hicks agreed that if an orthopaedist with a fellowship in hand surgery was available at the PAH, that that person would provide "an adequate service" on referrals by orthopaedic surgeons who did not do hand surgery. Dr. Hicks clarified that he did not have a trauma designation. He further testified that he did not have a large basis of referrals from general practitioners for elective surgeries at the LMH. Trauma surgery, which he equates to "broken bones", is performed by him during emergency and elective surgery time at the LMH.

Dr. Hicks said that in 2006, he was encouraged by the Chief of Surgery at the PAH to request elective time at the PAH but was then informed that there was no elective time available to him. The one time that Dr. Hicks previously sought Active staff appointment at the PAH, Dr. S was appointed to that position instead.

Dr. Hicks gave evidence that he currently has a lot of available time on his hands. He testified that he was bored with all the extra time he has on his hands without his participation in on-call coverage at the PAH. He said he has tried unsuccessfully to increase his number of referrals at the LMH.

Dr. Hicks was asked to address the question of his ability to practice as a *locum tenens* at the PAH. In response, he reiterated that if he was required to hand over his cases after a defined period during which he acted as a *locum tenens* or substitute for an Active

staff member, it would be a "schizophrenic mess". In his evidence he constructed various negative scenarios to emphasise the potential for diminished patient care and "legal problems" in a system in which he would be required to transfer patient care following his acting for a short duration as a *locum tenens* or as a substitute for an Active member pursuant to the Guidelines. He said that a *locum tenens* position is normally for a period of two weeks or a month, where the *locum tenens* looks after the referring physician's practice in full, including electives. He said that the resort to *locum tenens* arrangements requiring a transfer of patients at the conclusion of a shorter period of on-call participation is "asking for trouble". He considers that if he were to be used in a *locum tenens* capacity for short periods of time on-call, the process of patient turn-overs by him to other physicians would be highly undesirable.

In general, Dr. Hicks appeared opposed to the Guidelines, which promote a "team" concept within an orthopaedic department relating to patient care transfers. He testified that the development of "a cohesive and functioning group that understand each other's methods and means of communications and work together to make a very efficient system in which patients can be handed over so that they can be done when the time is available and when the physicians are available" was "the dream of the century". Apparently, in his view, it would never work in the context of limited duration on-call coverage scenarios.

Dr. Hicks was asked in re-direct examination whether he would follow the Guidelines and policies now in place for the use of *locum tenens* and Temporary staff, if he was to act in those capacities. He said that "the proposed idea of taking my Visiting Consulting and having me function as a limited locum in a bizarre circumstance with no follow-up is wrong, and is un-functional", but he nevertheless conceded that the Guidelines and policies relating to patient transfers would apply to him. According to Dr. Hicks, however, whereas the hand-off of patients after a "proper locum is entirely reasonable", applying the *locum tenens* concept to short-term temporary services at the request of an Active member would put him, the patients and his fellow orthopaedics in "an oddball circumstance and patients in jeopardy". He referred to the shorter on-call periods as constituting a "pseudo-*locum*". He does not consider that a true *locum tenens* could include weekend on-call coverage. He said that the use of the *locum tenens* concept for such short periods is not conventional and that he is not interested in short-term *locum tenens* appointments "if they're not going to let me do my surgeries and look after my patients".

On questioning about the amount of on-call coverage Dr. Hicks was providing prior to its being reduced following Dr. W's letter in early 2009, Dr. Hicks agreed that "when you look at the call I was doing, it was too much". With respect to the limiting of his on-call coverage to ten days per month pursuant to the undertaking of the College, Dr. Hicks acknowledged that common sense and reason played a big part in his agreeing to limit his aggregate on-call to ten days per month.

Dr. Hicks described his involvement in the P.U.L.S.E. program which he started in June 2009, and took two years to complete. It is a relatively expensive and onerous program that involved three hundred hours of academic study, including fifty hours of videotapes and CDs on six topics. Exams were required to be written by him in six areas of involvement and an eighty-five percent (85%) achievement is required in order to graduate. Written exams were followed by oral examinations. As to the reasons for his participation, Dr. Hicks acknowledged that his "interrelationships weren't the best" within

the hospital setting. He conceded that at times his behaviour had been abrupt at the PAH and that he could have done things in a more diplomatic manner in several instances.

Dr. Hicks acknowledges that he is aware that there had been some issues raised with respect to whether or not he was obeying all the rules and behaving in a manner consistent with the policies of the PAH. He acknowledges that he was asked as part of the Memorandum of Understanding relating to the P.U.L.S.E. program to consistently follow hospital admission and operating room booking practices and policies. He characterized the complaints giving rise to his involvement in the P.U.L.S.E. program and his entering into the behavioural contract on May 14, 2009 as "a list of altered implications, half-truths and snippets and out-of-context rubbish". Notwithstanding this, he concluded by saying that although he was forced into the P.U.L.S.E. program, he has, in retrospect, decided that it was valuable. Dr. Hicks says he benefited from the program and is now glad that he undertook it. He considers that others have reacted positively to his changed outlook and behaviours at the LMH.

Notwithstanding a good deal of questioning and evidence on the hearing of this Appeal relating to the P.U.L.S.E. program, the FHA did not, and does not now, seek to support its decision not to afford Dr. Hicks on-call coverage time with reference to Dr. Hicks' prior conduct giving rise to his P.U.L.S.E. program involvement.

On questioning by the Panel, Dr. Hicks was asked what he saw to be as the desired outcome of this Appeal from his perspective. He responded that although there were difficulties with his personality and interpersonal relations prior to his participation in the P.U.L.S.E. program, in that he had troubles with insight and some anger problems, he now would like "a fair shake". He said that he now had had a lot of time on his hands and he wanted to return to the PAH on-call. He would arrange his schedules at the PAH and the LMH so as not to conflict if he again was able to participate in the on-call rota at the PAH.

2. The Positions of the Parties on the Merits

Fundamentally, Dr. Hicks' position on the merits is that he has been treated unfairly by the FHA. He requests an Order reinstating him to the on-call orthopaedic schedule, with the Division of Orthopaedics to determine the extent of his participation. He contends that his utilization in the provision of on-call services, given that there may be a staffing shortage, is in the best interests of the patients at the PAH. He resides proximate to the PAH and within traveling distance of the LMH, and his ability to schedule his time at the LMH and the PAH in advance would enable him to provide up to four days per month on-call at the PAH.

Dr. Hicks' position is that when acting in his capacity as Consultant s*impliciter*, and not as a *locum tenens* or Temporary staff, the Guidelines should not apply to him in his provision of on-call services. He could, accordingly, provide for ongoing treatment and care without having to transfer patients over to another orthopaedic surgeon within the division. He relies upon *Rule* 5.8.3.3, which provides that "when a Consultant has participated in the care of an inpatient…that Consultant must continue to be available to respond to care needs arising for that patient or must specify another qualified and privileged Consultant to be available for any period that they themselves are not available". He correctly asserts the Guidelines do not refer specifically to Consultants.

While Dr. Hicks recognizes that currently there is no need for him to be regularly involved in the orthopaedic on-call schedule at the PAH, he argues that the evidence demonstrates that there are times when the Division of Orthopaedics at the PAH does require such assistance and, when those circumstances arise, the department should be free to utilize him in his capacity as a Consultant for the provision of on-call coverage. He points to the fact that Drs. JK, Y and S have elective time at other hospitals and the PAH and, when occupied at other hospital sites, cannot be available for on-call coverage at the PAH. He asserts that the same opportunity should hold in his case. Dr. Hicks would like an opportunity to help the PAH Active orthopaedic staff, when they require his assistance, to deal with on-call scheduling difficulties. Simply put, he says there are times when the PAH Active orthopaedic staff may have difficulty meeting their on-call coverage requirements and in such case, he ought to be able to participate therein to ensure appropriate patient coverage.

Dr. Hicks does not dispute that prior to the implementation of the D.O.T.T. program, the Division of Orthopaedic Surgery often performed surgeries after regular hours that extended into the evenings, with resulting pressures and strain on operating room resources and nursing staff. This, he says, was caused by all orthopaedic surgeons and their cumulative requirements and was not caused solely by him.

As to his removal from the on-call coverage schedule, it is Dr. Hicks' position that the FHA has used a colorable method to remove him from the PAH in order to avoid an appeal to this Board by, *inter alia*, hiring additional orthopaedic Active staff members. He contends the FHA acted in a coercive and intimidating manner in its dealings with the members of the Department of Orthopaedics at the PAH. He posits that the FHA's authority does not extend to directing the Orthopaedic Department to refrain from using a Consulting staff member for on-call services when there is a staffing shortage and that the authority to organize the on-call schedule at the PAH should rest exclusively with the members of the Orthopaedic Department. In summary, he alleges that the FHA has effectively modified or revoked his privileges without following the proper procedure for a review of his privileges. In his submission, the FHA does not have the authority to remove him from the on-call schedule in the manner it did.

In response, the FHA's position on the merits was essentially that the FHA's decision not to utilize Dr. Hicks on the on-call schedule was taken for proper reasons in accordance with the FHA's statutory authority and responsibilities, and that there is no demonstrated need to order Dr. Hicks' return to eligibility for on-call coverage. Currently, there is adequate orthopaedic coverage at the PAH, including coverage for emergency hand surgery which is being provided by Dr. FF.

The FHA submits that the evidence amply supports its decision to recruit additional Active members of the Department of Orthopaedics in 2009 relying, *inter alia*, on Dr. F's evidence that the FHA determined that it was necessary to hire additional orthopaedic surgeons in order to ease the workload on physicians, decrease wait times and provide better on-call coverage. The FHA says that it considered that the appointment of additional Active staff members to the Department of Orthopaedics was beneficial in ensuring proper and continuing patient treatment and care. There was a factual basis for concerns within the PAH's administration in 2008 and 2009 that Dr. Hicks was working excessive on-call coverage hours between the two hospitals, and therefore, could have scheduling difficulties in maintaining proper patient care at both hospitals having regard to on-call coverage requirements. The FHA points to Dr. Hicks' past practice and

apparent disinclination to transfer patient care of those seen by him during on-call coverage to Active PAH orthopaedic staff.

In 2008 and 2009, difficulties were associated with limited operating room resources and disproportionate overtime, particularly in relation to orthopaedic procedures, including the effect of procedures being slotted in by Dr. Hicks, who did not have an elective slate, but who was undertaking a great deal of on-call coverage.

The FHA's position is that it sought to solve problems of patient care and efficient utilization of operating room facilities by hiring additional orthopaedic surgeons and introducing the D.O.T.T. program. Dr. Hicks was not targeted by it. The combined effect of impressing mandatory on-call responsibilities on the Active staff and the incidental effect of removing the Consulting staff use in on-call, other than through *locum tenens* or Temporary appointment, is consistent with proper utilization and management of hospital resources and compatible with roles of the different categories of staff, as defined by the *Bylaws*. The FHA says that the successful implementation of the D.O.T.T. program reduced after-hours operating room time; however, Dr. Hicks' continued participation in on-call coverage did overlap the D.O.T.T. program for a time and did not wholly stop his use of after-hours operating room time. The FHA remains concerned that Dr. Hicks' participation of on-call coverage at the PAH could continue to lead to his continued use of after-hours operating room time for patients seen by him during his on-call coverage and which he was reluctant to–transfer to Active members of the orthopaedic staff for ongoing care and treatment.

The FHA contends that Dr. Hicks retains his Consulting privileges. He may act in a Consulting capacity upon being requested to provide assistance, and he may participate as a *locum tenens* or Temporary staff if requested to do so by a member of the Active staff or the department upon the FHA's approval. If Dr. Hicks did so, he would be bound by the Guidelines on the matter of patient transfer of care. In summary, the FHA's position is set out in the following extract from its submissions:

> Returning Dr. Hicks to the regular on-call rota is inconsistent with the direction the hospital has taken to strengthen and expand its orthopaedic service and its reasonable expectations that members of the active staff will generally cover their call obligations directly or through the use of *locums*. Dr. Hicks could have applied for a full-time active position at the hospital if he wished to do so but he did not. Because of the nature of the manner in which he has operated while on the on-call rota he has essentially been an "itinerant surgeon" who has not generally handed cases over to his colleagues and indeed gave evidence that he was not comfortable in doing so. It is not in the best interests of the hospital or the community it serves for Dr. Hicks to continue to be on the on-call rota as a regular member. That said he can be consulted by other physicians or, subject to the rules that apply to *locums*, he can act as a *locum*.

3. Decision on the Merits

If, by virtue of the 1996 Decision of the Medical Appeal Board, or the application of the analytical approach described in *Prairie North,* or for any other reason, it could be held that the FHA's decision to exclude Dr. Hicks from orthopaedic on-call coverage in 2009 was an actual or constructive modification or revocation of his privileges, within the meaning of s.46, *Hospital Act*, our alternative decision on the merits is set out below.

At the outset, it should be acknowledged that Dr. Hicks has for many years demonstrated his commitment to the institution and patients of the PAH. His dedication and service to the provision of orthopaedic medical care, and his continuing desire to participate in on-call coverage at the PAH, is laudable and demonstrates his ongoing commitment to the PAH and the provision of medical services to the public. On this hearing *de novo*, we do not understand the FHA to rely upon those apparent difficulties giving rise to Dr. Hicks' successful participation in the P.U.L.S.E. program to be indicative of his future conduct should he be returned to eligibility for participation in the orthopaedic on-call rota. The only evidence before us is that Dr. Hicks' relationships with the LMH staff have been satisfactory following his completion of the P.U.L.S.E. program. Accordingly, a consideration of potential discord between Dr. Hicks and the PAH staff, should he again participate in the on-call orthopaedic coverage, is not considered a factor in our reasoning.

Dr. Hicks continues to be privileged at the PAH as a member of the Consulting staff. As such, he may be requested by a member of the Active or provisional medical staff to evaluate a patient and provide recommendations for care, write orders for care and follow-up, or even assume the entire care of the patient and become the Most Responsible Practitioner. With the approval of the FHA he may act as a *locum tenens* or Temporary staff member, in which case he may participate in the orthopaedic on-call coverage rota subject to the Guidelines providing for transfer of patient care at the conclusion of his appointment as such. While acting as a *locum tenens* or Temporary staff member, he may admit and discharge patients, as well as participate in on-call coverage rota and utilize the elective surgery time of the physician he is replacing.

Having regard to the 1996 decision of the Medical Appeal Board, we consider that Dr. Hicks could have not have reasonably expected that his ability to continue on the orthopaedic on-call rota would necessarily continue for the entire duration of his privileges as a member of the Consulting staff. That decision informed Dr. Hicks and the PAH's administration that, should the orthopaedic medical staff be augmented by additional appointments such as to enable appropriate levels of on-call coverage, there would be no obligation to continue Dr. Hicks' participation in on-call coverage. The very event contemplated by the Medical Appeal Board subsequently occurred in 2009 with the appointment to Active staff of Drs. JK and B. As members of the Active medical staff, these orthopaedists were not only required by the *Bylaws* to participate in on-call coverage, but they actually sought that opportunity in order to increase their patient base and access to the PAH's resources.

In short, the circumstances which animated the decision of the Medical Appeal Board in 1996 ceased to exist in 2009. From that date, with several exceptions involving the use of *locum tenens*, the Active members of the orthopaedic staff consider that their numbers are adequate to ensure the provision of adequate 24/7 on-call orthopaedic coverage without the participation of Dr. Hicks. The needs of the patients at the PAH for hand surgery treatment are being met with the involvement of Dr. FF. In the event that the Active staff members were unable to provide full-time on-call coverage, it is open for their members to request the appointment of a *locum tenens* or, to meet particular divisional needs, the appointment of a Temporary orthopaedic staff member. In short, there is no continuing need for the participation of Dr. Hicks *qua* Consultant on the on-call rota.

We find that there was no pretence relating to the appointment of additional Active orthopaedic staff in 2009 and no colorable decision by the FHA to target Dr. Hicks for

removal from on-call coverage at the PAH. We accept the evidence that the reason for the recruitment and appointment of additional orthopaedic Active staff involved concerns for the overall performance of the Orthopaedic Department and the ensuring of the provision of comprehensive orthopaedic services at the PAH. The decision to recruit additional Active members was taken in consultation with the then Active members of the orthopaedic staff. The decision was also made on the basis that, with the appointment of additional Active medical staff, the pressure and stress imposed upon the operating room and its nursing staff as a result of the resort to late evening surgeries would be mitigated. The fact that Dr. Hicks was then without an elective slate and was not inclined to transfer patient care of those admitted during his on-call coverage time contributed to problems affecting the overall hours of operation of the operating room and related facilities at the PAH.

In our view, the decision by the PAH to recruit additional Active orthopaedic staff in 2009 was made in good faith, and not for an oblique or improper purpose to redress those complaints relating to Dr. Hicks' conduct that ended in his participation in the P.U.L.S.E. program. We further find that there were reasonable grounds for Dr. W to suspend Dr. Hicks' on-call coverage eligibility in February 2009 in that Dr. Hicks' combined on-call coverage time at both hospitals was excessive and could compromise patient health. Even Dr. Hicks agreed that the level of his on-call participation was excessive at that time.

Neither do we accept the characterization of the involvement of the FHA and its dealings with its Active orthopaedic staff in early 2009 as "coercive or intimidating". It is apparent that the Active members of the Orthopaedic Department at the PAH, out of concerns for potential legal repercussions against them if they were to unilaterally act to remove Dr. Hicks from the on-call rota, actively sought and obtained the direction Dr. Hicks complains of. The orthopaedic staff members at the PAH sought assurances that the FHA had followed appropriate procedures and would take responsibility for the fallout from any decision to end Dr. Hicks' participation in the on-call coverage rota.

We accept the FHA's position on the merits that the FHA's decision not to utilize Dr. Hicks on the on-call schedule was made for reasons relating to the workload on the orthopaedic staff, decreased wait times for surgery and the provision of better on-call coverage. The decision to remove Dr. Hicks from the on-call roster was merely a component of an overall effort, which included the implementation of the D.O.T.T. program, to increase efficiencies in the utilization of the operating rooms at the PAH in a manner consistent with the interests of surgical and nursing staff and, indirectly, patient care. These initiatives had the incidental effect of impacting Dr. Hicks, who was overly reliant as compared with other Active orthopaedic staff members, upon the use of operating room resources after normal hours.

The recruitment of additional Active orthopaedic staff members at the PAH in 2009 was to fill a perceived need to enhance the PAH's orthopaedic resources and ability to serve the increasing needs of the community for health care services. The goal of the PAH was, and remains, to ensure through its Active medical staff members a continuous and appropriate level of on-call orthopaedic coverage. In 2008 and 2009, the increasing regional population and related orthopaedic caseloads at the PAH demonstrated the need to increase the Active orthopaedic staff. We accept Dr. L's evidence in this regard and note that, at the same time, the PAH sought and recruited an additional general surgeon and a urologist to meet those same enlarged community health care demands. Dr. F as well as other members of the orthopedic staff who gave evidence agreed that additional

orthopaedic resources were necessary in 2009 to enable the PAH to meet its community health service obligations.

We further conclude that it was, and remains, reasonable for the FHA to concern itself with the possibility that if Dr. Hicks were returned to the PAH on-call coverage rota, there could be scheduling conflicts, or periods of time when Dr. Hicks was not available at the PAH having regard to his performing duties at the LMH. Although Dr. Hicks may endeavour to establish schedules which seek to avoid conflict in his performing his duties at both the PAH and the LMH, the *ad hoc* timing and nature of orthopaedic emergency services is not always compatible with maintaining pre-set schedules. In taking this view, we have considered the evidence of Dr. Hicks that he remains physically proximate to both hospitals so that traveling times would not be great were he required to move between them to meet emergent care requirements during his time on-call at either location.

Acknowledging that this is a hearing *de novo*, we have nevertheless addressed the question of whether the HAMAC was misled by the FHA as to the true basis of the decision of the orthopaedic staff to cease using Dr. Hicks on the on-call rota. A review of the materials presented to the HAMAC would, in our view, have communicated Dr. Hicks' position that the decision to remove him from on-call coverage participation was made on the basis of a direction by the FHA.

We accept that the loss of entitlement to participate in on-call coverage has resulted in a financial loss to Dr. Hicks. However, his interests must be fairly balanced with those of the FHA in making decisions in fulfilling its role and responsibilities for ensuring the proper utilization of hospital resources, access to patient care and the medical needs of the community served by the PAH. Ultimately, the FHA Board of Directors is accountable for the quality of care and provision of appropriate resources in the facilities and programs operated by the FHA. It was not made clear to us what the relative improvement in Dr. Hicks' financial position might be were he to be enabled, by a decision of this Board, to be eligible for up to an additional four days per month in aggregate participation in on-call coverage at the hospitals.

In considering this balance of interests, we further find that it is compatible with the role and responsibilities of the FHA, seeking to enlarge its Active orthopaedic staff at the PAH to be able to offer to potential recruits optimal access to hospital resources, through, *inter alia,* optimal participation in the on-call schedule. This would attract additional Active staff, who would benefit from on-call coverage time in building their practices and patient numbers.

We decline to make the Order sought by Dr. Hicks on this Appeal to reinstate him to the PAH's orthopaedic emergency on-call rota on the basis that the Division of Orthopaedic Surgery should be able to determine the extent of his participation without interference or influence by the FHA, or alternatively, that the matter of his participation in the on-call schedule be remitted back to the Division of Orthopaedic Surgery for a decision on his utilization. We are not prepared to circumscribe the role and responsibility of the FHA and the PAH administration by, in effect, enjoining them from participating, in appropriate circumstances, in determining whether any physician, including Dr. Hicks, may participate in on-call coverage so as to ensure adequate and safe levels of on-call coverage.

Allowing the Department of Orthopaedics to set its own scheduling does not mean that the FHA thereby abdicates its ultimate authority and responsibility to ensure the best interest of the public through the provision of 24/7 orthopaedic on-call services. The recommendation of the HAMAC and the decision of the FHA Board of Directors to the effect that "local call groups are responsible to determine their call schedules" is not incompatible with the ultimate responsibility of the FHA to ensure the presence at its hospital sites of qualified medical staff who are capable of providing on-call services safely and in a manner compatible with patient needs and hospital resources. In the event that Dr. Hicks is appointed as a *locum tenens*, he will have access to MOCAP funds: *Rule* 5.8.8. Dr. C confirmed the same in her letter to Dr. Hicks dated October 19, 2009.

Should Dr. Hicks be requested by an Active or provisional member to provide services as a *locum tenens*, we are told that the FHA will act upon the request; however, we do not consider it necessary or advisable to circumscribe the factors which should guide the FHA in its decision to grant or decline *locum tenens* privileges. Similarly, there is nothing to prevent Dr. Hicks from seeking appointment to a Temporary staff position, or even an Active member status at the PAH.

Should Dr. Hicks act in a *locum tenens* or Temporary position, he acknowledges, and the fact is, that he will be subject to the Guidelines and the *Bylaws* and *Rules* of the FHA.

Addressing the fundamental complaint by Dr. Hicks, we do not find that he has been treated unfairly by the FHA, as contended. To the extent that his interests have been adversely affected by the decision of the FHA, this result inheres, to a greater or lesser extent, in all decisions to modify, suspend or revoke what may be found to be privileges in a given case. We find that the facts and circumstances do not support the making of the Orders sought by Dr. Hicks on this Appeal. He cannot "carve out" what the FHA correctly asserts would constitute a special category of staff with rights not otherwise enjoyed by any of the staff categories established under the *Bylaws* and *Rules*.

III Decision

In conclusion, we find that the decision to remove Dr. Hicks from participation in the orthopaedic on-call coverage rota at the PAH does not fall within the scope of s.46 of the *Hospital Act*, and alternatively, if it does, we nevertheless would not allow the within Appeal on the merits.

The Appeal is accordingly dismissed.

Dated: June 17, 2013

"Derek Brindle"
Derek A. Brindle, Q.C., Chair

"Rick Riley"
Rick Riley, Member

"Paul Champion"
Dr. Paul Champion, Member