COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

IN THE MATTER OF:	The *Medical Act*, S.N.S. 1995-96, c. 10
	- and –
IN THE MATTER OF:	A Hearing Conducted Pursuant to Section 52 of The *Medical Act* Concerning Dr. Stani Osif
DATE HEARD:	September 27th, October 1, 2, 3, 4, 5th, November 5, 6, 7, 8, 9, 13, 14, 15, 2007.
LOCATION:	Halifax, Nova Scotia
HEARING COMMITTEE:	Mr. Raymond Larkin, Q.C., Chair Dr. William Acker Dr. Lesley Whynot Mr. Douglas Lloy Dr. Jan Sundin
COUNSEL:	Ms. Marjorie Hickey, Q.C. , and Mr. Alexander Benitah Counsel for the College of Physicians and Surgeons of Nova Scotia
	Mr. T. Donovan, Q.C., and Ms. L. Manning Counsel for Dr. Stani Osif

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PART I - INTRODUCTION

1. This is the decision of a hearing committee appointed under the *Medical Act* S.N.S. 1995-96, c. 10 to hear charges of professional misconduct and professional incompetence against Dr. Stani Osif, an emergency room physician at the Northside General Hospital in North Sydney.

2. Pursuant to Subsection 62(3) of the *Medical Act*, the Hearing Committee imposed a ban on the publication of the names of patients or family members. Members of the press were permitted to tape record the proceedings for the benefit of their note taking, but broadcast of those recordings was prohibited.

3. There are a large number of charges against Dr. Osif that are grouped into eight categories. The issue in each charge is whether:

a) the College of Physicians and Surgeons of Nova Scotia (the "College") has proven the conduct alleged in the charge; and
b) the proven conduct constitutes professional misconduct, professional incompetence, or both.

4. In addition to the issues raised by the charges themselves, there were issues raised by the parties relating to pre-hearing disclosure of documents and witness lists, and there were significant issues raised by counsel for Dr. Osif about the fairness of the investigation leading to these charges. These procedural issues require us to carefully set out the relevant background facts about the investigation by the College.

PART II – BACKGROUND FACTS

5. Dr. Stani Osif was born and educated in Bratislava, in what was then Czechoslovakia. She graduated as a Doctor of Medicine in 1978 and obtained Certification in Anesthesia and Resuscitation in 1981. In 1986, she fled Czechoslovakia with her husband and two children and was granted the status of a political refugee in Austria. In the spring of 1987 she was granted landed immigrant status in Canada and by Christmas 1987 she had passed the Medical Council of Canada exams to have her credentials as a physician accepted in Canada.

6. In April 1988, Dr. Osif began employment in Clarenville in Newfoundland as an emergency room physician. Over the next 19 years she worked as an emergency room physician in Clarenville and Stephenville, Newfoundland and from 1996 in the Northside General Hospital in North Sydney, Nova Scotia.

7. In her entire period of working in Canada, Dr. Osif has worked in the emergency room of a small rural hospital. Most of that time, she worked the night shift where she would be the only physician in the hospital. At the Northside General Hospital she had limited access to diagnostic services on site at night and limited nursing staff. The Cape Breton Regional Hospital was a half hour to 45 minutes away; there were more extensive diagnostic facilities and medical services available if Dr. Osif wished to transfer a patient. Dr. Osif could consult with the appropriate specialists who were on call at the Cape Breton Regional Hospital by speaking to them on the phone.

8. Emergency rooms are categorized by levels related to the availability of specialized diagnostic and medical services. The Northside General Hospital emergency room was categorized as Level III. That is compared to the emergency room at the QEII Health Sciences Centre in Halifax which is categorized as Level I, and the emergency room at the Colchester Hospital which is a Level II. All of Dr. Osif's experience was in Level III emergency room facilities.

9. Dr. Osif tried unsuccessfully to obtain certification from the College of Family Physicians of Canada and having been unable to do so, she has not been able to pursue certification as an emergency room physician with the designation CCFP(EM). Since coming to Nova Scotia, Dr. Osif has practiced under a defined license which limits her practice to a Family Medicine Practice and Emergency Medicine.

10. By December, 2005, Dr. Osif was an experienced emergency room physician in a Level III emergency room setting with close to 10 years service at the Northside General Hospital. During the evening on December 13, 2005, Dr. Osif treated A.B., an 11 year old girl, who was brought by her mother D.B. to the Northside emergency room complaining of fever, vomiting and abdominal pain for the previous two days. This visit led eventually to a complaint by D.B. to the College on January 20, 2006, the gist of which is captured by the following excerpts from her complaint:

> "On December 13th 2005, I brought my 11-year-old daughter, [A.B.], to the outpatients department at the Northside General Hospital. Upon arrival we went through the triage department and then went into a separate room to see the doctor. Dr. Osif came into the room and first asked my daughter to sit on the bed, she was sitting on a chair to be close to me. Dr. Osif did no actual physical examination, [A.B.] was asked to sit on the bed so that dr. [sic] Osif would speak directly to her, isn't it common procedure to physically examine any patient? The doctor then asked what the problem seemed to be. I informed her that [A.B.] had a low-grade fever for the last two days and that she had severe stomach pain. She proceeded to ask about [A.B.]'s eating and I told her once again that she wad severe stomach pain and was not eating well. The doctor then informed me that she was going to do a urinalysis and that we would chat later. I them [sic] proceeded to tell Dr. Osif that I believed it was my daughter's appendix, she told me that [A.B.] was much too young for it to be her appendix and she proceeded out of the room. A nurse then came in with the bottle and requested a urine sample. This was completed and the doctor was back in the room within about twenty min. She informed me that she did a swab test with [A.B.]'s urine and an infection did show up so she GUESSED that it was a urinary tract infection. The Dr.[sic] then commented on how pretty my daughter looked and left the room. A nurse then came in with gravol and Apo-Sulph/trim, an anti-biotic. I was raised to have faith in all doctors so I took the prescription without any questions and left the hospital."

11. On February 2, 2006, the College sent D.B.'s complaint to Dr. Osif asking her to respond with comments on the complaint and provide information about the circumstances. On February 19, 2006, Dr. Osif responded to the complaint in part as follows:

> "My first contact with [A.B.] and [D.B.] as attending physician was at 21:42. As [D.B.] is referring in her complaint, I asked [A.B.] to move from chair to examining stretcher where I was taking history and simultaneously performing physical examination, though this might not have been evident for [D.B.] sitting in distance. I examined [A.B.]'s abdomen and noted on the medical record I found it to be soft and non-tender.
>
> [D.B.] asked about possible appendicitis, which was discussed, however, on December 13, 2005, I did not feel that [A.B.] had symptoms or signs of acute appendicitis. With absence of more specific symptoms and the same laboratory findings over several weeks, my clinical impression was untreated urinary tract infection, for which I had prescribed antibiotics with best intention to treat [A.B.]'s condition."

12. D.B. was given an opportunity to reply to Dr. Osif's response to the complaint and she did on March 19, 2006. Dr. Osif was given the opportunity to address further comments to the College in light of this communication from D.B.; she sent additional comments to the College on March 28, 2006.

13. On March 13, 2006, the College sent Dr. Osif a copy of correspondence it had received from Dr. M.A. Naqvi, the Medical Director of the Cape Breton District Health Authority which operates the Northside General Hospital. The correspondence was provided for her information only and she was not required to respond to it. Dr. Naqvi's letter stated as follows:

> "Enclosed please find a copy of the events that occurred regarding a patient at the Northside Emergency Room. This event has been investigated by our Chief of Emergency Medicine, and his findings are enclosed as well. There have been concerns expressed by the staff at the Emergency Room at the Northside Hospital regarding Dr. Osif, but certainly the above case has been well documented and has a merit for the College Complaint Committee to review."

14. Attached to Dr. Naqvi's letter was a letter to him from the Cape Breton District Health Authority Department of Emergency Medicine's Chief, Dr. Tom Currie, whose comments included the following:

> "The mother has expressed sincere concern over Dr. Osif's initial assessment of her daughter. She insists that Dr. Osif did not perform any physical examination of [A.B.] and that when she expressed her concern about the possibility of appendicitis, her concerns were disregarded by Dr. Osif. [D.B.] does not complain about the post operative complications her daughter experienced but feels that the entire situation could have been avoided if Dr. Osif had examined her daughter and taken her concerns seriously.
>
> When I discussed the concerns with Dr. Osif, she initially reported that she did examine the patient but that it might have been through her clothing. She also did not feel the patient looked sick and attributed her tachycardia to the fever. Later; however, Dr. Osif told me that it was possible she didn't examine the patient and that the patient may not have received the attention she deserved. She attributed this to a great deal of stress that was affecting her at that time. Dr. Osif also felt that the urinalysis result was enough to explain the patient's symptoms.
>
> I am confident that this patient did not receive an adequate assessment on her initial presentation to Dr. Osif. Attributing the patient's symptoms to a urinary tract infection reveals poor judgement. Once cannot conclude that this patient's outcome would have been different if appendicitis had been recognized earlier, but this does not excuse a physician from providing safe emergency care."

15. On July 18, 2006, Investigation Committee "A" of the College met and took a number of steps to further investigate the D.B. complaint. The Committee deferred consideration of the complaint until September 7, 2006 and required Dr. Osif to attend a meeting on that date to discuss the complaint and to make further submissions. The Committee also decided to conduct an audit of Dr. Osif's emergency room records in order to determine if the issues arising from the complaint were isolated or raised general concerns. To this end, the College arranged for Dr. Simon Field to conduct the chart audit. Dr. Field is an Assistant Professor in the department of Emergency Medicine at Dalhousie University and a Staff Emergency Physician at the QEII Health Sciences Centre in Halifax. He reported on August 21, 2006 with the following general conclusion:

> "Having assessed the charts that were given to me, I believe that Dr. Osif has the necessary skills to make accurate diagnoses. Her documentation is of a high standard, and her notes reflect care and diligence in her history-taking and examinations. However, I believe that she tends to over-treat minor illnesses with inappropriate agents, often in the context of poor evidence to support her diagnosis. I am not convinced that this is due to a lack of knowledge or skill; this may reflect a practice pattern that is related to both patient expectations and pressure to see high volumes – hence the use of antibiotics to bring "premature closure" to the consultation."

Although Dr. Field's report was generally favourable as indicated above, it did include reference to unsubstantiated diagnosis of pharyngitis in certain patients and the inappropriate prescription of certain antibiotics.

16. As a result of its meeting on July 18th, the Committee also decided to request that Dr. Osif consent to a review of her complaint file at the Cape Breton District Health Authority. Dr. Osif's counsel provided this consent on her behalf on August 3, 2006. On the following day, the College wrote to Dr. Naqvi requesting him to forward to the College a copy of Dr. Stani Osif's complaint profile. On August 8, 2006, the College received a fax transmission sheet with a nine page document attached. Given the attention given to this material at the hearing of this matter, it is useful to include here the entire text of the fax transmission sheet which stated as follows:

> "Sent by: Shauna by verbal approval Dr. Naqvi and Dr. Foley. As per your request, attached is a complaint profile for your review. Dr. Naqvi has asked me to forward to you by Purolator copies of the concerns as per your request."

17. Attached to this sheet was a nine page document entitled Dr. Stani Osif Complaint Profile. The fax transmission sheet referred to material to be forwarded by courier. This material was received by the College on August 8, 2006. We will refer to this material as the Complaint File. It included 351 pages of documents which related to 38 different instances of patient care and included notes of discussions and correspondence between Dr. Osif and Dr. Currie relating to her performance and her scheduling.

18. The nine page document received with the fax transmission sheet was a summary of the Complaint File prepared by a secretary in Dr. Naqvi's office without any special instructions from him and forwarded to the College without any editing by him. This summary has been referred to in the hearing as the Naqvi Profile. This does not accurately describe the document given its method of preparation and we will refer to it as the Complaint File Summary.

19. The Summary presented information in a chart form set out in five columns. The following three examples of the material on the Summary indicate how this information was presented:

> [E.S.] April 5, 2001 Elderly pt fell and dislocated right shoulder. Seen by Dr. Brien. Referred to CBR ER by Dr. Osif.
>
> [K.S.] [M. S.] (Complainant's Father) June 15, 2003 Inappropriate treatment. Took pt to ER with shortness of breath, lack of appetite, slurred speech, pain, lack of bladder and bowel control, and weakness. Seen by Dr. Osif, treated for ear infection and sent home. A week later came back with same symptoms – refused to leave when told by Dr Osif to stop wasting dr's time. Pt was admitted next day with cancerous tumors in lungs, rectum and brain. Wants Dr Osif reprimanded for her behavior.
>
> [D.B.] [A.B.] December 13, 2005 Inappropriate treatment. Pt presented to NSG ER with abdominal pain. Seen by Dr Osif. Diagnosed with UTI and sent home. Two days later, returned to NSG ER with fever. Transferred to CBR for consult with Dr P Smith – had emergency appendectomy. Wants this issue addressed with Dr Osif."

20. On August 8, 2006, the College forwarded the Complaint File by courier to counsel for Dr. Osif. For some reason, whether an administrative error at the College or in the office of counsel for Dr. Osif, the nine page Complaint File Summary did not come to the attention of counsel, and because of this mix-up, Dr. Osif did not receive the Complaint File Summary at that time.

21. Dr. Osif reviewed the 38 cases in the Complaint File and prepared notes and written comments dated September 4, 2006. We will refer to these materials as "Dr. Osif's comments on the Complaint File".

22. Dr. Osif and her counsel met with Investigation Committee "A" on September 7, 2006. On that date, the Committee also interviewed Dr. Currie by telephone conference, reviewed the report from the Chart Audit by Dr. Simon Field and the material in the Complaint File and the Complaint File Summary. The Committee had concerns about Dr. Osif's clinical competence in the Emergency Department at the Northside Hospital and decided to defer the complaint of D.B. until Dr. Osif had a clinical assessment of her emergency room skills. Investigation Committee "A" directed that she not practice emergency medicine until that assessment had been conducted.

23. The College arranged with the head of the Queen Elizabeth II Health Sciences Centre Emergency Department, Dr. John Ross, to conduct a clinical assessment of Dr. Osif's skills. After consultation between Dr. Ross, the College and counsel for Dr. Osif, an assessment plan for Dr. Osif was produced and the College asked Dr. Ross to conduct the assessment as planned and prepare a report. The letter from the College instructing Dr. Ross provided background material for him including the D.B. complaint, the response of Dr. Osif and the related correspondence, the March 2nd letter from Dr. Naqvi and its attachments, the Report of the Chart Audit by Dr. Simon Field and the fax transmission document from Dr. Naqvi to the College, received by the College on August 8th, with the Complaint File Summary which was attached to it. The College did not send Dr. Ross the Complaint File but only the Complaint File Summary prepared by Dr. Naqvi's secretary.

24. On January 17, 2007, counsel for Dr. Osif wrote to Dr. Ross and stated as follows:

> "In addition, we note that the communication to you of January 9th contained a ten page summary of extracts from Dr. Osif's complaint profile which had not been seen by Dr. Osif previously and to her understanding represents a document prepared by the hospital for purposes of summarizing a much larger group of documents contained in the complaint profile compiled over her ten years or so at the Cape Breton

> District Health Authority. In order to allow you a more detailed review, if required, the entire copy of the complaint profile is attached. Dr. Osif is not suggesting that such a review is necessary but wanted to give you access to the source material should you find it necessary to enquire further regarding the material provided by the College.
>
> Further, prior to appearing before the Investigation Committee, Dr. Osif prepared a memo and commentary regarding certain aspects of the complaint summary. At Dr. Osif's request we have attached a copy of her summary document (which is correlated to the pagination of the original bundle of documents received from the hospital file) dated 2006/08/25 and addressed to Mr. Palov which consists of five pages and a one page overview memo dated September 4, 2006."

25. This letter from Dr. Osif's counsel was accompanied by the entire 351 page Complaint File and Dr. Osif's comments on the Complaint File.

26. Dr. Ross conducted the assessment as arranged and prepared a report. His conclusions are included in the following passage of his report dated February 27, 2007:

> "One of the conclusions I have reached from this assessment is that Dr. Osif appears to have an adequate knowledge base when discussing the approach to specific problems. She seems to be able to develop reasonable plans considering her practice location. However, I have significant concerns about her arriving at the right diagnosis considering her disorganization and at times incomplete history and physical examination – gathering the essential data that will lead to the formulation of a plan. Being able to answer specific questions about problems is very different from deciding which problems to consider. We all observed some 'early closure' meaning Dr. Osif appeared to reach a conclusion too early in the data gathering phase, without considering and possibly investigating all serious possibilities. In Emergency Medicine physicians always have to deal with the dichotomy of moving patients through the ED as quickly as possible (making decisions with limited information) but being thorough and not missing any significant problems."
>
> "Summarizing the above and other comments, I have grave concerns that Dr. Osif lacks insight. I am concerned some of this is a reaction to negative reactions and feedback she receives – possibly overcompensating for her deficiencies. The materials sent to me as background from the CPSNS and CMPA are very important for context. I quickly scanned the documents prior to the assessment and realized that it would be more objective for me to review them in more detail following the completion

> of the five day assessment. As mentioned above, conducting a thorough assessment of a physician's practice in the emergency setting involves many factors. In my role of chief of the QEII ED site as well as oversight for the District, I am very concerned about the breadth of Dr. Osif's complaint profile. I am certainly aware, having addressed numerous complaints as Chief, that there are often 204 sides to every story. However, the complaints involving Dr. Osif include communication, collegiality, professionalism, failure to diagnose, failure to treat, and worst of all, failure to acknowledge the significance of these complaints and seek assistance."

27. Dr. Ross' report was sent to Dr. Osif on February 28, 2007 along with the notice that Investigative Committee "A" required her to meet with them to discuss the report on March 29, 2007. She did meet the Committee on that date and the Committee deferred the matter pending further investigation.

28. This further investigation included a request to Dr. Bruce MacLeod to review the records of 15 of the cases on the Complaint File Summary. Dr. MacLeod is the head of the Department of Emergency Medicine at the Valley Regional Hospital in Kentville. To conduct his review he was given a modified version of the Complaint File Summary edited to include the information on 15 of the cases listed in the longer summary. He was given Dr. Osif's comments on the Complaint File and the hospital records for each patient on the modified Complaint File Summary.

29. Dr. MacLeod reviewed the materials provided to him and prepared a chart review on these 15 cases and concluded in his report of April 25, 2007 as follows:

> "… Two of the charts had no documentation that related to Dr. Osif that I could find so I was unable to comment on these. Of the remaining 13 I judged the care to be:
>
> Standard of care: 6
> Standard of care marginal: 3
> Below standard: 4
>
> I was unable to comment on a couple of physician interactions that alleged 'rudeness' but Dr. Osif's explanation document does lead me to believe

> that she has some problems with communications with patients and other physicians.
>
> Of the 4 cases where the care was felt to be below standard:
> #1 was a FB with a relatively minor adverse outcome.
> #7 was a failure to attempt to reduce a dislocated ankle and provide adequate pain management.
> #12 was a failure to attempt to reduce a shoulder dislocation and provide adequate pain management.
> #13 was a failure to adequately consider a serious medical diagnosis in a patient presenting with complex medical problems.
>
> There were three marginal cases where the basics of care seemed to be there but not the comprehensive care I would have expected of an experienced physician….
>
> In addition to the documented care Dr. Osif's explanations show a real lack of insight and are at times bizarre, as in the case of the FB (#1). In some ways I am more concerned about these comments than the cases themselves. Whereas we all make mistakes, especially in complex cases, most of us admit that this does occur. Dr. Osif seems to find something else to blame to excuse these errors and her contention that this complaint rate is of questionable significance is not reassuring. In my experience this is a very high complaint rate with many related directly to patient care issues.
>
> After consideration of all the cases I would say that, at best, Dr. Osif is practicing at the margins of acceptable ER care for an experienced ER physician even after giving her the benefit of the doubt in some cases. By and large her investigations seemed appropriate while her consults were perhaps overly cautious and not that of one with several years experience."

30. Investigation Committee "A" met again on May 10, 2007 and concluded its investigation with the following decision:

> "As a result of the investigation into this matter, the Committee felt there was reasonably believable evidence demonstrating serious problems with your assessment skills, and significant problems with making diagnosis and developing an appropriate treatment plan. The Committee also had serious concerns that you did not appear to recognize problems in areas of your medical skills and knowledge, even after provided with feedback. These concerns arose in the initial complaint and appeared to be in all areas of your care assessed.

> From this investigation, the Committee is of the opinion the information reviewed appears to demonstrate global deficiencies in your medical knowledge, skills and judgment, that if proven indicate incompetence and pose a threat to patient safety. Therefore pursuant to Section 54(1) *(a), (b), and (c)* of the *Medical Act, 1995*, the Committee has concluded that it is in the public interest to immediately suspend your registration and license to practice medicine in Nova Scotia as of Friday, May 11, 2007 at 12:01 pm."

31. As required by the *Medical Act* the Committee provided Dr. Osif with an opportunity to meet to hear from her about the suspension. Eventually, Dr. Osif indicated that she did not wish to appear before the Investigation Committee for this purpose.

32. The College issued a Notice of Hearing containing eight sets of charges against Dr. Osif and advised that a hearing would be held beginning on September 27, 2007. This notice was later amended by the withdrawal by some of the charges and changing the first day of hearing to October 1, 2007.

33. Some of the charges against Dr. Osif relate to D.B.'s complaint, but others arose out of the random chart reviews conducted by Dr. Simon Field, the clinical assessment by Dr. Ross, the review of 15 cases from the complaint file by Dr. MacLeod and from Dr. Osif's comments on the Complaint File. The College alleges that in relation to those charges, Dr. Osif's conduct amounted to professional misconduct and/or professional incompetence.

PART III - MANDATE OF THE HEARING COMMITTEE

34. This Hearing Committee has been appointed pursuant to subsection 58(1) of the *Medical Act*, S.N.S. 1995-96, c. 10 for the purpose of hearing charges related to Dr. Osif. In circumstances such as these where a suspension has been imposed by the Investigative Committee, the mandate of the Hearing Committee is captured by Sections 55 and subsection 58(1) of the *Act* which provide as follows:

> 55 Notwithstanding any other provision of this Act, where a decision is made pursuant to subsection 54(1), subject to any disposition made pursuant to subsection 54(5), a hearing committee shall be appointed pursuant to subsection 58(1) to proceed with a hearing to determine whether the member or associate member is guilty of charges relating to a disciplinary matter. 1995-96, c. 10, s. 55.
>
> 58 (1) A hearing committee shall be appointed for the purpose of hearing any charges relating to a disciplinary matter against a member or associate member when a disciplinary matter is referred, in whole or in part, to a hearing committee.

35. The term "disciplinary matter" in these provisions is defined in Section 2(j) of the *Act* as follows:

> (j) "disciplinary matter" means any matter involving an allegation of professional misconduct, conduct unbecoming a medical practitioner or professional incompetence including incompetence arising out of physical or mental incapacity;

36. The *Medical Act* requires the Hearing Committee to hold a hearing to determine whether the medical practitioner is guilty of charges relating to a disciplinary matter and gives considerable discretion to the Committee over the conduct of that hearing. Under subsection 66 (2)(a) " A hearing committee shall hear each case in such a manner as it deems fit". Subsection 58(5) provides that "….the hearing committee may do all things necessary to provide a full and proper inquiry".

37. The medical practitioner who is subject to the charges under consideration by the Hearing Committee has the right to be fairly treated in this process. Subsection 66(1) of the *Act* provides:

> 66 (1) At a hearing of the hearing committee, a member or associate member is entitled to all the rights of natural justice, including the right to be represented by legal counsel, to know all the evidence considered by the hearing committee, to present evidence, and to cross examine witnesses.

38. In conducting a hearing, the Hearing Committee must bear in mind the purpose of the *Medical Act* set out in subsection 4(3) "that the public interest may be served and protected". The public interest in a disciplinary matter includes both the protection of the public and fair treatment for a medical practitioner against whom charges have been brought. Obviously it is essential that the public be protected from professional misconduct and professional incompetence. It is not inconsistent with that objective to require that a medical practitioner be treated fairly, both in respect of the procedure followed by the Committee, but also in considering the substance of the charges.

39. In considering the charges against Dr. Osif, we are guided by the decision by the Court of Appeal in *Dhawan v. College of Physicians and Surgeons of Nova Scotia* [1998] N.S.J. No. 170 which was cited to us by both counsel for the College and counsel for Dr. Osif. In our view, there is a burden on the College in this proceeding to prove its charges against Dr. Osif on the balance of probabilities. The College's proof must be clear and convincing and based on cogent evidence. The decision of the Court of Appeal states as follows at paragraphs 26, 27 and 28:

> "26. As I shall show later, proceedings such as these are not criminal proceedings. The burden of proof of professional misconduct is the burden of proof on a preponderance of evidence. It rests upon the professional society throughout the proceedings. "Clear" and "convincing" proof based on "cogent" evidence is required only because the gravity of the charge is such that something less is not sufficient to warrant the conclusion that the balance of probabilities has been tilted. In *Continental Insurance Co. v.*

> *Dalton Cartage Co*., [1982] 2 S.C.R. 164, Laskin, C.J.C., speaking for the Court, said at p. 169:
>
> Where there is an allegation of conduct that is morally blameworthy or that could have a criminal or penal aspect and the allegation is made in civil litigation, the relevant burden of proof remains proof on a balance of probabilities. So this Court decided in *Hanes v. Wawanesa Mutual Insurance Co*., 1963 CanLII 1 (S.C.C.), [1963] S.C.R. 154 ...
>
> 27. Laskin, C.J.C. then quoted the following passage from the decision of Lord Denning in *Bater v. Bater*, [1950] 2 All E. R. 458 at p. 459:
>
> It is true that by our law there is a higher standard of proof in criminal cases than in civil cases, but this is subject to the qualification that there is no absolute standard in either case. In criminal cases the charge must be proved beyond reasonable doubt, but there may be degrees of proof within that standard. Many great judges have said that, in proportion as the crime is enormous, so ought the proof to be clear. So also in civil cases. The case may be proved by a preponderance of probability, but there may be degrees of probability within that standard. The degree depends on the subject-matter. A civil court, when considering a charge of fraud, will naturally require a higher degree of probability than that which it would require if considering whether negligence were established. It does not adopt so high a degree as a criminal court, even when it is considering a charge of a criminal nature, but still it does require a degree of probability which is commensurate with the occasion.
>
> Laskin, C.J.C. then said at p. 171:
>
> I do not regard such an approach as a departure from a standard of proof based on a balance of probabilities nor as supporting a shifting standard. The question in all civil cases is what evidence with what weight that is accorded to it will move the court to conclude that proof on a balance of probabilities has been established.
>
> 28. Thus, there is no third standard of proof applicable here which is higher than the civil standard."

40. There is little difference between the College and Dr. Osif on the meaning of "professional misconduct" and "professional incompetence". Although neither professional misconduct nor professional incompetence is defined in the *Medical Act*, the Court of Appeal in *Dhawan* accepted the approach taken by a hearing committee in that matter and gave the following guidance on the determination of what constitutes professional misconduct.

"8. In its decision, the Committee observed that the Act does not contain a definition of the term "professional misconduct". The Committee stated that the determination of what constitutes professional misconduct is appropriately left to the determination of the peers of the professional. It quoted the following from *Dr. X. v. College of Physicians and Surgeons of British Columbia* (1991), B.C.J. No. 2410 (C.A.):

The test of whether misconduct by a medical doctor is infamous or unprofessional is a determination that should be made by the doctors' professional brethren applying the standards and ethics of the profession.

11. In my opinion, the Committee did not err in the statement of the appropriate test or in its general approach to the evidence. "Professional misconduct", like "negligence", can only be defined in general terms. Specific applications of the principle to a given set of facts takes place each time a committee is called upon to make a determination whether conduct is or is not professional misconduct. In this connection, it is useful to keep in mind that deference is owed towards decisions of discipline bodies of self governing professions. As Cory, J. noted in *Re Milstein v. College of Pharmacy, et al.* (No. 2) (1976), 13 O. R. (2d) 700 (H.C.) at 707:

. . . The power of self-discipline perpetuated in the enabling legislation must be based on the principle that members of the profession are uniquely and best qualified to establish the standards of professional conduct . . .

12. In *Pearlman v. Manitoba Law Society* 1991 CanLII 26 (S.C.C.), (1991), 6 W.W.R. 289 (S.C.C.), lacobucci, J. for the Supreme Court of Canada at p. 297 quoted with approval the statement in *Law Society of Manitoba v. Savino* (1983), 1 D.L.R. (4th) 285 (Man.C.A.) that no one was better qualified to say what constitutes professional conduct than a group of practicing barristers who are themselves subject to the rules established by their governing body.

13. I am not prepared to consider this principle inapplicable to the deliberations of the Committee here simply because two of its members out of five were not medical doctors. The Legislature, in its wisdom, has provided for the appointment to committees of persons other than medical doctors. Such persons constituted a minority of the Committee. The principle approved by lacobucci, J. should still be the general approach

> where, as here, the majority of the members of a panel belong to the profession whose member is in judgment before it.
>
> 14. As I have noted, this Court's jurisdiction is limited to questions of law. As long as a tribunal has not erred in law, we cannot interfere. Having examined the numerous authorities presented to us dealing with professional misconduct, I am of the opinion that the Committee did not err in adopting the statement from the British Columbia Court of Appeal quoted above as its guide post, or in its application of that principle to this case."

41. In our opinion, these comments from the Court of Appeal apply equally to the determination of professional incompetence. In considering whether Dr. Osif is guilty of either professional misconduct or professional incompetence, the members of the Hearing Committee, the majority of whom are medical practitioners, will use their best judgment as to what constitutes professional conduct and professional competence, applying the standards and ethics of the medical profession.

42. Counsel for Dr. Osif argued, and we accept, that professional misconduct goes beyond mere carelessness or an error in judgment. Mr. Donovan cited a helpful decision of the New South Wales Supreme Court which surveyed the jurisprudence in that court on the meaning of "misconduct in a professional respect". In *Pillai v. Messiter* [No.2](1989) 16 N.S.W.L.R. p. 197, at p. 200 the court stated as follows:

> "The words used in the statutory test ("misconduct in a professional respect") plainly go beyond that negligence which would found a claim against a medical practitioner for damages: re: Anderson (at 575). On the other hand gross negligence might amount to relevant misconduct, particularly if accompanied by indifference to, or lack of concern for, the welfare of the patient: cf. re: Anderson (at 575). Departures from elementary and generally accepted standards of which a medical practitioner could scarcely be heard to say that he or she was ignorant could amount to such professional misconduct: Ibid. But the statutory test is not meant by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner…."

43. The Hearing Committee will, accordingly, find professional misconduct only where we are convinced by cogent evidence that Dr. Osif deliberately departed from accepted standards or failed to meet those standards in such a manner, which although not deliberate, portrays indifference or a lack of concern for the welfare of the patient involved or amounts to an abuse of the privileges of a medical practitioner licensed under the *Medical Act*.

44. As to the meaning of "professional incompetence", there was no real disagreement by counsel that proof of professional incompetence requires evidence of a pattern of carelessness rather than simply an isolated incident. Where there is a pattern of incidents which taken together show inadequate skill knowledge or judgment, that may indicate professional incompetence. Whether it constitutes professional incompetence is a matter of judgment by Dr. Osif's peers who are the majority of this Hearing Committee, together with the Chair and the lay member, applying the standards of the medical profession to the evidence.

45. In exercising this judgment, the Hearing Committee accepts the submission of Mr. Donovan on the standard of care expected of a medical practitioner. He cites and we accept the following passage from *Crits and Crits v. Sylvester* (1956) 1D.L.R. (2d) 502 (Ont. C.A.) at p. 508:

> "Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. *He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing,* and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability". [Emphasis added]

46. In determining whether there is professional misconduct or professional incompetence in this case, the Committee will consider whether the conduct of Dr. Osif is that of a normal, prudent practitioner of the same experience and standing. In this case, Dr. Osif is an experienced emergency room physician in a Level III emergency room. She should exercise the degree of care and skill that is expected of a normal, prudent practitioner with that experience. She is a general practitioner not a specialist but is especially knowledgeable and skilled in

providing care in an emergency room in the context of a small hospital with limited access to diagnostic services and limited support from medical specialists.

47. In summary, the mandate of this Hearing Committee in considering the charges against Dr. Osif is to assess the evidence provided to us by the College and Dr. Osif on each of the charges against her, and to decide whether there is clear and convincing proof that she engaged in conduct which constitutes professional misconduct or professional incompetence. If Dr. Osif's conduct departs from the accepted standards of a normal prudent practitioner of the same experience and standing, we will only conclude that there is professional misconduct if her conduct is more than mere carelessness or an error in judgment, and we will only conclude that there is professional incompetence if there is a pattern of departure from the accepted standards.

PART IV - PRE-HEARING DISCLOSURE

48. On a number of occasions in the course of this hearing, the Hearing Committee was asked to exercise its discretion under subsection 59(2) of the *Medical Act* to allow the introduction of evidence which was otherwise inadmissible pursuant to subsection 59(1).

49. Section 59 provides:

> "59 (1) The following evidence is not admissible before a hearing committee unless the opposing party has been given, at least ten days before the hearing,
>
> (a) in the case of written or documentary evidence, an opportunity to examine the evidence;
>
> (b) in the case of evidence of an expert, a copy of the expert's written report or if there is no written report, a written summary of the evidence; or
>
> (c) in the case of evidence of a witness, the identity of the witness.
>
> Power to allow evidence
>
> (2) Notwithstanding subsection (1), a hearing committee may, in its discretion, allow the introduction of evidence that would be otherwise inadmissible under subsection (1) and may make directions it considers necessary to ensure that a party is not prejudiced. 1995-96, c. 10, s. 59."

50. The purpose of Section 59 is to ensure that both the College and the medical practitioner get full disclosure in advance of written or documentary evidence and expert reports as well as the identity of the witnesses to be called.

51. Section 59 must be read in the context of the discipline process in the *Act* and the *Act* as a whole. The purpose of the discipline process is to protect the public from professional misconduct, conduct unbecoming a medical practitioner or professional incompetence. This

relates directly to the overall purpose of the *Act* which is to serve and protect the public interest. The scheme of the *Act* as it relates to discipline is to vest very broad powers of investigation in the Investigation Committee including the power to restrict the practice of a medical practitioner at the investigative stage. The final disposition of a complaint by a finding of guilt and imposition of appropriate penalties or restrictions is to be determined in a judicial style adversarial process with the full right of parties to present evidence, call witnesses and cross-examine the witnesses of other parties.

52. As noted earlier the Hearing Committee is given broad discretion on how to conduct a hearing process in subsection 58(5) and subsection 62(2)(a). However, the Committee is bound to ensure that the medical practitioner is treated fairly in exercising that discretion.

53. In this overall context, subsection 59(1) prohibits the admission of evidence before a hearing committee unless the opposite party has been given disclosure of that evidence at least 10 days in advance of the hearing. Both the College and the medical practitioner are prohibited from providing documentary or expert evidence or using witnesses without disclosure in advance. Section 59(2) gives discretion to the Hearing Committee to allow the introduction of such inadmissible evidence and to give directions to ensure that a party is not prejudiced by doing so. In our view, that discretion must be exercised in accordance with the purpose and scheme of the *Act* and the particular purpose of Section 59. That discretion should be exercised to admit evidence if it is necessary to ensure a full and proper inquiry so long as the hearing is fair overall and the medical practitioner enjoys all of the rights of natural justice. To that end, the Committee may give directions that will prevent prejudice to a party who did not receive disclosure in advance as required by subsection 59(1).

54. Prejudice under subsection 59(2) is prejudice in a procedural sense. The evidence sought to be admitted under subsection 59(2) may be very significant evidence; that does not prejudice a party. To paraphrase the comments of McLauchlin, J., as she then was, in *R. v. S. G. G.,* 1997 CanLII 311 (S.C.C.) at paragraph 100, dealing with a different type of case, prejudice for the purposes of this inquiry is used in the legal, procedural sense. The fact that the evidence tendered may be powerful evidence for a party does not lead to a conclusion of prejudice. The

inquiry into prejudice focuses not on the effect the evidence may have on the outcome of the hearing, but on its effect on a fair hearing for both parties. In many cases, prejudice can be avoided by granting an adjournment to the party who did not receive disclosure in advance. However, that will not necessarily be so and in each case the Hearing Committee must exercise its discretion on whether to depart from the clear requirement of disclosure in advance under subsection 59(1).

55. In the course of this hearing, we were asked on four occasions to exercise our discretion to depart from the requirement of advance disclosure in subsection 59(1). On two of those occasions, counsel for Dr. Osif sought to rely on documentary evidence which had not been disclosed in advance. The College did not object to the admission of those documents and the Committee exercised its discretion to allow them to be admitted subject to the right of the College to call evidence in response to their admission. The other two matters were considerably more substantive.

56. In a pre-hearing motion made more than the 10 days before the hearing beginning on October 1, 2007, counsel for Dr. Osif requested the Committee to exercise its discretion to permit him to introduce an expert report and call the expert as a witness in the hearing without providing the report to counsel for the College at least 10 days in advance of the hearing. The Committee received written submissions and issued a letter decision on September 14, 2007 rejecting this request for the reasons set out in that letter, which is attached as Appendix A to this decision. We do not consider it necessary to add to those reasons in this decision.

57. The fourth occasion on which we were asked to exercise our discretion under subsection 59(2) was a request from counsel for the College. This request was made after the College had called all of the witnesses whose names were on the witness list provided to Dr. Osif under subsection 59(1). Those witnesses had been heard over five days of hearing between October 1st and October 5th, 2007. The hearing had adjourned and was scheduled to resume on November 5th to begin the evidence called on behalf of Dr. Osif, subject to the possibility that counsel for the College might call evidence necessary to deal with the documentary evidence which had earlier been admitted pursuant to subsection 59(2) as noted above.

58. During the period of adjournment, counsel for the College decided not to call evidence in response to the documents earlier admitted under Section 59(2) but notified the Committee that she wished to introduce documentary evidence which related to the Electronic Medical Records for A.B. and three witnesses who would be needed to identify and speak to those documents. The key documents had been provided to counsel for Dr. Osif more than 10 days in advance of the hearing which began on October 1, 2007. The other documents were information requested by counsel for Dr. Osif provided after the initial disclosure. The three witnesses were not on the College's list of witnesses disclosed in advance of the hearing although the name of one of the witnesses had been made known to counsel for Dr. Osif more than 10 days before the hearing began.

59. The College requested the Hearing Committee to exercise its discretion to admit into evidence the documents which had not been disclosed in a timely manner and to permit three witnesses to testify who had not been identified as witnesses as required by subsection 59(1). The substance of the requested exercise of discretion was to allow the witnesses to testify even though they had not been disclosed as witnesses in advance as required. We understood that without the witnesses, the documents could not be reliably proved.

60. Counsel for Dr. Osif objected to the calling of this evidence and urged the Committee to exercise its discretion not to allow its admission. He argued that to do so would create prejudice for Dr. Osif that could not be avoided by directions from the Committee. Mr. Donovan identified the following types of prejudice:

- Consideration would have been made to additional witnesses on Dr. Osif's witness list,
- Witnesses for the College would have been cross-examined differently,
- Experts would have been retained to advise counsel in preparation for the hearing, in cross-examining the witnesses for the College and possibly to be called as witnesses for Dr. Osif,

- Allowing the evidence at this stage could cause an adjournment and delay in completing the hearing which would cause financial loss to Dr. Osif who has been suspended since May 10th, 2007 and therefore unable to earn her income;
- Allowing admission of this evidence would increase the cost of the hearing itself.

61. The Committee concluded that most of the elements of prejudice identified by Mr. Donovan could be remedied by an adjournment if he requested one. This would permit him to consult an expert and to determine whether he needed to call any further witnesses.

62. Furthermore, delay and cost are inherent in conducting a full inquiry into these charges as mandated by the *Medical Act*. There are a great many charges in this case. Some of these involve complex facts. There are complicated legal issues which have been raised. A reasonable period of time is necessary to hear these charges to ensure procedural fairness and to protect the interests of the parties and the public.

63. However, we did not exercise our discretion to admit the evidence proposed by the College because we were not convinced that it would be fair to Dr. Osif to do so in all the circumstances. The request to call this evidence came at a point in the hearing where 11 witnesses had been called by the College and had been cross-examined by counsel for Dr. Osif. In the absence of appropriate disclosure under subsection 59 (1), Mr. Donovan was entitled to conduct his cross-examination without any concern for the Emergency Medical Record issue raised by the proposed evidence. He told the Hearing Committee that if he had known of the three additional witnesses in advance, he would have cross-examined the witnesses differently. Counsel for the College recognized this point in her oral submissions and offered to recall any witnesses requested by Mr. Donovan for further cross-examination.

64. The Hearing Committee accepted that cross-examination could have been conducted differently if the names of the three proposed witnesses had been provided as required by

Subsection 59(1), and that it would not be fair to Dr. Osif to, in effect, deny her the full right of cross-examination to which she was entitled pursuant to Subsection 66(1) of the *Act*.

65. We did not consider it practical or desirable to recall a number of witnesses for cross-examination. Those witnesses left the hearing free to discuss their testimony with others as appropriate. They may or may not have been influenced by intervening events or communications. We had at this point concluded five full days of hearing. Furthermore the purpose of this evidence seemed to be to contradict anticipated evidence from Dr. Osif about her use of the Emergency Medical Record in connection with her treatment of A.B. There was no charge specific to the Emergency Medical Records; this point seemed to relate more to Dr. Osif's credibility rather than the elements of the facts in issue in the charges related to A.B.

66. We were not convinced that the protection of the public in these circumstances and a full inquiry into the charges required the introduction of this evidence. On the other hand, we thought to do so would be unfair to Dr. Osif in these circumstances. Protection of the public interest in a fair hearing for Dr. Osif led us to exercise our discretion in a manner consistent with the overall purpose of Section 59(1) which required full disclosure to Dr. Osif of documentary evidence and the names of witnesses to be called by the College.

67. For these reasons, the Hearing Committee ruled that it would not exercise its discretion to admit this evidence. We made no determination as to whether or not it would be appropriate to call this evidence as rebuttal evidence by the College after having heard the evidence called on behalf of Dr. Osif. No request was made to call rebuttal evidence after Dr. Osif's case.

PART V - OBJECTIONS TO THE INVESTIGATIVE PROCESS

68. Counsel for Dr. Osif made a pre-hearing motion which was heard on September 27, 2007 requesting the Hearing Committee to exclude the evidence related to the clinical assessment conducted by Dr. Ross and the review of 15 files conducted by Dr. MacLeod. Further, he requested that the Hearing Committee dismiss all of the charges which were based on Dr. Ross's clinical assessment and Dr. MacLeod's chart review.

69. Mr. Donovan submitted that Dr. Osif had not been treated fairly in the investigation process and had suffered extreme prejudice in the handling and use of the Complaint File Summary prepared by Dr. Naqvi's secretary in the course of the investigation. He argued that the Complaint File Summary was misleading in that it gave the impression of a large number of valid complaints against Dr. Osif between 1999 and 2006. This was compounded by not providing it to Dr. Osif before she prepared her comments in relation to the 351 page Complaint File, so that she was not able to respond to it adequately. He also argued that some of the matters in the Complaint File were so far in the past that Dr. Osif could not respond adequately in any event.

70. Mr. Donovan urged that the effect of the misleading Complaint File Summary and the failure to provide Dr. Osif with an adequate opportunity to address it was to taint the evidence of Dr. Ross and his clinical assessment and, by providing a modified version of the Complaint File Summary to Dr. MacLeod, to contaminate his chart review. Mr. Donovan argued that the manner in which this Complaint File Summary was handled in the investigation process was contrary to the rules of natural justice and breached Section 7 of the *Charter of Rights and Freedoms* by denying Dr. Osif fair treatment consistent with the principles of fundamental justice.

71. Mr. Donovan not only based his request to exclude this evidence and dismiss certain charges on the irregularities he alleged in the investigation process but also on its impact on the fairness of this hearing. He argued that the evidence of Dr. Ross and Dr. MacLeod was so

tainted that it should not be admitted at this hearing and that charges based on Dr. Osif's response to the Complaint File in her memo and comments of September, 2007 in all of the circumstances could not be fairly assessed in this process.

72. The Hearing Committee decided that it was unable to address these issues on a pre-hearing basis. We had no adequate record to consider whether there were irregularities in the investigation process that would affect a fair hearing. In our view, the question of whether or not Dr. Ross or Dr. MacLeod were tainted or unduly influenced by misleading material provided to them could be fully explored in cross-examination. We also believed that we could not make any finding about the Complaint File or Dr. Osif's comments on the Complaint File without having that file and hearing her evidence.

73. The Hearing Committee has very considerable scope to determine its own procedure. We are entitled to conduct the hearing as we see fit so long as the process is fair and allows the parties full scope for their rights under the *Act*. Accordingly, we were not prepared to deal with this issue raised by counsel for Dr. Osif on a preliminary basis.

PART VI - COMPLAINT RELATING TO A.B.

74. A.B. was an 11 year old girl who came with her mother D.B. to the Northside General emergency room on December 13, 2005 complaining of fever, vomiting and abdominal pain for the past two days. She saw Dr. Osif who diagnosed a urinary tract infection and ordered a prescription for an antibiotic and Gravol.

75. On December 15, 2005 A.B. returned to the emergency room complaining of fever and abdominal pain and was diagnosed with appendicitis and sent for immediate surgery to the Cape Breton Regional Hospital where she was found to have had a perforated appendix. She was discharged from the hospital and returned home but again returned to the emergency room on December 26, 2005 suffering from what was found to be intra-abdominal abscesses. She developed a bowel obstruction and was sent to the IWK Hospital in Halifax where she had a laparotomy on December 29th.

76. The complaint in this case relates to A.B.'s visit to the Northside General Hospital on December 13, 2005. A.B.'s visit and her treatment by Dr. Osif has resulted in the following charges against Dr. Osif:

> "3. On December 13, 2005, you failed to demonstrate adequate skill, care, and knowledge during the emergency room examination of an eleven year old patient presenting with fever, vomiting, and abdominal pain, including:
>
> (i) the failure to take an appropriate history, including the failure to take into account information from nurses' notes;
> (ii) the failure to perform an appropriate physical examination;
> (iii) the failure to request the necessary investigative tests;
> (iv) the failure to properly analyze a urinalysis, resulting in a misdiagnosis of a urinary tract infection;
> (v) the failure to properly diagnose a serious medical condition;
> (vi) the failure to refer the patient to an appropriate expert; and/or
> (vii) the failure to establish proper follow-up management.

7. With respect to your medical care provided to a patient on December 13, 2005 you provided an inaccurate account of an emergency room physical examination conducted on a patient, both on the patient's chart and when asked to do so by the Supervisor of the Emergency Department."

8. On a number of occasions you failed to communicate with others in an effective and/or courteous manner, specifically you failed to:

   (iii) appropriately respond to reasonable concerns raised by a family member of a patient on December 13, 2005.

77. The emergency/ambulatory care record ("the chart") generated by A.B.'s visit on December 13, 2005 indicates that she arrived at 9:17 p.m. and was seen by the triage nurse Deborah Hart at 9:35 p.m., who recorded that she had a temperature of 38 degrees, a heart rate of 124 beats per minute, a respiratory rate of 20, and oxygen saturation of 98%. She was complaining of upper abdominal pain which she was unable to quantify. The chart indicates no obvious distress. A.B. was seen by Dr. Osif at 9:42 p.m. who recorded the following on the chart:

" [Physician record time] 21:42
11y/oc/o pyrexia
HEENT: no obvious focal infection.
Chest clear A/E bilat good HS regular S1S2
Abdomen soft, non tender, peristaltics +
MSK good tonus. Stable.
Urinalysis √ filed & sent
Px: Septra 1 ½ BID x 10/ 7
Gravol 25 mg 1 Q6HPRN 2 (tab) to go
[Diagnosis] UTI [Discharge] √ [Departure time] 23:10
[Physician advised] √"

78. As recorded by Dr. Osif on the chart, a urinalysis was performed on a specimen from A.B. collected at 10:40 p.m. and received in the Northside General Laboratory at 10:45 p.m. The urinalysis was reported as follows:

"Specimen: 1312:U00316U Collected: 13/12/05-2240 Received: 13/12/05-2245

TEST	RESULTS	FLAG	REFERENCE RANGE
>URINALYSIS			
>URINE MACROSCOPIC			
>COLOR	YELLOW		
>APPEARANCE	CLEAR		
>SPECIFIC GRAVITY	1.020		1.002-1.030
>PH	6.0		5.0-8.0
>PROTEIN	NEGATIVE		<0.15 g/L
>KETONES	1.5		<5.0 mmol/l
>BILIRUBIN	NEGATIVE		<l7umol/L
>BLOOD	10		<25 /u1
>NITRITE	NEGATIVE		NEGATIVE
>UROBILINOGEN	68	H	<17.0 UMOL/L
>LEUK ESTERASE	25	H	<25 /ul
>GLUCOSE, URINE		NORMAL	<3 mmol/L
>MICROSCOPIC			
> RBC	0-2		0-2 /hpf
> WBC	2-5		0-5 /hpf
>EPITH CELLS	2-5		/hpf
>BACTERIA	MODERATE (2+)		/hpf
>MUCUS	SMALL"		

79. Dr. Osif's notes on the chart indicate that she diagnosed a urinary tract infection and prescribed an antibiotic and Gravol, and discharged A.B. at 11:10 p.m.

80. In the decision of the Supreme Court of Canada in *Ares v. Venner* [1970] S.C.R. 608 at paragraph 26, the court indicates that a record like the emergency ambulatory care record prepared on December 13, 2005, can be used in a legal proceeding as follows:

> "Hospital records, including nurses' notes, made contemporaneously by someone having a personal knowledge of the matters then being recorded and under a duty to make the entry or record, should be received in evidence as *prima facie* proof of the facts stated therein. This should, in no way, preclude a party wishing to challenge the accuracy of the records or entries from doing so. Had the respondent here wanted to challenge the accuracy of the nurses' notes, the nurses were present in Court and available to be called as witnesses if the respondent had so wished."

81. In this matter, the physician's notes by Dr. Osif can be accepted as prima facie proof of the facts stated in those notes. In the charges related to A.B. and in all of the other charges where the chart is relevant, we have accepted the chart as an accurate description of the history, the examination and the treatment of the patient, unless a party produced credible evidence that the chart was not accurate.

a) Reaching a Diagnosis

82. Dr. Osif is charged that she failed to demonstrated adequate skill, care and knowledge in treating A.B. including a failure to take an appropriate history, to perform an appropriate physical examination, to request the necessary investigative tests, to properly analyze a urinalysis resulting in a misdiagnosis of urinary tract infection, to properly diagnose a serious medical condition, to refer the patient to an appropriate expert and to establish proper follow-up management. For most of these charges the failure to perform an appropriate physical examination is fundamental. Most of the other errors with which Dr. Osif is charged would flow directly from that failure.

83. Three witnesses compared Dr. Osif's handling of A.B.'s treatment on December 13th with what could reasonably be expected from an experienced emergency room physician in a

Level III emergency facility. Dr. Currie is the Head of Emergency Medicine at the Cape Breton District Health Authority. Dr. Michael Levesque was called by the College to give opinion evidence; he is an emergency room physician at the Moncton Hospital. Dr. Michael Howlett gave evidence for Dr. Osif; he is an emergency room physician at the Colchester Regional Hospital. There was a great deal of agreement among these witnesses.

84. These witnesses agreed that the presentation of an 11 year old girl complaining of fever, vomiting, and abdominal pain for two days with a low grade fever of 38 degrees centigrade and a heart rate of 124 beats per minute should have given rise to consideration of a possible diagnosis of appendicitis, a possible diagnosis of urinary tract infection, and a possible gastroenteritis. They agreed on the approach expected of an emergency room physician in reaching a diagnosis. What was expected was a differential diagnosis; the physician should have considered the possible conditions causing the problems uncovered by a focused history and a careful physical examination. Having considered the differential diagnosis, the proper approach would have been to rule out one or more of the possible diagnoses to come to the probable diagnosis.

85. These witnesses agreed that appendicitis is a difficult diagnosis. They agreed that the complaints of A.B. and the vital signs recorded on the chart would require a normal prudent emergency room physician in an emergency room like the Northside General Hospital Emergency Room to take a careful history and to conduct a physical examination which included palpation of the child's abdomen, with the child partially undressed, at least enough to palpate the abdomen thoroughly.

b) Taking a History

86. With respect to the appropriate history taking in these circumstances Dr. Michael Howlett and Dr. Christopher Levesque agreed that it was important to note such things as the duration of the symptoms, whether they were constant or whether they were worsening, whether the child was eating, whether there was any urgency, frequency or burning sensation on voiding, the suddenness of onset, the location and nature of pain in the beginning and how it has

progressed over time or loss of appetite. These were all matters that should be explored where there is a possible diagnosis of appendicitis and a possible diagnosis of urinary tract infection. For the most part, the witnesses agreed that all of these points should be recorded on the patient's chart, but they recognized that it is not uncommon to have less careful charting.

87. The chart does not indicate that Dr. Osif considered a differential diagnosis that included appendicitis. It does not indicate that she inquired about the duration of A.B.'s symptoms, whether they were constant or whether they were worsening, whether A.B. was eating, whether there was an urgency, frequency or burning sensation on voiding, the suddenness of the onset of pain, the location and nature of pain and how it progressed over time. The only history noted on the chart by Dr. Osif is that of an 11 year old complaining of fever.

88. The record of history taking on the chart is confirmed by the evidence of D.B. and of Dr. Osif herself. D.B. described a very minimal exchange with the none of the elements of an appropriate history taking as suggested by Dr. Howlett and Dr. Levesque. Dr. Osif had no memory of what she actually asked and the answer she received. She said she understood the girl was not well for sometime.

89. None of the evidence shows that Dr. Osif took the history of A.B. that would have been taken by a normal prudent emergency physician of her experience in this type of hospital.

c) Performing a Physical Examination

90. D.B. was called as a witness in this hearing and she gave evidence which was substantially different than the information recorded on the chart which indicated that Dr. Osif had performed a physical examination of A.B.

91. D.B. testified that A.B. was a healthy 11 year old who was very active and involved in sports who was well until two days before her visit to the Northside General Hospital emergency room. In November of 2005 she saw her family physician, Dr. E.M. who sent her for blood work and a urinalysis. Dr. E.M. telephoned D.B. after the tests were analyzed and

informed D.B. that "everything was ok" and that there was nothing out of the ordinary. No medications were prescribed. This evidence was borne out by Dr. E.M's file which was presented in evidence before us.

92. D.B. also testified that, two or three days before December 13th, A.B. developed flu-like symptoms including vomiting, not eating and a low grade fever. These symptoms got worse on December 13, 2005 and D.B. brought her to the Northside General Hospital Emergency Room. D.B. said that when they arrived at the Emergency Room A.B. "wasn't walking straight. She had a little bend to her, she was pinkish….she had discoloration in her face….she was very flushed. Her eyes were droopy". D.B. described A.B. as wearing clothing that included a shiny pair of black pants, a black camisole and blouse and over that a thick belt and a big silver buckle.

After seeing the triage nurse, A.B. and D.B. were placed in one of the treatment rooms where they were soon joined by Dr. Osif. D.B. described Dr. Osif's actions as follows:

> "Q. Okay. What did Dr. Osif say to you when she arrived?
>
> A. She asked [A.B.] to move to the gurney or the bed.
>
> Q. And did you observe [A.B.] doing that, walking from the chair?
>
> A. I walked with her to the bed.
>
> Q. And what does that mean "you walked with her"?
>
> A. Just beside her. [A.B.] was weak, too, so I wouldn't have let her walk by herself to the bed.
>
> Q. Okay.
>
> A. At this point she hadn't eaten in days, too, so …
>
> Q. Okay. So you've described yourself and [A.B.] in the room and you've described Dr. Osif.
>
> A. Mm-hmm.

Q. Was there anyone else in the room that evening when Dr. Osif was present?

A. When Dr. Osif was present? No, but at different times throughout the evening when the doctor wasn't present there were nurses that came in and out.

Q. Okay. So let's start, then, with Dr. Osif coming into the room and can you just take us through, to the best of your recollection, what happened, what was said, what was done?

A. Okay. Like I said, we moved to the bed. She asked [A.B.] what seemed to be her problem. [A.B.] wouldn't speak. I answered the question. I told the doctor that I had told the triage nurse earlier that [A.B.] was lethargic, she wasn't eating. She was vomiting and that she had a fever. And then …I told the doctor at that point that I believed it was appendicitis. It was a gut feeling that I had. Nothing was said at that time. She said she was going to do a urine test. So she proceeded out of the room."

93. D.B. testified that there was no physical contact between Dr. Osif and A.B., that Dr. Osif did not touch A.B. in any way. D.B. gave the following evidence:

"Q. Did she remove any her clothing?

A. No. And I know that specifically because [A.B.] was dressed in layers and to get the belt that she had on and off it would be me that would have done it.

Q. Did she lift any of her clothing at any time?

A. No, she didn't.

Q. How long was Dr. Osif in the room with you and [A.B.]?

A. Just a few minutes.

Q. Did you leave [A.B.] alone at any point while Dr. Osif was in the room with you?

A. Absolutely not! I never would have left her side.

Q. You pointed out on the diagram, [D.B.], that you were standing at the foot of the bed with [A.B.] sitting on the side of the bed…

A. Mm-hmm.

Q. Did [A.B.] remain sitting…

A. Yes, she did.

Q. Throughout the time Dr. Osif was present?

A. Yes. [A.B.] did remain sitting the entire time Dr. Osif was present."

94. According to D.B., after Dr. Osif left the treatment room where she had been speaking with D.B. and A.B., a urine sample was collected and analyzed and later Dr. Osif returned to the treatment room where she told D.B. that A.B. had an infection and there was a rise in her white blood count. D.B. indicated that she thought it was appendicitis but Dr. Osif told her that A.B. was much too young for appendicitis, that this was a urinary tract infection and she was going to prescribe an antibiotic and that A.B. was to take Gravol. D.B. testified that after Dr. Osif gave her the diagnosis of urinary tract infection, D.B. and A.B. thanked her and Dr. Osif left the room. D.B. testified that on neither of these two occasions did Dr. Osif touch A.B. She also testified that she never left A.B. at any time while they were in the emergency room.

95. Obviously, there is significant conflict between Dr. Osif's notes on A.B.'s chart and the account given by D.B. in the hearing of this matter. By D.B.'s account Dr. Osif performed no examination of A.B. The chart indicates a full head, ears, eyes, nose and throat assessment, examination with a stethoscope of the chest and heart sounds, a physical examination of A.B.'s abdomen finding it soft and non-tender and a musculoskeletal assessment.

96. Dr. Osif's testimony differed from the chart, the evidence of D.B. and her written response to the College in this matter. Dr. Osif's testimony on direct examination was that she first learned of A.B. on the evening on December 13th, when the triage nurse gave her a verbal report that A.B. was an 11 year old girl with fever, with some on-going vomiting and a recent urinary tract infection. She read on the chart that there was an elevated temperature, mildly elevated tachycardia in 124 beats per minute and that the patient was unable to quantify the pain and unable to localize the pain about which she complained.

97. Dr. Osif testified that she went to the treatment room where she observed A.B. and D.B. sitting on two chairs at the opposite end of the room about twenty feet from a stretcher in the middle of the room. She says that she introduced herself and asked A.B. to stand up and walk over from the chair around the stretcher to sit on the stretcher close to the equipment on the wall needed for a physical examination. Dr. Osif said that she observed A.B. walking and that she did not have any problem walking and that she did not have any symptoms while she was moving. She says that A.B. sat on the stretcher during her initial examination and that D.B. remained seated 20 feet away.

98. Dr. Osif testified that she examined A.B.'s upper body and then was called away to another patient with profuse bleeding in another treatment room. The chart of that other patient indicates that his first contact with Dr. Osif was at 9:47 p.m. Dr. Osif indicated that after about 10 minutes she returned to the treatment room to finish the examination of A.B. and that A.B. was still sitting there but that her mother was out of the room. The transcript of her evidence indicates as follows:

> "Q. Okay. And what happened then?
>
> Well I … but I already know the girl, she knew me, so I ask her to lie down on the stretcher. She didn't have any problem to move from sitting to lying. If lift up the outfit, that's the top and the pants, just to expose the abdomen.
>
> Q. Can I stop you there for a second? We heard the recollection of the mother about a large belt. Do you have any recollection of that?
>
> A. No. I don't recall belt on her waist, but on this chair they have piled the clothes was the coats and so it might have been here on this … the chair.
>
> Q. All right. So let's go back to what you were describing. You asked her to lie down and you lifted up her clothes. And what happened then?

A. Yeah. I exposed the abdomen and I palpate through the abdomen looking at the girl's face, if she would react. She didn't have any reaction. I ask her if she has any pain. She said , No. Then I auscultate the abdomen. The peristalsis was perfectly fine, so I found unremarkable exam on the abdominal examination.

Q. Okay. What happened next?

A. So I finished the examine and, as I remember, when I was … I … leaving the room, I left … I met [D.B.] in the corridor … so here.

Q. Some place just outside the room?

A. Outside the room.

Q. And what happened then?

A. So I took her back to the room and I told her that at this point I need urine test done."

99. Dr. Osif also testified that when she later made her notes on the chart in the nurses' station she observed D.B. in the waiting room talking on the phone. She denied that she failed to perform a physical examination and insists that she did so.

100. Dr. Osif also indicated that when she received the results of a screening test preliminary to the urinalysis by the lab, that she returned to the treatment room and told D.B. that this test was showing infection and that the sample was being sent for microscopic examination in the laboratory. Dr. Osif says at this time D.B. asked her about appendicitis that she was surprised because A.B. did not have symptoms of appendicitis and remarked that A.B. is a little bit too young to have appendicitis and that A.B. looked too good to have appendicitis.

101. Dr. Osif says that while she was waiting to receive the results of the urinalysis, she checked the electronic medical record which indicated that there was another urine test done three weeks earlier which showed infection. This confirmed for her the information she had that A.B. had recently had a urinary tract infection. Dr. Osif indicated that from her clinical assessment and her reading of the urinalysis from the lab on December 13th that A.B. had a urinary tract infection and that she decided to give antibiotics to treat it.

102. In cross-examination Dr. Osif testified further about her examination of A.B. when she returned from dealing with the patient with profuse bleeding and examined A.B. in the absence of her mother. Dr. Osif said that she asked A.B. to lie down, that she moved without distress on the stretcher and that Dr. Osif had exposed her belly for the abdominal examination by partially undressing her, lifting A.B.'s sweatshirt up and pulling her pants with an elastic waist down. Dr. Osif said that she was not wearing a belt as described by D.B. As to the physical examination of the abdomen, Dr. Osif testified that she palpated A.B.'s abdomen, watching her face to see if she would react. There was no reaction. She said she asked A.B. "Am I hurting you?; answer was no". She said she did not find any resistance when she palpated, that A.B. did not react to the examination and that she told her she had no pain.

103. Dr. Osif testified initially in cross-examination that she did not conduct any other physical examination of A.B. after she made the decision to do the urinalysis. Dr. Osif said "No, but I just glanced on the skin when I wondered if she had any rash, like, the skin examination partial. But no, I didn't do any more physical examination."

104. However, on further cross-examination, Dr. Osif testified about returning to the treatment room to inform D.B. that the urine screening test showed infection and that D.B. asked if it was appendicitis. After Dr. Osif told her that A.B. did not have symptoms of acute appendicitis, D.B. was reluctant to accept this. Dr. Osif then testified as follows:

> "Q. Why do you say that?
>
> A. Because I remember than I ask the girl, lie down on the stretcher again. And in front of [D.B.], I palpate through the abdomen through the clothes this time to show the mother that her girl, indeed, doesn't have right lower quadrant pain, doesn't have any pain in the abdomen.
>
> Q. So this is a second examination of the abdomen that you are doing in the presence of [D.B.].
>
> A. Well, second time this was meant to show mother that the girl does not have symptoms of appendicitis.

Q. When you did the second examination, Dr. Osif, what did you do with respect to [A.B.]'s clothes?

A. I just went with my hand, palpate through the clothes just to show the mother that there is … the girl has no tenderness and she does not react to palpation with pain or she doesn't push my hand away. So like, this was, like, modified examination just aimed to show the mother, to reassure the mother that, indeed, this girl does not have abdominal pain.

Q. And what was [A.B.] wearing when you went through her clothes to show that the patient did not react to pain at this time?

A. She had sweatshirt and she had some black tights or …

Q. Sweatshirt and black tights.

A. Yeah, like pants. Like, it wasn't jeans, it was like ….

Q. Was she wearing a belt on this occasion?

A. No. No, I didn't see any belts."

105. D.B. complained to the Cape Breton District Health Authority in January about Dr. Osif's care for A.B. Her main complaint was that Dr. Osif did not perform an actual physical examination on A.B. Dr. Tom Currie, the Head of Emergency Medicine for the Cape Breton District Health Authority spoke to Dr. Osif by phone on January 12, 2006 and Dr. Osif told him that she did examine A.B.

106. In response to the complaint by D.B. to the College of Physicians and Surgeons of Nova Scotia in her letter dated February 19, 2006, Dr. Osif indicated in part as follows: " … as [D.B.] is referring in her complaint, I asked [A.B.] to move from chair to examining stretcher where I was taking history and simultaneously performing physical examination, *though this might not have been evident for [D.B.] sitting in distance*. I examined [A.B.]'s abdomen and noted on the medical record I found it to be soft and non-tender" [emphasis added].

107. Around this same time, Dr. Osif had another conversation with Dr. Currie about D.B.'s claim that she had not examined A.B. Both Dr. Currie and Dr. Osif testified that Dr. Currie's letter of February 12, 2006 to Dr. Naqvi accurately summarized the conversation with Dr. Currie. In this letter Dr. Currie records:

> "When I discussed the concerns with Dr. Osif, she initially reported that she did examine the patient but that it might have been through her clothing. She also did not feel the patient looked sick and attributed her tachycardia to the fever. Later; however, Dr. Osif told me that it was possible she didn't examine the patient and that the patient may not have received the attention she deserved. She attributed this to a great deal of stress that was affecting her at the time. Dr. Osif also felt that the urinalysis result was enough to explain the patient's symptoms."

108. There are significant inconsistencies between the various accounts given by Dr. Osif of her examination of A.B. on December 13, 2005. In the chart she documents a thorough physical examination including palpation of A.B.'s abdomen. When Dr. Currie first talked to her about D.B.'s complaint to the authority, her response was consistent with the information she had recorded on the chart and she confirmed that she had examined A.B. In her response to the College to D.B.'s complaint, she again reported that she had performed a physical examination "though this might not have been evident for [D.B.] sitting in distance", indicating that she had examined A.B. in the presence of D.B.

109. In her conversation with Dr. Currie around the same time as her response to the College, she conceded that it was possible that she did not examine the patient. In her direct and cross-examination she attempted to explain this as an attempt to end the conversation with Dr. Currie and get off the phone because he kept asking her whether she examined A.B.

110. In her direct examination and initially in her cross-examination, Dr. Osif claimed that she conducted a physical examination from A.B.'s head to chest when she was interrupted and when she returned to find A.B. alone, she conducted a thorough physical examination of A.B.'s abdomen in the absence of her mother. Later in cross-examination Dr. Osif for the first time described a second physical examination of A.B. and explained this as an effort to demonstrate to D.B. that her daughter had no symptoms of appendicitis.

111. We cannot accept Dr. Osif's testimony that she conducted a physical examination on A.B. on December 13th. Her accounts of this point are extremely inconsistent in themselves and completely inconsistent with the evidence of D.B. To us, it seems much more probable that D.B.'s account is correct. Her recollection was clear and straightforward. It was consistent with written statements that she made close in time to the event. Her description of the clothes that A.B. was wearing is much more probable than the description of the clothes by Dr. Osif. On the other hand certain aspects of Dr. Osif's testimony seem unlikely. It would be unusual for a physician to examine an 11 year old child in the absence of their parent. Furthermore, certain aspects of Dr. Osif's testimony conflict with that of several witnesses. This puts her overall account in doubt.

112. Dr. Osif's testimony about the events of December 13, 2005 differs from the evidence of D.B. and the other witnesses. D.B. described A.B. as not walking straight and bent over. Hannah MacKay, one of the registered nurses on duty in the Emergency Room saw A.B. in the treatment room and described her as somewhat bent over the back of the chair, with her left arm across her stomach and holding her right lower side. When she provided her with the medication ordered by Dr. Osif, she described her as "still hunched over". This difference in the evidence between Dr. Osif and D.B. and Hannah MacKay is significant because a child suffering from acute appendicitis would often be hunched over or bent over to get comfortable.

113. We reject the evidence of Dr. Osif where it conflicts with that of Hannah MacKay and D.B. on whether A.B. was hunched over. In our opinion, it is most likely that A.B. presented at the Emergency Room on December 13th, hunched over and bent over and did not walk normally or without pain when Dr. Osif observed her in the treatment room initially.

114. Furthermore, in the view of the Committee, it is extremely unlikely that Deborah Hart told Dr. Osif that A.B. had a recent urinary tract infection. Dr. Osif's testimony on this point is inconsistent with that of D.B. and Deborah Hart, the triage nurse. D.B. testified that her family physician had ordered blood work and a urinalysis in November of 2005 and later had called D.B. to inform her that everything was ok and that no medications had been prescribed. Dr.

Osif said in her evidence that the triage nurse, Deborah Hart, told her that A.B. had had a recent urinary tract infection. This was not charted by Deborah Hart on her triage nurse notes. In her direct examination she made no reference to this and she was not asked about it in her cross-examination. This information was not mentioned in Dr. Osif's letters or conversations responding to the complaint by D.B. to the Cape Breton District Health Authority or the College. There is no indication in Dr. E.M.'s physician records of a urinary tract infection. There is no reason why Deborah Hart would say so. We reject the claim that Deborah Hart told Dr. Osif of a recent urinary tract infection.

115. In all the circumstances, D.B.'s description of the beginning of A.B.'s symptoms two days before December 13th, and her description and that of Hannah MacKay of A.B. as hunched over are consistent with the development of appendicitis. Furthermore, on December 15th, A.B. returned to the emergency room with a ruptured appendix and required emergency surgery. As discussed below, there was no evidence of a urinary tract infection on December 13th. All of these factors make it probable that A.B. did have acute appendicitis on December 13, 2005, and that if a proper physical examination of her abdomen had been performed, symptoms in keeping with appendicitis ought to have been discovered. We do not accept Dr. Osif's account of conducting a physical examination or physical examinations and finding no pain or tenderness in these circumstances.

116. Accordingly, the Hearing Committee accepts the evidence of D.B., and where the evidence of Dr. Osif is inconsistent with the evidence of D.B., rejects Dr. Osif's evidence. We find that Dr. Osif did not conduct a physical examination of A.B. She provided an inaccurate account of her examination on A.B.'s chart and to the initial inquiries of Dr. Currie. We find that her response to the College that she did perform a physical examination was not correct. We reject her evidence given before this Hearing Committee that she performed two physical examinations of A.B.

117. The College has provided cogent evidence that Dr. Osif failed to perform an appropriate physical examination on December 13th, 2005, with the result that she failed to properly diagnose the existence of a serious medical condition suffered by A.B. In the circumstances, in

our view, the history in A.B.'s chart is not reliable. We accept D.B.'s evidence of the extent of the history taken by Dr. Osif. We find that Dr. Osif failed to take an appropriate history.

118. The Hearing Committee finds that Dr. Osif failed to demonstrate adequate skill and care of A.B. on December 13, 2005 by her failure to take an appropriate history or to perform a physical examination.

d) Diagnosis of Urinary Tract Infection

119. While Dr. Osif cannot be faulted that she did not diagnose appendicitis, she failed to give any real consideration to whether A.B. was suffering from appendicitis despite D.B. asking her on two occasions whether she had appendicitis. Her response about whether A.B. may have had appendicitis was that A.B. was much too young for appendicitis. We accept the evidence of D.B. about these discussions and find that Dr. Osif did not communicate in an effective manner with D.B. and failed to appropriately respond to reasonable concerns raised by her on December 13, 2005.

120. Other than Dr. Osif, the physicians who testified about the urinalysis, Dr. Currie, Dr. Levesque and Dr. Michael Howlett agreed that the urinalysis performed on December 13, 2005 was at best equivocal and did not rule out a diagnosis of appendicitis. They agreed that the leukocyte esterase result of 25/ul on the urinalysis report of December 13, 2005 was less significant than the results of the microscopic examination indicating 2 – 5 white blood cells/hpf, which was itself in the normal range. There was no dispute that the moderate bacteria count of (2+)/hpf could point to a urinary tract infection but was more likely the result of contamination in this sample in light of the result for epithelial cells of 2-5/hpf. No one, including Dr. Osif, claimed that a urinary tract infection could be diagnosed from this lab report alone. All of the witnesses agreed that a lab report has to be interpreted with the whole clinical picture in mind, including a careful history and a physical examination.

121. We agree that Dr. Osif quite appropriately ordered a urinalysis and accept the evidence of the medical witnesses that the urinalysis in this case did not rule out appendicitis. In the

Committee's opinion, Dr. Osif did not properly analyze the urinalysis. The white blood cells were in the normal range and the leukocyte esterase reading was at the upper limit of normal. In our opinion, there is no evidence on which a normal prudent emergency room physician of Dr. Osif's experience could conclude that A.B. had a urinary tract infection. For whatever reason, Dr. Osif came too quickly to the conclusion that A.B. likely had a urinary tract infection and took steps to confirm the diagnosis. She then misread the urinalysis and came to a diagnosis of urinary tract infection. We find that Dr. Osif failed to properly analyze the urinalysis resulting in a misdiagnosis of a urinary tract infection.

e) Follow Up Management

122. If Dr. Osif had taken the approach that would be expected of an experienced emergency room physician in this type of hospital, she would have contacted a surgeon at the Cape Breton Regional and referred A.B. to the surgeon on an urgent basis. Appendicitis is a difficult diagnosis so consultation was completely appropriate and the surgeon would be able to make the decision on whether to operate and remove the appendix.

123. There was controversy in the evidence about whether Dr. Osif was correct that Deborah Hart had provided a vomiting handout sheet to A.B. before she left the hospital, or told A.B. that if there was any further problems she should return. We are not able to make any findings on those points. However, once again, if Dr. Osif had taken an appropriate history and performed an appropriate physical examination, and analyzed the urinalysis properly but failed to refer A.B. to a surgeon, at the very least, she should have instructed D.B. to bring A.B. back to the hospital in the morning to be further checked. Because of the series of errors that Dr. Osif committed there really was no proper follow-up management for A.B.

f) Conclusion on A.B.

124. The Hearing Committee finds that Dr. Osif failed to demonstrate adequate skill and care of A.B. on December 13, 2005 by her failing to take an appropriate history, to perform an appropriate physical examination, to properly analyze the urinalysis resulting in a misdiagnosis

of a urinary tract infection, to properly diagnose a serious medical condition, and her failure to refer the patient to an appropriate expert or to establish proper follow-up management. We also find that Dr. Osif provided an inaccurate account of an emergency room physical examination conducted on A.B. on the her chart because she did not perform the physical examination she noted on the chart. She also failed to communicate with D.B. in an effective manner by failing to appropriately respond to reasonable concerns raised by her about whether A.B. had appendicitis. We were not convinced that Dr. Osif failed to request the necessary investigative tests.

PART VII - CHARGES RELATING TO M.S.

125. M.S. was a 71 year old man who was brought by ambulance to the Northside General Emergency Room at 6:45 p.m. on June 15, 2003, with complaints that included slurred or garbled speech and complaints of weakness and pain all over. As a result of Dr. Osif's treatment of M.S. on June 15, 2003, and again later on June 23, 2003, she is charged with the following:

> "2. On or about June 15 and June 23, 2003, you failed to demonstrate adequate skill, care, and knowledge during the emergency room management of a patient with significant pre-existing medical problems, who presented with generalized pain, breathing problems and slurred speech, including the failure to:
>
> (i) provide adequate investigative tests;
> (iii) properly diagnose the patient's medical condition;
> (iv) refer the patient to an appropriate expert; and/or
> (v) establish proper follow-up management.
>
> 8. On a number of occasions you failed to communicate with others in an effective and/or courteous manner, specifically you failed to:
>
> (ii) appropriately respond to reasonable concerns raised by a family member of a patient on June 23, 2003."

126. M.S. was accompanied by his daughter K.S. on both visits to the Northside General Emergency Room. She testified that:

> "Well, coming in June things took a major …… it's like the bottom fell out of everything with him. He was losing his bowels, his kidneys, pain, slurred speech, so I took him to the Northside General Hospital …. he didn't want to eat. He was weak. He wouldn't get up. My dad likes to smoke, he wouldn't get out of bed for a smoke ….".

127. K.S. also testified that M.S. had been relatively well before 2003, but that he became unwell in May 2003 and saw his family doctor, Dr. L., who was making arrangements to admit

him to the Northside General for tests and further examinations when the events leading to this complaint occurred.

a) June 15, 2003

128. The triage nurse at the Northside General Emergency Room recorded on June 15, 2003 that M.S. had a temperature of 36.7, a heart rate of 86, a respiratory rate of 20 and oxygen saturation of 95%.

129. She also reported that K.S. had told her that M.S. was complaining of pain from hemorrhoids, that in the past few weeks he was being tested for diabetes and that he "had few episodes of garbled speech". He was "alert and oriented on arrival – answers questions appropriately but not very talkative. Pleasant. Pressure sore beginning - left hip".

130. Dr. Osif saw M.S. and recorded the following two entries on the chart:

> "June 15, 2003
>
> [Physician record time] 18:47
> c/o slurred speech/chills
> c/o hemorrhoids/bilat amputee for PVD, c/o pain in stumps. Seen by FMD at home Tuesday
> 10/06/03
> o/e Alert, oriented, disheveled, pale
> HEENT right sided earache/pharyngitis. Neck no opposition. Incipient pressure ulcers. Chest clear A/E bilat good. HS reg S1S2. Abdomen soft non tender, peristaltics + MSK bilat amputee
> A/knees. Rectal exam – hemorrhoids.
> CBC, Blood Cultures, CPK, LFT's Lytes, BUN, creatine glucose urinalysis
> [Diagnosis] r/o UTI /Hemorroids/Pharyngitis/Otitis right
> [Departure time] 21:40

EMERGENCY ROOM
PHYSICIANS RECORD II
[DATE/TIME]
June 15/03 2050 blood work↑review WBC 13.1
Urinalysis (sample) still pending
2120 O-E otitis R/pharingytis/UTI/hemorrhoids
Daughter agrees to take patient home
px Proctosedyl supp. 1Q/D 48
~~Amoxil~~ Ceclor 250 mg T/D x 10/7
Can be discharged"

131. K.S. testified that Dr. Osif told her that M.S. had an ear infection and gave him a prescription for an antibiotic. She said that she asked Dr. Osif whether the ear infection would give her father all of his symptoms and Dr. Osif answered in the affirmative. M.S. was taken home, took the prescription and for a few days started to improve, and then his symptoms returned.

132. There were two expert witnesses who testified about the treatment of M.S. on June 15 and June 23, 2003. Dr. Bruce MacLeod is an emergency room physician practicing at the Valley Regional Hospital in Kentville, Nova Scotia, also working some shifts in smaller hospitals in Middleton and Digby, Nova Scotia. Dr. Colin Sutton is an emergency room physician at the Aberdeen Hospital in New Glasgow.

133. Dr. MacLeod considered that Dr. Osif's care of M.S. was below the standard expected of an emergency room physician. He expressed concern about the diagnosis given by Dr. Osif on June 15th. He agreed that it was reasonable to rule out urinary tract infection but indicated that there was no basis for the diagnosis of pharyngitis and otitis, and the prescription of an antibiotic. In his opinion, her diagnosis was completely unsupported by her own data and her own history and physical, and that it was a very unusual diagnosis for a 71 year old.

134. In his written report to the College of April 25, 2007, Dr. MacLeod makes the following comments:

> "Case Summary: This is a rather complex case of a 71 year old that presented with generalized weakness and pain, with an episode of garbled

> speech, and seemed to have a complaint of hemorrhoids. During this initial visit he seems to have had a fairly complete physician exam with a rectal lesion noted that was felt to be a hemorrhoid. As would be expected he had blood work ordered the results of which are not provided to me. He did not have a CXR. He was diagnosed with an otitis and discharged.
>
> He returned a week later with complaints of breathing difficulties and slurred speech and was admitted to the family doctor it appears as a placement problem.
>
> The family doctor arranged medical consultation about the rectal lesion, which turned out be a carcinoma and subsequent CXR and CT showed mets to both these regions.
>
> Standard of care: below.
>
> Comment: Complaints of non-specific weakness, in this age group, have a very broad differential and are not easy to diagnosis in one visit. During the first visit the exam and blood work seemed very appropriate. A CXR was not done, which would have suggested the diagnosis, and is a concern but not necessarily a critical omission given there were no chest related complaints. The fact that he was discharged was less a concern than the diagnosis of otitis, an unusual diagnosis in this age group especially where I can see no complaint of earache. Dr. Osif did not recognize the rectal lesion as a carcinoma, but then neither did the family doctor although he did arrange for a surgical opinion on it."

135. Dr. Colin Sutton also gave opinion evidence with respect to the treatment of M.S. on June 15, 2003. Dr. Sutton expressed the opinion that Dr. Osif's clinical examination of MS on June 15, 2003 was incomplete. Given the information on the chart about episodes of garbled speech and complaints of slurred speech, he thought that her examination was incomplete because she had done no neurological examination. For this reason, he considered that her care for M.S. on June 15th was marginal. On cross-examination Dr. Sutton agreed that the expected standard of an emergency room physician would have been to conduct a neurological examination on a patient with these presenting symptoms. He also agreed that the examination conducted by Dr. Osif as recorded on the chart would not be an adequate neurological examination.

136. Dr. Sutton also testified on cross-examination that, in his opinion, Dr. Osif should have made inquiries to the family doctor about whether the family doctor was planning referral to a

specialist or certain tests. He indicated that the expected appropriate follow-up from a prudent emergency room physician in these circumstances would have been to make these inquiries.

137. Dr. Osif in her testimony said that she did perform a neurological assessment by assessing M.S.'s orientation, his alertness and his speech. She indicated that M.S. was talking to her and he did not have any signs of slurred speech and that he had good muscle tone on the upper body.

138. Dr. Osif indicated that her diagnosis of otitis was consistent with the weakness and chills reported by M.S., because these are signs of infection especially in elderly people. She said that infection would cause weakness for them and also would cause garbled speech. She also indicated that she asked M.S. if he had an earache, and he answered that his right ear hurt.

139. Dr. Osif indicated that no follow-up tests were ordered for M.S. because she understood that the family doctor was arranging his admission to hospital and that she was leaving it to the family doctor to do the necessary follow-up. After three hours in the emergency room she did not consider it necessary to order any further investigative tests because the family doctor was already working to get him into hospital.

140. The members of the Hearing Committee accept that it was reasonable for Dr. Osif to rule out a urinary tract infection, but find that her diagnosis of otitis and pharyngitis was not supported by any clinical findings on the chart or by the evidence before us. We accept the evidence of Dr. Bruce MacLeod that her diagnosis of pharyngitis and otitis were unsupported by the history and the physical.

141. More importantly, however, the members of the Committee agree with Dr. Sutton that the expected standard of an emergency room physician would have been to conduct a neurological examination on a patient with M.S.'s presenting symptoms. Dr. Osif's examination of M.S. was not an adequate neurological examination.

142. Garbled speech and slurred speech were very significant in a patient of M.S.'s age and circumstances. There was no reason to doubt the report of garbled speech and slurred speech from K.S. Garbled speech or slurred speech in a man of the age of M.S. could indicate very serious medical problems. Failing to perform a proper neurological examination and follow-up appropriately does not meet the standard of a normal prudent physician of similar experience and standing.

143. The Committee also concludes that Dr. Osif did not follow-up adequately by simply relying on the information that she had been provided that the family doctor was arranging an inpatient admission. In the view of the Committee, Dr. Osif should have contacted or directly notified the family doctor to ensure that M.S. was being followed up for appropriate investigation.

144. The Committee does not think that Dr. Osif failed to provided adequate investigative tests herself, nor was it necessary for her to refer M.S. to an expert for further assessment, but she should have contacted the family doctor to follow up.

145. Accordingly, the Committee finds that Dr. Osif failed to demonstrate adequate skill and care during her emergency room management of M.S. on June 15, 2003, by reaching an unsupported diagnosis of otitis and pharyngitis, by failing to perform a complete neurological examination and by failing to follow-up adequately with the family doctor in the circumstances rather than assume that the follow-up would be done without any intervention from her.

b) June 23, 2003

146. With respect to the return visit of M.S. on June 23, 2003, here again, both Dr. MacLeod and Dr. Sutton expressed the view that the records indicate that M.S. appeared to have significant medical issues requiring further medical investigation.

147. On June 23, M.S. was not getting better and K.S. feared that he would die that night, so she called an ambulance to take him back to the Northside General. He returned to the

emergency room on June 23, 2003 by ambulance at 11:42 pm. The triage nurse recorded that M.S. had a temperature of 36.7, a heart rate of 93, a respiratory rate of 32 and an oxygen saturation of 92%.

148. She also recorded that he returned to the emergency for reassessment having been in Sunday for an ear infection. She writes "family states pain on right hip, breathing shallow, speech slurred, not eating. Also lower back pain". M.S. was seen by Dr. Osif who recorded the following on his chart:

> "June 23, 2003
>
> [Physician record time] 00:05
> Seen in ER 8/7 ago. Family was waiting for FMD to make arrangements for admission.
> c/o weakness, weight loss, unable to move to wheelchair, Bilat. legs amputee A/K
> HEENT URTI. Chest A/E bilat. good no creps, few rhonchi. HS reg. S1S2. Abdomen soft, peristaltics +, MSK decubital ulcer sacrum/left hip.
> Hold. Social Services consult. AM CBC Lytes TSH
> Consult [Dr. L.] CPK BUN
> LFT's creatinine
> Amylase glucose
> Lipase Urinalysis
> [Diagnosis] Placement Problem. PVD (peripheral vascular disease)
> [Disposition time] 00:05 detain"

149. As noted in Dr. Osif's record she ordered a number of blood tests and urinalysis. She also completed an outpatient/social work referral indicating the following:

> "Social Work Referral
>
> Outpatient
>
> Date of Admission: Hold in ER Date of Referral: 23/06/03
> Date of Initial Contact:
> Source/Reason for Referral: ER
> Medical Diagnosis: Peripheral vascular disease
> Past Medical History: Bilateral (illegible) legs amputation
> sacral/left hip pressure ulcers"

150. The chart indicates that M.S. was re-triaged at "0005" and records the following:

> "Seen and examined by Dr. S. Osif. Daughter advised by Dr. S. Osif. To be held overnight. Lab work drawn. Grandson sitting with patient. Both side rails up."

151. As noted above, M.S. was kept in the emergency room overnight and was seen by his family doctor in the morning, who arranged for suitable tests and referral to experts. These tests and referrals revealed very serious medical problems.

152. K.S. was present when M.S. was assessed by Dr. Osif on June 23rd. Her testimony was consistent with the complaint that she filed with the Northside General Hospital shortly after these events in 2003. At pages 2 and 3 of her handwritten complaint, she states as follows:

> "Dr. Osif was the on-call physician again this particular night. She came into where we were at and asked me straight out "Why was I back here with him, and only in the evenings?" I was rather stunned to be spoken to in this manner but I gave her once again the above-mentioned symptoms. She gave him a quick once over and told me she would call a "social worker". My father didn't need a social worker, he needed medical attention. He had some bed sores so I figured maybe she, (Dr. Osif) thought I was just trying to pass my dad off to someone else. This wasn't the case. She told me to take him home and someone would contact me. I refused to take my dad home this time because I knew for sure something was terribly wrong. I informed her again that [Dr. L.] was still booking a bed for [M.S.] but I believe this fell on deaf ears. She told me [M.S.] could stay the night at the outpatient area but he would need a relative to monitor him."

153. K.S. also says on page 4 of her report:

> "But when you have a so-called medical professional looking down her nose at you like you shouldn't be wasting her time because she immediately can't see the problem, I think it's time to complain."

154. In her testimony K.S. gave evidence as follows:

> "Q. And what happened after Dr. Osif suggested your father needed a social worker?
>
> A. I told her I wasn't there to waste her time, that I felt there was something terribly wrong. She told me to take my dad home and I refused."

155. If the account of the June 23, 2003 visit given by K.S. is correct, Dr. Osif would not meet any expected standard of care.

156. On June 23, 2003 Dr. Osif again ignored the potential serious medical condition which should have been explored by a complete neurological examination and warning signs in the vital signs. Her diagnosis of a placement problem bears no relation to the medical issues faced by M.S. that evening.

157. The Committee does not fault Dr. Osif for failing to refer M.S. to an expert or for further follow-up. She did keep M.S. in the emergency room until the morning and he was referred to the family doctor, but nevertheless, x-rays could have been ordered as one step toward a more thorough work-up which was called for in the circumstances.

158. In her evidence Dr. Osif denied the comment to M.S. about why she was back with her father at that hour of the night only in the evenings. She said that a comment of this sort was made but by another member of the staff. She also denied telling K.S. that she told K.S. to take her father home and only kept M.S. in the hospital when K.S. refused. She says that she arranged the social service consultation in anticipation that M.S. would be further assessed as an in-patient, and would need social services assistance when he was discharged because K.S. told her that she couldn't look after her father anymore. She denied that she told K.S. to take her father home and testified that was not an option, K.S. could not provide care for M.S. at home which Dr. Osif accepted and therefore decided to keep M.S. in the emergency room overnight.

159. The discrepancy between the evidence of K.S. and Dr. Osif is important because it reflects on a level of care given to M.S. on June 23, 2003 and on the charge that Dr. Osif failed to appropriately respond to reasonable concerns raised by K.S. on June 23, 2003.

160. The Committee found K.S. to be a credible witness. Her evidence was consistent with the complaint that she wrote approximately a month after the events. Her evidence is also consistent with the chart and Dr. Osif's diagnosis of a placement problem and with Dr. Osif's out-patient social work referral. Dr. Osif's failure to conduct a proper neurological examination and the amount of time recorded on the chart for her examination are all consistent with the evidence of K.S. Dr. Osif does not seem to have treated M.S. as having a serious medical problem. Her quick and inadequate assessment reflects the account given by K.S. Accordingly, we are not able to accept Dr. Osif's evidence where it conflicts with the evidence of K.S.

161. We find that Dr.Osif did ask K.S. when she first saw her on June 23rd why she was back with her father and at that hour of the night, only in the evenings. We have no reason to reject the evidence of K.S. Dr. Osif's claim that another staff member made the comment is inconsistent with her explanation to the hospital on October 14, 2003 where she said:

> "Eight days after on June 23, 2003 at 23:42 p.m., K.S. returned to Emergency Room Northside General Hospital with M.S. with complaint that M.S.'s condition is getting worse, they did not hear from family physician about arrangements for admission and K.S. stated she is unable to provide care for her father at home anymore. M.S. was found to be in stable condition and was held in holding area in Emergency Room for further assessment and decubital ulcers care."

162. We also find that she did tell K.S. to take her father home and only kept him in the emergency room area because K.S. refused to do so. Dr. Osif's conduct and her communications with K.S. were inappropriate. M.S. was gravely ill but Dr. Osif did not take seriously the reasonable concerns of K.S. Dr. Osif's indifference to M.S.'s condition and her communications with K.S. are below the standard of a normal prudent physician of Dr. Osif's experience and standing. In our view, she failed to communicate with K.S. in an effective or

courteous manner by failing to appropriately respond to the reasonable concerns raised by K.S. on June 23, 2003.

163. Our conclusion is that Dr. Osif failed to demonstrate adequate skill and care during the emergency room management of M.S. on June 23, 2003 by failing to conduct an appropriate medical examination including a complete neurological examination, by failing to order x-rays and generally by failing to take seriously the reasonable concerns of K.S.

c) Objection Regarding Complaint File Summary As Regards M.S.

164. In his final argument, counsel for Dr. Osif renewed his motion that the Hearing Committee dismiss the charges arising from Dr. MacLeod's report. This includes the charges related to M.S. We were not prepared to deal with this issue on a pre-hearing basis, but will address it here having heard the evidence.

165. It should be borne in mind that it is not improper that Dr. Osif be investigated and charged in respect of a matter which was discovered in the course of the investigation of the D.B. complaint. Section 51 of the *Medical Act* provides:

> "51 A person or disciplinary committee investigating a disciplinary matter concerning a member or associate member may investigate any other disciplinary matter concerning the member or associate member that arises in the course of the investigation. 1995-96, c. 10, s. 51."

166. Given the protection of the safety of the public which is at stake in these issues, it is not surprising that the Investigation Committee has the right to pursue matters like the M.S. case that come to the Committee's attention. It was therefore not unfair that the Investigation Committee required Cape Breton District Health Authority to provide Dr. Osif's complaint profile and as a result received the Complaint File.

167. Pages 26 to 48 of the Complaint File relate to M.S. K.S. made a complaint to Cape Breton District Health Authority around July 14, 2003. Her complaint related to Dr. Osif's care

of M.S. on June 15th and 23, 2003; it included a five page description of those events. Dr. Osif provided a written reply to this complaint on August 14, 2003. Her reply reflects her access to the hospital records relating to M.S.'s visits. This provided Dr. Osif with a record created by herself close to the time of the events on June 15th and June 23rd, and the ability to respond to the factual allegations made by K.S., which were substantially the same as those in this hearing.

168. Given this and the cross-examination of K.S. and Dr. MacLeod, as well as the evidence of Dr. Sutton and Dr. Osif herself, we conclude that Dr. Osif was not prejudiced in making a complete response in this hearing on the M.S. matter. In our opinion, Dr. Osif has not been prejudiced in the procedural sense by the passage of time and the *Medical Act* contemplates the investigation of matters like the M.S. case in the context of the A.B. complaint in 2006. Given her full opportunity to cross-examine the witnesses and present evidence in this hearing, Dr. Osif has had the opportunity to provide a complete response to the charges against her in the M.S. matter.

169. Dr. MacLeod was provided with a modified version of the Complaint File Summary, Dr. Osif's comments on the Complaint File and the Emergency Room Records for each patient identified in the modified Complaint File Summary; he was not provided with the Complaint File itself, upon which the modified Complaint File Summary is based and to which Dr. Osif's comments were directed.

170. The first aspect of Mr. Donovan's submission is that providing the modified Complaint File Summary to Dr. MacLeod contaminated his evidence to the extent that it would be unfair in this hearing to require Dr. Osif to respond to the issues relating to M.S. This submission is based on the following entry related to M.S. on the modified Complaint File Summary:

> "NSG M.S. 15-June-03 Inappropriate treatment.
> Took patient to ER with shortness of breath, lack of appetite, slurred speech, pain, lack of bladder and bowel control, and weakness. Seen by Dr. Osif, treated for ear infection and sent home. A week later came back with same symptoms – refused to leave

> when told by Dr. Osif to stop wasting dr.'s time. Patient was admitted next day with cancerous tumors in lungs, rectum and brain. Wants Dr. Osif reprimanded for her behavior."

171. We agree with Mr. Donovan that this summary of the M.S. matter is misleading. It begins with the label "Inappropriate treatment". This makes it appear that the District Health Authority considered that Dr. Osif's care of M.S. in 2003 was somehow inappropriate. In 2003, the District Health Authority actually reached the opposite conclusion. The Complaint File, which was not provided to Dr. MacLeod, includes a letter dated August 26, 2003 in which the District Health Authority responds to the complaint from K.S. by indicating "it appears appropriate care has been rendered".

172. The Complaint File Summary is also misleading when it indicates that K.S. was "… told by Dr. Osif to stop wasting dr.'s time". While it is true that K.S. felt Dr. Osif thought she was wasting her time, there is no evidence that Dr. Osif told her to stop wasting her time.

173. The second aspect of Mr. Donovan's submission is that providing Dr. Osif's comments on the Complaint File to Dr. MacLeod was misleading without an explanation that those comments were prepared by reference to the Complaint File itself, which had not been sent to Dr. MacLeod. In her comments on the Complaint File, Dr. Osif writes as follows about the M.S. case:

> "Pages 26-49 M.S. 71M ER visit 2003/06/15. This complaint reflects unavailability of hospital beds. Page 34 Dr. Naqvi confirmed that appropriate care has been rendered."

174. As indicated in this quotation, the comments relate to the Complaint File but not to the summary provided in the Complaint File Summary. The letter to Dr. MacLeod leaves the impression that Dr. Osif's comments related to the Complaint File Summary. This is misleading because Dr. Osif did not have the Complaint File Summary at the time of her comments and her comments were not responsive to the points raised by the Summary.

175. The Hearing Committee agrees with Dr. Osif that it was not appropriate to provide these misleading documents without a better explanation to Dr. MacLeod. The question that we need to decide is whether this failure in the investigation process makes it unfair for Dr. Osif to be required to answer the charges arising out of the M.S. case in **this** hearing.

176. The Hearing Committee has concluded that despite the misleading nature of the documents provided to Dr. MacLeod, the hearing before us was a fair hearing in which Dr. Osif had a complete opportunity to answer the charges related to the M.S. matter.

177. Furthermore, we find that Dr. MacLeod was not actually misled by the documents relating to M.S. that were presented to him. His report on the M.S. case relies on the medical records. His reasoning and conclusions appear to us to be based on the medical records not on the Complaint File Summary.

178. In his report, Dr. MacLeod does make one comment which referred to the Complaint File Summary. He says "I am unable to comment on the complaint that she told the patient to stop wasting her time, but obviously this would have been appropriate if said." In our view, Dr. MacLeod was not tainted by the misleading comment because he expressly did not rely on an undocumented allegation.

179. Dr. MacLeod did, however appear to be influenced to some degree by Dr. Osif's comments on the Complaint File. In the last paragraph of his report on M.S. he states as follows: "… Of somewhat more concern is Dr. Osif's dismissal that this occurred because of unavailability of patient beds. Had she explained that this was a complex patient with vague complaints, I may well have felt that she did meet the standard of care." This gave rise to the charge against Dr. Osif that she gave an inappropriate response to an assessor from the College. As will be seen later in this decision, we have rejected that charge against Dr. Osif.

180. Despite any influence on Dr. MacLeod's written report, we conclude that this has not produced any procedural or substantive unfairness in this hearing. Dr. MacLeod was subject to cross-examination on this point. Additional evidence was put to him that had not been provided

when he did his written report. He answered the questions put to him in a straightforward manner conceding points where he had insufficient facts when he prepared his written report. Dr. Osif testified about the circumstances of writing her comments. The Committee has decided not to put any weight on statements that she made in her comments on the Complaint File. We were able to assess the evidence that she gave at the hearing and draw our conclusions without being influenced by her comments on the Complaint File or by Dr. MacLeod's reference to them.

181. Looking at Dr. MacLeod's evidence as a whole, it does not appear to us that he was misled to any significant degree by the materials provided to him and that, in the context of the case as a whole, Dr. Osif has suffered any prejudice in respect of the M.S. case. It is worth noting that Dr. MacLeod and Dr. Sutton did not disagree significantly on the points in which we have concluded that Dr. Osif did not provide adequate care to M.S. We had the advantage of cross-examination of both physicians, the evidence of K.S. and of Dr. Osif herself. Our conclusions have not been affected by any irregularity in the investigation process.

182. Accordingly, we see no basis to dismiss the charges against Dr. Osif which have been proved by the College and which relate to M.S.

PART VIII - REDUCTION CASES

a) E.S. Shoulder Dislocation

183. E.S. was a 79 year old woman who sought care at the Northside General Care Emergency Room on April 5, 2001. As a result of the care provided to E.S. that evening, Dr. Osif has been charged with the following:

> "1. (i) You failed to demonstrate adequate skill, care, and knowledge on April 5, 2001, during the emergency room management of a fracture-dislocation of the shoulder where there was evidence of neurological compromise; and by failing to perform immediate and effective reduction, and failing to provide appropriate pain management."

184. The essential facts relating to this charge are found in Dr. Osif's notes on the chart on April 5, 2001. She recorded the following:

> "April 5, 2001
>
> [Physician record] (blank)
> Frequent falls; fell while getting out of car side ways c/o pain R shoulder
> ↓ ROM
> X-ray review: posterior R humeral head dislocation
> R arm neurovascular findings intact.
> Post CABG 10 years ago; multiple medical problems.
> No attempt for reduction done.
> Transfer to orthopedic surgeon on call Dr. Brian via ambulance
> Anesthesia stand by for IV analgesia.
> [Diagnosis] Dislocation right shoulder
> [Admit]
> [Discharge time] written/changed to illegible"

185. The chart also indicates that Dr. Osif ordered administration of 25 mg of Demerol intramuscularly and 25 mg of Gravol. In his report, Dr. Bruce MacLeod made the following comments about the care given to E.S. on this occasion. He states as follows:

> "Case 12: E.S. Age: 79 Y Visit: April 5, 2001
>
> Patient complaint: Dislocation shoulder
>
> Problem with case: Unclear
>
> Case summary: 79 year old who suffered a fracture-dislocation of her shoulder. She was referred to orthopedics. The complaint around this case is unclear to me but I assume it was that attempt to reduce the shoulder was not initially attempted.
>
> Standard of care – below
>
> Comment: It is likely that most emergency physicians would have attempted to reduce this shoulder without referral to orthopedics. The referral to Orthopedics is not in keeping with an experienced ER physician. Again basic pain management was inadequate."

186. Dr. Colin Sutton expressed a different view in his report where he states as follows:

> "Dr. Osif appears to have correctly identified the problem in a timely fashion, provided supportive care and made appropriate arrangements for urgent orthopedic consultations/reduction. The decision to reduce at NSGH would depend on the expertise/availability of support staff. I'm not aware of what those resources were and thus cannot comment on her decision <u>not</u> to reduce."

187. The Committee agrees with Dr. MacLeod that the reduction of a dislocated shoulder is a treatment which would readily be performed by a prudent and experienced emergency room physician. However, in this case there were sufficient other factors involved that we are not convinced that Dr. Osif's care was inadequate.

188. At 8:30 in the evening the Northside General Emergency Room had limited resources. Dr. Osif was the only physician on staff. There was a small complement of nurses; there was no access at that location in the evening to consultants or to diagnostic equipment other than x-rays. The patient was a 79 year old woman with a history of cardiac disease. In order to effect the reduction it would be necessary to provide intravenous sedation which would then require invasive monitoring and dedication of one of the registered nurses during her recovery. If an emergency developed she might have to go to a cardiac unit or an intensive care unit but there

was none on site. The transfer to the Cape Breton Hospital was a half hour away by ambulance where all of these support services were available.

189. Dr. Sutton points out that there was a greater risk of neurovascular compromise the longer that the shoulder was out of position, but that at the time that she was examined, E.S. had no neurological compromise. In our view, given the absence of neurovascular compromise and the risk of performing the reduction without sufficient backup, Dr. Osif's decision to transfer E.S. to the Cape Breton Regional Hospital was not unreasonable.

190. With respect to pain control, 25 mg of Demerol is a very small dose. But again, we have a 79 year old patient for whom sedation posed risks, and administration of an analgesic by IV titration could have interfered with her transfer to the Cape Breton Regional Hospital by ambulance.

191. The Committee is not satisfied that there is clear and convincing proof that Dr. Osif failed to exercise the degree of care and skill which could reasonably be expected of a normal prudent experienced emergency room physician in a hospital like the Northside General Hospital. We therefore dismiss the charge related to E.S.

192. E.S. is also one of the cases referred to Dr. MacLeod with the modified Complaint File Summary and Dr. Osif's comments on the complaint file. There is nothing in Dr. MacLeod's report nor in his evidence before us that would indicate that he was misled by these documents. The entry in the Complaint File Summary related to E.S. is very straightforward and not misleading "Elderly patient fell and dislocated right shoulder. Seen by Dr. Brien, referred to CBRER by Dr. Osif."

193. Dr. Osif's comments on the Complaint File indicated as follows:

> "15/Page 121 unable to identify the reason why this ER visit is included in complaint file. E.S. 79F ER visit 2001/04/05 this lady suffered dislocation right shoulder. There was questionable fracture/dislocation. Dr. Brian orthopedic surgeon was consulted. Because of multiple co morbid conditions I requested intravenous analgesia for reduction in the presence

> of anesthetist. Patient was transferred to CBRH and admitted by family doctor Dr. Hickey to Northside General Hospital for ongoing rehabilitation for about seven weeks until 2001/05/25."

194. The Complaint File itself had no information about E.S. There was nothing in Dr. MacLeod's report or his evidence that indicated that he relied upon Dr. Osif's comments about E.S. on the complaint file. We find that Dr. Osif's comments were not prejudicial to her in this hearing.

195. We might well have been concerned about the fairness of charging Dr. Osif in a matter going back to 2001 about which there was no complaint brought to her attention at the time, and no information provided in the Complaint File, but Dr. Osif was able to respond effectively in her comments and in her evidence before us, and we have concluded that there is insufficient cogent evidence to constitute clear and convincing proof of inadequate care by Dr. Osif.

196. The Hearing Committee dismisses the charge against Dr. Osif relating to E.S.

b) The Fracture/Dislocation of R.M.

197. On May 29, 2006, R.M. sought treatment for an injured right ankle at the Northside Emergency Room. This has led to the following charge against Dr. Osif.

> "1. (ii) You failed to demonstrate adequate skill, care and knowledge: On May 29, 2006, during the emergency room management of a fracture-dislocation of an ankle by failing to perform immediate and effective reduction, and failing to provide appropriate pain management."

198. RM was a 51 year old woman who fell down some stairs and injured her right ankle. The triage nurse noted that R.M. fell off a step and injured her right ankle and that R.M. was able to move to some degree, had a small amount of swelling and was unable to weight bear. She noted later as follows:

> "examined by Dr. Osif with nurse present. X-ray right ankle done. Slab cast applied to right ankle by Dr. Osif. Med given for pain. Transferred via ambulance to CBRH to see Dr. Brien."

199. Dr. Osif's notes on the chart for this patient indicate the following:

> "May 29, 2006
>
> [Physician record] time 01:08
> Fell on stairs. Gross deformity R ankle/? Anterior dislocation. Painless. Local swelling. X-ray dislocation anterior, # lateral malleolus displaced, # medial malleolus x-ray R. ankle (filed), back slab R leg B/K
> Toradol 10 mg PO
> Transfer to CBRHER for Dr. Brian, orthopedic consult via ambulance
> Diagnosis: Fracture/dislocation right ankle
> [Physician signature] S. Osif
> [Discharge] √
> [Departure time] 02:00"

The chart also indicates that Dr. Osif ordered 10 mg of Toradol by mouth which was given to her five minutes before her departure by ambulance.

200. Dr. Osif testified in direct examination as follows:

> "So I examine her, palpate the pulse … pulse is there. She has good colour, good capillary refill. It's obviously dislocated fractured ankle. We ask the patient if she needs analgesia … she refuse. The patient … this lady doesn't want any analgesia. She's going for x-ray, comes back with the pictures. And I have x-ray right here. "Dislocation. Anterior fractured lateral malleolus was displaced; fractured medial malleolous." Next to it like it's "X-ray ordered" what I wrote earlier.
>
> And with this I am calling orthopedic surgeon. When I see the x-ray, I see like large fragments there … the ankle is disrupted as a whole joint. So I consult orthopedic surgeon. It is again, Dr. Brian by chance. And he asked if the patient has pulse. I confirm, yes, I have good pulse, good colour. She's not much in pain. He says, Splint it and send it to me."

201. Dr. Osif also testified as follows:

> "So I consulted the specialist. It was clear to me that this patient needs internal fixation. She needs to go to the operating room to have definite treatment.
>
> Also at this time, there was no impending lacerations through the skin by the bony fragment. The joint was fairly compound, so there was swelling there, but there was no immediate danger that the fragment would protrude through the skin. So actually the lower leg was in relatively good shape. "

202. Upon R.M.'s arrival at Cape Breton Regional Hospital, a nurse recorded:

> "Patient to ER bed #11 via EHS.
> Patient has ® ankle fracture, posterior splint in place from NSGH.
> Patient reports ↑[increased] pain "worse than before she put the wrap on it". Cap refill [less than] 3 [seconds], [no] pedal pulse. Dr. Norm Kienitz notified of patient status. Extremity elevated on pillow."

203. The nurse also recorded that R.M. was given morphine for pain at 3:20 am and a closed reduction was performed at that time in the Cape Breton Regional Emergency Room.

204. R.M. had surgery at 8:30 in the morning for what was described as "fracture dislocation of the right ankle". The surgeon was assisted by an anesthetist and made the following note: "this very pleasant patient suffered a fractured dislocation of the ankle that was properly reduced in the Emergency Room. As it is not stable, it needs to be fixed by surgery."

205. Dr. MacLeod made the following observations in his report:

> "Case 7: R.M.K. Age 51Y Visit: May 29, 2006
>
> Patient complaint: Fracture-dislocation ankle
>
> Problem with case: Nursing concern that splint was applied to swollen ankle; the patient was transferred with vascular compromise.
>
> Case summary: 51 year old presented with displaced fracture dislocation of an ankle. He was treated with PO Toradol and splinted then referred to orthopedics. At CBRH the ER physician reduced the ankle prior to seeing orthopedics.
>
> Standard of care – below
>
> Comment: This ankle required fairly urgent reduction, which is something an experienced ER physician, should have carried out. He should have been given morphine prior to transfer, which does not appear to have been done. Oral Toradol is completely inadequate. It is unclear if there was vascular compromise to me and even if there was the best thing that could have been done, and was done, was to transfer to orthopedics. As for waiting for the swelling to go down prior to splinting, as seems to be the complaint is completely without foundation. The lack of immediate reduction and adequate pain management is regrettable and reflects a minimal level of care and is not in keeping with an experience physician."

206. Dr. Sutton considered that R.M.'s care was marginal after noting that there was "no record of pulse or neurological function" and that "Patient not likely given adequate pain medication given the extent of injury, PO meds pt who will likely require sedation" and made the following comments in his report:

"1. Subject to instruction from orthopedic surgeon (did he tell her just to "send") then care may have been acceptable.
2. The ability to successfully reduce a fracture/dislocation (as was done at CBRH) is dependent on the necessary staff with the skill set to provide conscious sedation in a safe environment. The details as what constitutes acceptable care for conscious sedation is well documented in The College of Surgeons and Physicians Guidelines for Conscious Sedation. (See reference below). If this meant calling out staff (either a second physician if available or respiratory technologist) then the delay in performing the procedure would be longer than the transfer time to CBRH. I assume these discussions were held with the orthopedic surgeon on call at the time he accepted the case.
3. Being a rural feeder hospital to CBRH, the sooner this transfer took place, the better. This patient was under the care of Dr. Osif for approximately 50 minutes. This does not seem to be an inordinate amount of time given that during this time the patient needed to be assessed, X-rays needed to be taken and read, a call to the consultant needed to be made and an ambulance had to be called to complete the transfer.
4. I have not been made aware of what back-up structure is in place at Northside General Hospital at 2:00 a.m. to safely proceed with attempt at reduction.
5. It is noted that the College's own guidelines for procedural sedation were only published in March 2007."

207. In his evidence at the hearing Dr. MacLeod expressed his concerns about the treatment of R.M. He testified as follows:

"Q. You mentioned you had two concerns with this matter.

A. Two major concerns. The second major concern is that when this ankle is out of joint, there's a problem with that. And there's a couple of problems. One, it can stretch the arteries going to the leg … in which case, if they're stretched, there may not be blood supply to the foot. And in rare but definite cases, you need to do something about that on a very urgent basis. And what needs to be done is the ankle needs to be roughly put back in joint. There's other reasons for that … other than the pulse not being present. When this is out of joint, the skin is stretched. When the skin is stretched, it loses some amount of blood supply. And down the road that skin can break down and ulcerate … and a week or two later, that is a major problem for the patient and the orthopedic

> physicians. So as a rule … as a very general rule, this ankle should be reduced as quickly as can be accomplished. So … and by "reduced' I mean you basically put it back roughly where it came from. This is not the definitive treatment this patient needs to go to the operating room. But once you put it back in joint and then splint it, then the pain is improved, the pulses if they were a problem are improved, the skin is definitely improved once you get it back in joint … and then the patient can be managed on an urgent basis, not in an emergent basis. Then the patient could actually be just … could have even conceivably been held overnight and sent in the morning.
>
> Q. Dr. MacLeod, do you need equipment to reduce any ….
>
> A. You don't need any equipment. You do need to be able to administer a sufficient dose of analgesia to do this. Now it can be done … you know, where you put the patient almost virtually asleep in the emergency room. It really doesn't need to go to that level, but for many of us that do this routinely, we are quite comfortable with that and we do that. But simply to give this patient Morphine, plus or minus a tiny bit of Valium … and I would assume that all experienced ER physicians should be comfortable giving some amount of Morphine, some amount of an anxiolytic such as Valium or Versed, another medication, and would have attempted reduction in this.
>
> I know personally if I had seen this patient even prior to an x-ray, I would have put this back in joint because it's obvious that it's broken. You don't need an x-ray for that. Now maybe that's … because I've done it a long time and I'm fairly comfortable, I would have been quite happy to say. Yes, get that x-rayed, bring them back. I would have assumed that most physicians, even in this type of centre … if I was in Digby, which I think is fairly equivalent, I would do this. I would put it back in and I would do it prior to the x-ray. That's not necessary, but that's the sort of speed I think that needs to be done. There's a timing to this. So it's not appropriate just to say, Well, I sent it off to the orthopedic guy, it's like someone coming in with a heart attack … well, I've consulted Cardiology. But there's numbers of steps before you get there that need to be done. And I think this needed to be done."

208. The Committee agrees generally with Dr. MacLeod about the need for an immediate reduction of the ankle in this type of case. An experienced emergency room physician in this setting should have been able to perform a reduction with proper pain control. Dr. Osif was

quite right to consult with the orthopedic surgeon Dr. Brien, but Dr. Brien's advice to send R.M. to the Cape Breton Regional does not relieve Dr. Osif of her responsibility for the risk to R.M.'s health by not performing an immediate reduction.

209. The chart has no record of R.M.'s pulse in her right foot at the Northside General Emergency Room; the first record of pulse is that taken at the Cape Breton Regional where the nurse records that there was no pulse. Dr. Osif in her testimony indicated that there was a pulse but that she did not record it on the chart. The point is important because both Dr. MacLeod and Dr. Sutton agree that the expected standard of care of an emergency room physician of a similar experience and standing as Dr. Osif, would be to perform a reduction in the circumstances documented on the chart. Given the nature of the injury and the report of no pulse at the Cape Breton Regional 45 minutes after transfer, we are unable to conclude that this is simply an incident of poor charting. The issue of vascular compromise and lack of blood flow to the feet is so significant in these circumstances, given the extent of the injury, that pulse and neurological function should have been recorded. We do not accept Dr. Osif's evidence on this point and will rely on the chart as an accurate record of her examination of R.M.

210. Even if we accepted Dr. Osif's evidence about R.M.'s pulse, the gross nature of the injury in this case, in our opinion, required at least an attempt to reduce the dislocated ankle, as was performed successfully later in the emergency room at the Cape Breton Regional Hospital.

211. With respect to pain management, both Dr. Sutton and Dr. MacLeod agreed that the Toradol was an ineffective medication in the circumstances. Even if the patient did not experience pain while her foot was stationary, she did complain that she could not put weight on her foot and she did complain of pain after her ankle was splinted and upon her arrival at the Cape Breton Regional Hospital.

212. In our opinion, a prudent physician of similar experience and standing to Dr. Osif, would not have provided a mild analgesic like Toradol by mouth, but would have started an intravenous titration of a stronger medication. If that was not possible, the circumstances might

have even called for the administration of pain medication intramuscularly, but medication by mouth in these circumstances was inadequate and inappropriate.

213. The Hearing Committee finds that Dr. Osif failed to demonstrate adequate skill and care on May 29, 2006 during the emergency room management of R.M. by failing to perform an immediate and effective reduction, and failing to provide appropriate pain management.

214. The Hearing Committee also concludes that the provision of the modified Complaint File Summary and Dr. Osif's comments on the complaint file to Dr. MacLeod did not prejudice her in these circumstances or deny her a fair hearing before us.

215. We agree that the entry in the Complaint File Summary is misleading. It states as follows:

> "CBR R.M. 29-May-06 Inappropriate treatment. Patient arrived at ER from NSG with greater amount of pain than before splint applied to right ankle by Dr. S. Transferred with dislocated fracture and vascular compromise. RN feels Dr. Osif should have waited for swelling to do down before applying splint."

216. Dr. MacLeod does not appear to have been misled by this document. In his report and in his evidence Dr. MacLeod relied on the information in the chart at the Northside General Emergency Room, and at the Cape Breton Regional. He expressly rejected the comment in the Complaint File Summary that an RN felt that Dr. Osif should have waited for the swelling to go down before applying a splint. He was subject to cross-examination, and was cross-examined on the basis for his opinion on the treatment of R.M. He gave his evidence in a manner that was clear and objective. We have no reason to conclude that Dr. MacLeod was misled or influenced by the Complaint File Summary.

217. Dr. Osif had the opportunity to give evidence related to R.M. and did so and was able to present Dr. Sutton as an expert witness on the point. In the circumstances, regardless of

whether the entry on the modified Complaint File Summary was misleading, it did not deny Dr. Osif a full and fair opportunity to respond to the charges against her, and did not affect the substance of Dr. MacLeod's testimony.

218. Likewise, the entry in Dr. Osif's comments on the Complaint File relating to R.M. did not mislead Dr. MacLeod. His report and his evidence were an objective analysis of the material on the chart, and he was subjected to cross-examination on this point. Dr. Osif had the opportunity to present evidence before us. We put no weight on Dr. Osif's comments on the Complaint File in light of the circumstances in which they were produced. We find that Dr. Osif was not prejudiced in this hearing by the College providing his comments on R.M. to Dr. MacLeod.

219. The Committee finds that providing Dr. Osif's comments to Dr. MacLeod in the circumstances did not deny her a fair hearing before us and that the College has provided clear and convincing proof of Dr. Osif's failure to demonstrate adequate skill and care of R.M. by failing to perform an immediate and effective reduction and failing to provide appropriate pain management to her.

PART IX - CHART AUDIT BY DR. SIMON FIELD

220. On July 24, 2006 Investigation Committee "A" requested Dr. Simon Field to conduct a broad-based audit of Dr. Osif's Emergency Room records at the Northside General Hospital and review approximately 25-50 charts and to provide a written report to the Committee. He requested 50 randomly chosen charts from the Division of Health Records at the Northside General Hospital. He specified that 25 of the charts should be pediatric patients.

221. Dr. Field reviewed the charts, noting his observations in various categories, including legibility, data gathering, physical examination, management plans and follow up arrangements. He also looked for consistency in reaching diagnoses, adherence to accepted clinical practices and guidelines and appropriate use of investigations and treatment modalities. Dr. Field indicated that he did not believe that Dr. Osif was practicing to a standard that is unacceptable or that she falls below the standards set by her peers. He noted that there were certainly areas in which she could make improvements.

222. He indicated one area in which she could make improvements related to diagnosis in pediatric cases. In this respect, he indicated as follows:

> "The pediatric cases (and to a lesser extent, the adults) showed some poor decision-making regarding diagnoses. Largely, these appeared to be unsubstantiated to unlikely diagnoses given the history, physical examination, vital signs and investigations. Typically, these appeared to be fairly minor (likely viral) illnesses which were treated with antibiotics-often inappropriately broad-spectrum agents."

223. A number of charges have been made against Dr. Osif as a result of Dr. Field's chart audit. These relate primarily to Dr. Osif's diagnosis of pharyngitis in a number of patients and her prescription of certain antibiotics to treat it.

1. Conflicting Evidence on the Standard of Care

224. Dr. Field and Dr. Sutton both testified about the diagnosis of pharyngitis for which antibiotic treatment is indicated, and their views about the choice of antibiotics for this purpose. Both Dr. Field and Dr. Sutton distinguished between viral and bacterial pharyngitis. Both agreed that most cases of pharyngitis are viral and should not be treated with antibiotics. There was no dispute between them that a bacterial pharyngitis is indicated when there is a sore throat, fever, enlarged tonsils or exudate (pus) on the tonsils and swollen lymph nodes. Dr. Field indicated that a diagnosis of bacterial pharyngitis might be made without all four of these clinical signs and that scoring systems are used to take into account these signs and the patient's age. Dr. Colin Sutton testified that he did not use a scoring system in reaching a diagnosis of bacterial pharyngitis, but that he did look for the presence or absence of certain particular findings which included fever greater than 38 degrees, the absence of cough, tonsillar swelling or exudate present, and tender or enlarged lymph nodes.

225. Both Dr. Field and Dr. Sutton agreed that a physician has to make a clinical judgment based on a proper history and on a physical examination in which some combination of those indicators can be observed. They agreed that, in the absence of all of those indicators, bacterial pharnygitis is not present and no antibiotics should be prescribed.

226. A normal prudent emergency room physician of Dr. Osif's experience in a Level III Emergency Room would reasonably be expected to know the difference between viral and bacterial pharyngitis, the nature of the clinical signs for bacterial pharyngitis and the appropriateness of prescribing antibiotic medication when there is no bacterial pharyngitis.

227. Dr. Field and Dr. Sutton agreed, that, absent other factors, a first line antibiotic such as Penicillin VK should be prescribed for a bacterial pharyngitis. Other antibiotics are appropriate if the patient is allergic to first line antibiotics or if treatment with a first line antibiotic has failed. Furthermore, certain antibiotics which are not first line antibiotics may be appropriate based on the physician's clinical judgment of the circumstances of the patient, in which case a

patient's chart should provide an adequate record in which the basis for that departure from the norm has been taken.

228. There were differences between Dr. Field and Dr. Sutton regarding the proper circumstances in which a first line antibiotic ought to be prescribed as opposed to a broad spectrum antibiotic. Dr. Field indicated that the usual prescription for a diagnosis of bacterial pharyngitis is Penicillin VK. In his view, this is the treatment of choice with the exception being in very young children, where Amoxil can be used because it has a better taste, and it is often better tolerated in small children. He said that most references suggest that Penicillin VK be used unless there are contraindications to using it. Other antibiotics such as Ceclor attack a broader spectrum of bacteria than Penicillin VK. Dr. Field indicated that most recommendations are that Ceclor should not be used as a first line therapy against bacterial pharyngitis. It would be appropriate to use Ceclor in people that for various reasons would not be able to take standard therapy because of allergy or in cases of failed therapy, where there is a proven bacterial infection.

229. Dr. Field referred to numerous clinical practice guidelines which are available in choosing the appropriate antibiotics. He indicated that the standard reference for most antimicrobials or for most antibiotics would be the "Sanford Guide". The "Sanford Guide" is a small handbook that lists various infections and antibiotics, and the use of those antibiotics in specific infections. Dr. Field said there are other clinical practice guidelines. For example, in certain provinces, professional colleges or the provincial governments have released guidelines for treatment of certain infections. There are no such guidelines in Nova Scotia.

230. Dr. Field contrasted guides like the Sanford guideline with the CPS, that is the Compendium of Pharmaceuticals and Specialties, which is a large book which consists of all the product monographs for all drugs that are commonly available in Canada as supplied by their manufacturers. The CPS would have the legally acceptable or licensed uses for particular drug, the recommended dosages, side effects and other like information. According to Dr. Field, listing in the CPS means that the drug company has the drug license to be used for a particular indication. However, the CPS would not be regarded as being a guideline for treatment.

231. For example, Ceclor is indicated in the CPS as a treatment for bacterial infections but, in cases of proven or high suspicion for bacterial pharyngitis, according to Dr. Field, Ceclor would not be commonly prescribed or an appropriate drug to use, according to most practice guidelines for the treatment of pharyngitis.

232. Dr. Sutton indicated that he recognized that current academic teaching and recommendations suggest narrow spectrum antibiotics such as Penicillin VK as the better choice where there is a diagnosis of bacterial pharyngitis. However, he reported that, research in rural hospitals across Canada, about 60% of the time, physicians are prescribing drugs like Amoxil for upper respiratory tract infections and particularly for pharyngitis. With respect to Ceclor, he agreed that current academic teaching is that Ceclor is a second line choice of antibiotics usually for failed otitis media or for sinusitis. However, Dr. Sutton says that the CPS is a widely used reference among physicians in Canada and it indicates that Ceclor is indicated in the treatment of pharyngitis and otitis media, and that it is licensed by Health Canada for this purpose.

233. Dr. Sutton contrasted current academic teaching with the practice of rural physicians. "Current academic teaching" is the approach that medical graduates are taught in medical school and the manner in which academically based emergency rooms like those at the Queen Elizabeth II's Health Science Centre, or the IWK Hospital operate. He contrasted the current academic teaching with the practice of Dr. Osif's peer group which he identified as emergency room physicians, family physicians and walk-in clinics. Dr. Osif's peer group, particularly those in rural settings frequently prescribe antibiotics in the absence of the indicators of a bacterial pharyngitis, and do not prescribe first line antibiotics routinely, but instead use either broad spectrum antibiotics such as Ceclor or other second line antibiotics to treat pharyngitis. Dr. Sutton also indicated that Dr. Osif's peer group does not necessarily routinely chart all of the factors from the patient's history or physical examination that would allow the reader to note the presence of the relevant indicators of bacterial pharyngitis or the basis for describing something different from a first line antibiotic.

234. Dr. Field and Dr. Sutton agreed that the overuse of antibiotics and the use of broad spectrum antibiotics when they are not needed creates other problems. By overusing antibiotics, by treating viral illnesses, the antibiotics may be less effective when they are actually needed. The use of broad spectrum antibiotics or more powerful antibiotics than are required gives rise to a broader problem of antibiotic resistance as bacteria evolve.

235. In our view, the picture painted by Dr. Sutton of current academic teaching followed by new graduates and Level I emergency room physicians contrasted with emergency room doctors in Level III rural hospitals is overstated. Both he and Dr. Field refer to clinical practice guidelines of various types and to continuing medical education on updates on infectious diseases and agents and antibiotics. These resources are available to the group of physicians which Dr. Sutton includes in Dr. Osif's peer group.

236. In approaching the charges related to these issues, we will assume that the patient's emergency room chart is an accurate record unless we have been shown otherwise. When the chart indicates none of the indicators of a bacterial infection or if any other observations point clearly against this diagnosis, we will conclude that Dr. Osif failed to demonstrate the appropriate assessment or have sufficient evidence available prior to reaching a diagnosis. Where the chart records an observation on examination or from the patient's history that could support prescribing a particular antibiotic in the circumstances we will conclude that Dr. Osif did not fail to demonstrate the appropriate assessment or have sufficient evidence available prior to reaching a diagnosis, or that she inappropriately ordered or failed to order the appropriate or recommended first line of antibiotics in response to her diagnosis.

237. In light of Dr. Sutton's evidence of widespread practices of over-prescription of antibiotics or inappropriate choice of antibiotic treatment, we cannot conclude that Dr. Osif would be guilty of misconduct by doing so. We will have to consider whether there is a pattern of inappropriate prescription of antibiotics or inappropriate choice of antibiotics that constitutes incompetence. In considering whether Dr. Osif's pattern of diagnosis and treatment constitutes incompetence, we will assess her against the standard of a prudent physician of similar experience and standing, that is a physician of 15 years experience and a Level III emergency

room. Some of the findings may indicate incompetence by that standard, but others may not if they conform to the normal practices of Level III emergency room physicians.

2. Diagnosis of Pharyngitis

238. The charges against Dr. Osif relating to the diagnosis of pharyngitis are the following:

> "4. In the following cases you failed to demonstrate the appropriate assessment, request the necessary investigative tests, take the appropriate histories, and/or have sufficient evidence available prior to reaching a decision:
>
> (i) An 11 year old female complaining of asthma, who you diagnosed with pharyngitis;
> (ii) A 3 year old female with sore throat x 3 days, temperature of 37.9 who you diagnosed with pharyngitis;
> (iii) A 9 year old female with sore throat and temperature of 37.5 who you diagnosed with pharyngitis;
> (iv) A 14 year old male with diarrhea and vomiting and temperature of 36.0, who you diagnosed with pharyngitis;
> (v) A 12 year old female with earache and a history of asthma with a temperature of 36.8, who you diagnosed with Otitis Media and pharyngitis;
> (vi) An 8 year old female with sore throat and a temperature of 37.4 who was diagnosed with bilateral Otitis Media and pharyngitis;
> (vii) A 2 year female with fever, sore throat and cold symptoms, temperature of 37.8 who you diagnosed and pharyngitis;
> (viii) A 33 year old male with sore throat and cough for one week, temperature 37, and chest clear who you diagnosed with pharyngitis;"

a) A.S.

239. A.S. was an eleven-year old girl who came to the Northside General Emergency Room on November 8, 2005 seeking a refill of her prescription for asthma medicine. Her chart indicates a temperature of 36 degrees. She was examined by Dr. Osif, who recorded the following on the chart:

"November 8, 2005

[Physician record time] 21:00
Known asthma – Note: mother not available but aware of this visit
Cough, HEENT pharyngitis
Chest prolonged exp. Phase, A/E bilaterally good. HS regular S1S2
Abdomen soft nontender, peristaltics +. MSK good tonus. Stable.
Airways patient. Skin 0 exanthema
Rx: Ventolin Inhaler 1, II puffs QID Ventolin 0.5 ml
Flovent Inhaler 236 mcg I (puff) BID 1 Pulmicort 0.5 mg in
Rx: Amoxil 250 mg I. TID x 10/7 3 ml N/S
[Diagnosis] Asthma, pharyngitis [Departure time] 21:40"

240. As indicated above, Dr. Osif diagnosed asthma and pharyngitis and prescribed an antibiotic Amoxil. Despite the fact that Dr. Osif prescribed Amoxil which indicates a diagnosis of bacterial pharyngitis, nothing on the chart indicates the clinical signs of bacterial pharyngitis. A.S.'s temperature was 36 degrees (less than a normal temperature of 37 degrees Celcius). Although the chart indicates a reddened throat ("pharyngitis"), there is no record of a sore throat. The chart indicates that A.S. had a cough. There is no documentation of tonsillar swelling or exudate. There is no documentation of any enlarged lymph nodes. As noted by Dr. Field and by Dr. Sutton on cross-examination, the diagnosis of bacterial pharyngitis is not supported in this case. In the opinion of the Committee, Dr. Osif failed to demonstrate the appropriate assessment or have sufficient evidence available to reach a diagnosis of bacterial pharyngitis.

b) M.B.

241. M.B. was a three year old child who was brought to the Northside General Emergency Room on February 9, 2006 with a sore throat and chest congestion. The chart indicates that she had a temperature of 37.9 degrees, but the triage nurse noted that she had had a fever of 40.5 degrees four hours earlier and had been given Tylenol for this fever. The triage nurse recorded that she had a sore throat for two or three days and a congested cough which was unproductive. Dr. Osif's notes on the chart indicate as follows:

"M.B.

February 9, 2006

[Physician record time;]: 19:15 c/o pyrexia x 3/7 ↑ cough
Good appetite. Pale. No distress. HEENT pharyngitis. No lymphadeopathy. Chest clear A/E bilat. HS regular S1S2. Abdomen soft no distention, peristaltics +. MSK good tonus. Skin ø exanthema.
(Rx) Amoxil susp. 5 ml/125 mg 6.5 ml TID x 10/7
[Diagnosis] Pharyngitis [Departure time] 19:30"

242. Dr. Osif diagnosed pharyngitis and prescribed Amoxil. A diagnosis of bacterial pharyngitis is not substantiated. M.B. had a low grade fever but increased cough, no record of tonsillar swelling or exudate, and a noted lack of swollen lymph nodes.

243. Dr. Field expressed the opinion that apart from the word "pharyngitis" in the notes of Dr. Osif's examination, there is nothing to indicate how the diagnosis was made. In his view, there does not appear to be anything substantiating the diagnosis of pharyngitis. Dr. Sutton expressed his view that the diagnosis of bacterial pharyngitis could be made on the basis of a complaint of sore throat plus two of the other clinical findings, including a red throat and a high fever. However, M.B. did not have a high fever.

244. We find that the clinical findings do not indicate the likelihood of a bacterial pharyngitis. In our opinion, Dr. Osif failed to demonstrate an appropriate assessment or have sufficient evidence available prior to reaching a diagnosis of bacterial pharyngitis.

c) B.R.

245. B.R. was a nine year old girl who came to the Northside General Emergency Room complaining of a sore throat and fever. She had a temperature of 37.5 degrees celsius. The triage nurse noted complaints of sore throat and fever and that she had taken Tylenol more than seven hours earlier. Dr. Osif's notes on the chart indicate as follows:

"July 2, 2005

[Physician record time] 22:55
c/o sore throat. Subpyrexial. HEENT pharyngitis. No allergies. Airways patent. Chest A/E bilat good. HS reg. S1S2. Abdomen N. MSK good tonus. Stable.
Ceclor susp. 5 ml/125 mg 1 and ½ tsp TID x 10/7
[Diagnosis] Pharyngitis [Departure time] 23:10 (corrected from 23:30)
[Physician advised] √

246. As noted, Dr. Osif diagnosed pharyngitis and prescribed the antibiotic Ceclor. The chart does not indicate tonsillar swelling or exudate, tender or swollen lymph nodes or a cough. A diagnosis of bacterial pharyngitis is not substantiated on the chart. We find that there is no basis to conclude that there is a bacterial pharyngitis and prescribe an antibiotic. In our view, Dr. Osif failed to demonstrate the appropriate assessment or have sufficient evidence available to reach her diagnosis.

d) K.C.

247. K.C. was a child who came to the Northside Emergency Room complaining of vomiting and diarrhea and sore eyes. He had a temperature of 37.6 degrees celsius. The triage note referred to vomiting and diarrhea and the complaint of sore eyes but noted no redness or crusting. K.C. was seen by Dr. Osif who noted the following in the chart:

"K.C.

Date illegible

[Physician record time] 20:45
c/o pain left eyebrow. Given Px for Tobramycin ophthalmic drops II. TID by FMD
c/o vomiting/diarrhea. HEENT: pharyngitis; chest clear A/E bilat good. HS regular S1S2.
Abdomen soft nontender, peristaltics +. MSK good tonus.
↑ PO fluids
Px Amoxil 250 mg TID x 10/7
Gravol 25 mg QID PRN x 2/7
[Diagnosis] Pharyngitis, headache [Departure time] 21:00

Dr. Osif diagnosed pharyngitis and prescribed Amoxil."

248. In this case there was no indication of a sore throat, a fever, tonsillar swelling, or exudate or any documentation of tender or swollen lymph nodes. We find that there is no basis on the chart for a diagnosis of bacterial pharyngitis. Both Dr. Field and Dr. Sutton indicated that the presentation of vomiting and diarrhea would not lend itself to a diagnosis of pharyngitis in this case. The Committee concludes that Dr. Osif failed to demonstrate an appropriate assessment or have sufficient evidence available before reaching a diagnosis of pharyngitis.

e) H.N.

249. H.N. was a 12 year old girl who came into the Northside Emergency Room complaining of sore ears. She had a temperature of 36.8 degrees. The triage nurse noted that she had sore ears for a week with increasing pain in her left ear, and had been crying at home from the pain and complaining of pressure in her ear. Dr. Osif saw her and made the following notes on the chart:

> "April 22, 2006
>
> [Physician record time] 20:07
> c/o cough. Mother is smoker. Discussed with the father.
> Bilateral earache. HEENT otitis left, mild pharyngitis, no lymphadenopathy. Chest wheezing, bilat prolonged expirium. HS regular S1S2. Abdomen soft, no distention, peristaltics +. MSK good tonus. Skin no exanthema.
> Multiple antibiotics allergies.
> Px. Clindamycin 150 mg QID x 10/7
> Ventolin inhaler 1 II Puffs QID x 2/52
> Pulmicort 0.5 mg
> Ventolin 0.5 ml in 3 ml N/S
> [Departure] Otitis left. Asthma [Departure time] 20:40"

250. In this case, Dr. Osif's diagnosis was otitis in H.N.'s left ear and asthma. Her reference to pharyngitis in the text of the notes of her examination appears to be merely a reference to a red throat not a diagnosis.

251. To the extent that Dr. Osif is charged with a failure to appropriately diagnose pharyngitis in paragraph 4(v) of the Revised Notice of Hearing, Dr. Osif is not guilty of that charge. However, she is also charged in connection with her diagnosis of otitis media. Apart from the fact that her diagnosis is otitis left, the Committee is not convinced that Dr. Osif failed to demonstrate the appropriate assessment or have sufficient evidence available before reaching a diagnosis of otitis. Although this girl did not have a fever, she had a bilateral earache for a week and a lasting cold. She could have had otitis and the Committee is not satisfied that there is cogent evidence providing clear and convincing proof of a failure to meet a proper standard of care.

f) B.Y.

252. B.Y. was an eight year old girl who came to the Northside Emergency Room complaining of a sore throat. She had a temperature of 36.4 degrees. The Triage nurse notes that she had been seen in the emergency room earlier with the same problem, and that her sister had been prescribed an antibiotic for her sore throat. Dr. Osif records the following on the chart:

> "December 17, 2005
>
> [Physician record time] 01:45
> 8y/o c/o sore throat
> HEENT bilateral otitis/pharyngitis. Airways patent. Chest clear A/E bilat good. HS reg. S1S2.
> Abdomen soft, non tender, peristaltic +. MSK good tonus. Stable. Skin no exanthema.
> Px. Ceclor susp. 5ml/125 mg 7.5 ml TID x 10/7
> [Diagnosis] Pharyngitis [Departure time] 01:55"

As noted Dr. Osif diagnosed pharyngitis and prescribed the antibiotic Ceclor.

253. The charge in this case seems to be based on a misunderstanding of Dr. Osif's notes on the chart. In Dr. Osif's charting of her examination of these patients, she, as in this case, often writes pharyngitis under the examination part of the notes. In this case, she wrote "bilateral

otitis/pharyngitis". We take this to merely be an indication of a physical observation of a red throat or red ears. In this case, Dr. Osif would not be guilty of failing to take the appropriate assessment or have sufficient evidence in relation to bilateral otitis media. That was not her diagnosis and she is not guilty of that charge. With respect to her diagnosis of pharyngitis, she records a sore throat but there is no significant fever, no documentation of swelling of the lymph nodes, no documentation of tonsillar swelling or exudate. We find that the diagnosis of bacterial pharyngitis is not substantiated by the material on the chart. The Committee concludes that Dr. Osif failed to demonstrate the appropriate assessment or have sufficient evidence available prior to reaching a diagnosis of bacterial pharyngitis in this case.

g) I.M.

254. The chart indicates that she had a temperature of 37.8 degrees, having received Tylenol less than 4 hours earlier. The complaint was fever and sore throat for the past two weeks. Dr. Osif's chart notes indicate as follows:

> "March 28, 2006
>
> [Physician record time] 07:10
> c/o pyrexia/sore throat x 2/52. Seen in ER re URTI HEENT coryza, pharyngitis. Posterier neck distention, peristaltics +. MSK good tonus. Stable. Skin no exanthema.
> Px Zithromax susp. 5 ml/100 mg 7 ml day 1, 3.5 ml day 2-5
> [Diagnosis] Pharyngitis [Departure time] 07:20"

255. In this case there is documentation of low grade fever and sore throat, but no documentation of tonsillar swelling or exudate, or swollen lymph nodes.

256. The Committee is not convinced that Dr. Osif is guilty of failing to conduct a proper assessment or have sufficient evidence before reaching her diagnosis. This 2 year old girl had both a fever and sore throat. She had been sick for two weeks. As noted by Dr. Sutton, a viral pharyngitis would likely have come to an end during the two week interval. In this case,

The evidence is not sufficiently cogent to lead us to conclude that Dr. Osif is guilty of the charge against her.

h) R.H.

257. R.H. was a 33 year old man who came to the Northside Emergency Room complaining of a sore throat. The chart indicates a temperature of 37 degrees. The triage nurse indicates a cough with green phlegm in the morning only and a sore throat since the previous week with no fever. Dr. Osif saw R.H. and recorded the following on the chart:

> "April 6, 2005
>
> [Physician record time] 20:35
> 1/52 flu like symptoms. No improvement with the OTC meds. HEENT pharyngitis. Obesity. Post neck full ROM. Airways patent. Chest clear A/E bilat. good. HS reg S1S2. Abdomen soft, no distention, obese. MSK good tonus. MSK good tonus. Stable.
> Give Keflex 500 mg I. (Q) 6 H 2 tide over. Px. Ceclor 500 mg I. TID x 10/7. No allergies.
> [Diagnosis] Pharyngitis. [Physician advised] √. [Departure time] 20:50"

258. As noted, Dr. Osif diagnosed pharyngitis and prescribed an antibiotic. In this case, there is evidence of a sore throat but no evidence of fever, swollen tonsils or exudate on the tonsils, and no documentation of swollen lymph nodes. The symptoms are more indicative of a viral infection and not indicative of a bacterial pharyngitis. The Committee concludes in respect of R.H. that Dr. Osif failed to demonstrate the appropriate assessment or have sufficient evidence available prior to reaching a diagnosis of pharyngitis in this case.

3. Inappropriate Prescription of Antibiotics

259. Dr. Field's audit report indicated that a number of cases of fairly minor viral illnesses were treated with antibiotics and often inappropriate broad spectrum antibiotics. As a result, Dr. Osif has been charged as follows:

"5. In the following cases you inappropriately ordered or failed to order the appropriate or recommended first line of antibiotics in response to your diagnosis:

(iv) A 9 year old female with sore throat and temperature of 37.5 who you diagnosed with pharyngitis; and treated with Ceclor;
(vi) A 12 year old female with earache and a history of asthma with a temperature of 36.8, who you diagnosed with Otitis Media and pharyngitis and treated with Clindamycin;
(vii) An 8 year old female with sore throat and a temperature of 37.4 who was diagnosed with bilateral Otitis Media and pharyngitis and treated with Ceclor;
(viii) A 2 year old female with fever, sore throat and cold symptoms, temperature of 37.8 who you diagnosed with pharyngitis and treated with Zithromax;
(ix) A 33 year old male with sore throat and cough for one week, temperature 37, and chest clear who you diagnosed with pharyngitis and treated with Ceclor;
(x) A 24 year old female with dysuria and a temperature of 36.3 who you diagnosed with a UTI and treated with a 7 day course of Norfloxacin; and
(xi) A 26 year old female with PV spotting and a negative urinalysis who was treated with Norfloxacin."

260. Paragraphs 5(iv) (viii) and (ix) involve B.R., H.N. and R.H. who we have dealt with above and in relation to whom there was insufficient evidence of a bacterial pharyngitis. In those three cases the prescription of antibiotics is not indicated at all. Antibiotics can be effective against a bacterial pharyngitis, but not a viral pharyngitis or other viral infection. Accordingly, in those three cases, the Committee finds that Dr. Osif inappropriately ordered antibiotics when they were not indicated.

a) B.R.

261. As seen above, B.R. was a nine year old girl with sore throat and fever with an unsubstantiated diagnosis of pharyngitis. Dr. Osif prescribed Ceclor, a broad spectrum antibiotic rather than the standard first line drug, Penicillin VK. Assuming that an antibiotic was appropriate and that this was a case of bacterial pharyngitis, we find nothing on the chart to indicate why Ceclor was ordered. There are a range of choices in prescribing an antibiotic, there is no documentation on this chart as to why Ceclor was chosen.

262. Given the combination of an unsubstantiated diagnosis of bacterial pharyngitis, and no indication for choosing Ceclor rather than first line antibiotics, the Committee concludes that Dr. Osif inappropriately ordered Ceclor in these circumstances.

b) H.N.

263. H.N. is the 12 year old girl with bilateral earaches. We previously found that Dr. Osif did not diagnose pharyngitis, but did diagnose otitis, in circumstances where we could not accept that there was clear and convincing proof of inappropriate assessment. Assuming that the diagnosis of otitis was correct, the charge is that it was inappropriate to prescribe Clindamycin for this condition.

264. It is noted on the chart that H.N. had an allergy to a number of antibiotics. Dr. Field indicated that in his view Clindamycin is an antibiotic that would not commonly be used, and that another drug would be more appropriate. Dr. Sutton in his report indicated that Clindamycin was a questionable choice but in his evidence indicated that she was not outside the bounds of normal practice, given that she is using a drug that is licensed for that purpose in Canada.

265. On cross-examination, Dr. Sutton agreed that Clindamycin is an antibiotic that is not recommended for otitis, and indeed not listed in the CPS as indicated for the treatment of otitis. In cross-examination he agreed that Clindamycin is generally recommended as a second line treatment and only in cases where there has been a failure to antibiotic therapy after 48 – 72 hours. He agreed that Clindamycin is often not appropriate in suspected bacterial otitis, because it does not provide coverage for two or more of the common causes of that illness, and that there is a relatively frequent serious side effect.

266. Given the presence of multiple allergies, we have concluded that it would be appropriate for Dr. Osif to prescribe an antibiotic other than a first line antibiotic. In these circumstances

the Committee does not conclude that Dr. Osif inappropriately ordered Clindamycin to treat H.N.'s otitis.

c) B.Y.

267. B.Y. was the eight year old girl with a sore throat who was diagnosed with pharyngitis, and Dr. Osif ordered Ceclor to treat it. Apart entirely from whether pharyngitis was an appropriate diagnosis, we are not convinced that it was inappropriate to order Ceclor. B.Y. had been seen in the emergency room earlier with the same problem. It is not clear that Ceclor would be inappropriate for a bacterial pharyngitis in these circumstances. Nonetheless, given the inappropriate diagnosis of pharyngitis, obviously prescribing Ceclor was not appropriate.

d) I.M.

268. I.M. was the two year old girl with fever and a sore throat for two weeks, who was diagnosed as having pharyngitis. Dr. Osif prescribed Zithromax. According to Dr. Field, Zithromax would not be regarded as a first line therapy in bacterial pharyngitis. Dr. Sutton testified that Zithromax is considered acceptable as a first line medication in cases where there is a Penicillin sensitivity. Both of them thought that a first line antibiotic would be appropriate in these circumstances. The Committee's conclusion is that in the absence of a substantiated diagnosis of bacterial pharyngitis, it was not appropriate to order Zithromax in these circumstances. We find that there was no documented reason to order Zithromax. The Committee's conclusion is that in the absence of a substantiated diagnosis of bacterial pharyngitis and of some indication of penicillin sensitivity, it would not be appropriate.

e) R.H.

269. R.H. is the 33 year old man with a sore throat and cough for whom Dr. Osif reached a diagnosis of pharyngitis and prescribed Ceclor.

270. Aside from the inappropriate diagnosis of pharyngitis, there is nothing indicated on the chart that would provide a rationale for ordering Ceclor rather than a first line antibiotic. RH has no documented allergies as noted twice in the chart, and had not been taking any other antibiotics. There was no apparent reason to prescribe Ceclor. The Committee concludes that it was inappropriate to order Ceclor rather than a first line antibiotic.

f) C.B.

271. C.B. was a 24 year old woman who was diagnosed by Dr. Osif as having a urinary tract infection. Dr. Osif prescribed Noroxin. Noroxin is a second line drug.

272. Dr. Field testified that Noroxin is in the category of antibiotics known as Fluoroquinolones. The Sanford Guide actually recommends to try and avoid using Fluoroquinolones in the straightforward uncomplicated case of urinary tract infection. Dr. Sutton testified that the CPS indicates that Noroxin may be used as a first line drug in the treatment of an uncomplicated urinary tract infection. Dr. Sutton did agree however, that the accepted practice in the absence of any contraindications would be to prescribe a first line antibiotic.

273. In our view, there is no indication anywhere on the chart why a first line antibiotic would not be an appropriate response to this urinary tract infection, and no indication to use a second line antibiotic such as Noroxin.

g) A.M.

274. A.M. was a 26 year old female diagnosed by Dr. Osif as having a urinary tract infection. She prescribed Noroxin. Dr. Field testified that there was very little in the chart that would lend itself to a diagnosis of urinary tract infection, and if it was a urinary tract infection, Noroxin would not be a standard therapy for a young healthy female with no drug allergies, and was therefore inappropriate.

275. Dr. Sutton was also concerned about the diagnosis. He was concerned about the absence of a vaginal exam. He indicated that while he could accept Noroxin, the absence of a vaginal exam would cause him to mark this case as marginal case.

276. In the opinion of the Committee, there is nothing on the chart that would indicate that it was appropriate to prescribe Noroxin to A.M.

PART X - ASSESSMENT AT THE QUEEN ELIZABETH II HEALTH SCIENCE CENTRE AND DARTMOUTH GENERAL HOSPITAL

277. Dr. John Ross with the assistance of Dr. Todd Howlett, and Dr. Patricia Wren conducted a clinical assessment of Dr. Osif at the request of the College on February 5, 6, 7, 8, and 9, 2007. This resulted in two distinct sets of charges against her. A number of charges related to the actual clinical assessment conducted on those days:

> "4. In the following cases you failed to demonstrate the appropriate assessment, request the necessary investigative tests, take the appropriate histories, and/or have sufficient evidence available prior to reaching a diagnosis:
>
> (ix) three cases on February 5, 2007 where you conducted examinations in the Emergency Department of the QEII in the presence of an assessor;
> (x) a case on February 6, 2007 at the Dartmouth General Hospital where you conducted an examination in the presence of an assessor on a patient with a history of ischemic heart disease who presented with shortness of breath and were you reached a working diagnosis of anxiety/depression;
> (xi) a simulated case on February 7, 2007 where a 6 year old patient presented with a seizure and you assumed this was a febrile seizure and did not give appropriate consideration to the child's history and did not consider the differential diagnosis of meningitis;
> (xii) a simulated case on February 7, 2007 where you failed to consider a differential for unknown altered lack of consciousness in the case of a 49 year old unconscious patient;
> (xiii) a case on February 8, 2007 at the QEII where you conducted a disorganized and incomplete examination in the presence of an assessor of a 50 year old patient with an altered level of consciousness."

278. The other charges against Dr. Osif arising out of the clinical assessment related to things that she had written in her comments on the Complaint File and memo, which had been provided to Dr. Ross. These are:

"6. In a document provided to a College assessor addressing complaints lodged with the Cape Breton District Health Authority you provided an inappropriate explanation:

(i) as the basis of your referral of a patient to a specialist on April 10, 2002;
(ii) by diagnosing a patient on June 15, 2003 with otitis and stating "This complaint reflects unavailability of hospital beds"; and
(iii) by stating in response to a complaint of a failure to locate and remove a foreign body in a patient's arm, "This was likely case of self administration of Oxycontin tablet intramuscular way. This method of drug abuse is known in this area, however I did not think about this possibility when this girl presented to ER."

1. Clinical Assessment – Queen Elizabeth II

a) W.P.

279. W.P. was a 65 year old man who was seen by Dr. Osif, accompanied by Dr. Ross, in the non-acute area of the Queen Elizabeth II Health Sciences Centre Emergency Room. He had a complaint of back pain and recent chest pain. Dr. Osif's notation on the chart is as follows:

"QEII 2007/02/05

Chief complaint: Back pain
Triage time: 10:16 triage notes: x4 days seen in ED last week for CP 2007/02/05 11:58
Heavy Lifting 4 days ago, upper back pain, able to ambulate, (N) extremity sensation x 4
MD time: 15:10 L sided chest pain 3/7 ago. Seen in ER c/o persistent symptoms left sided chest pain, left mid back pain below left shoulder blade, between shoulder blades.
No diaphoresis. MSK pain worsening with active movement. Chest clear a/e bilaterally good, HS regular S1S2 no murmur audible
Past history: Diabetes mellitus
c/o Pain LLQ abdomen (left lower quadrant) o/e abdomen soft, no distension, no organomegaly palpable. No change in bowel habit. (Hx of hernia, no surgery)
Exposure to heavy lifting 3/7 ago / fall
EKG
Impression: MSK pain sprain left pectoral muscle, left mid back
CXR
MSK sprain abdominal wall

> Glucose (GM) 11.1 mmol/1
> X ray review: negative for bony injury
> advised OTC analgesia (over the counter analgesics). F/U by FMD (follow up by family doctor).
> Diagnosis: MSK sprain left anterior chest/mid back
> Dr. Ross's writing: *MSK Chest Pain*
> Time of Discharge: 16:30
> Minor Treatment Record 2007/02/05 14:40 States fell while carrying sewing machine 4 days ago.
> Stated was seen here. Did not have CXR done. Glucometer 11.1 S/B Dr. Ross
> RN signature"

280. Dr. Ross's testimony indicated that Dr. Osif wrote these notes on the chart after seeing the patient, and the notes are an amalgam of things that she noticed and recorded and the things that were noted as a result of the interaction with Dr. Ross. Dr. Ross testified that Dr. Osif's history and physical explored the possibility that W.P. had a musculoskeletal strain problem. However, Dr. Ross, taking into account WP's age, his history of diabetes and his history of recent chest pain was concerned that there could be an acute coronary syndrome. Although some of the possible coronary problems are quite uncommon, Dr. Ross said they carry a significant amount of morbidity and mortality. Dr. Osif concluded that the problem was musculoskeletal, and it was not until Dr. Ross pointed out that there were other things that needed to be considered, and that some simple tests should be ordered, there was an order for an electrocardiogram and chest x-ray, and blood glucose. These were easily obtainable tests in the emergency department and they were completed and there were no significant abnormalities. Dr. Ross reassured himself of the musculoskeletal problem by his own examination. He could reproduce W.P.'s pain by moving his arm in a certain way.

281. Dr. Osif testified that she did consider a heart related phenomenon for this patient given that she ordered an EKG, and noted on the chart "no diaphoresis". She said "so it means that this pain, what the patient experienced, doesn't cause him sweat, so it means that it was not cardiac. This is description of the differential diagnosis for cardiac pain". Dr. Osif testified that she disagreed with Dr. Ross's evidence that the heart related issues only arose after he had intervened to discuss that aspect of the patient with her.

282. In the opinion of the Committee, the handling of W.P. by Dr. Osif was not adequate. Dr. Osif quickly reached the conclusion that W.P. had a musculoskeletal issue. In our view it would be dangerous to rule out cardiac problems in these circumstances based on her explanation that there was no diaphoresis, that is the patient did not sweat. This is not an adequate cardiac history. Except for the intervention of Dr. Ross, Dr. Osif did not demonstrate the appropriate assessment, request the necessary investigative tests, take the appropriate history or have sufficient evidence available prior to reaching a decision. We accept Dr. Ross's evidence as to how the issue of cardiac problems were raised and his role in ensuring that there was an appropriate assessment, proper investigative tests and sufficient evidence to support the diagnosis of musculoskeletal chest pain.

b) S.H.

283. S.H. was a 41 year old woman who came to the Queen Elizabeth II Emergency Room with an injury to her left hand. Dr. Ross testified that she was quite distraught and tearful. Dr. Ross did not get a sense that Dr. Osif was necessarily dealing with this as well as he would have liked so he interrupted very quickly to calm down the patient.

284. The doctor's notes on the chart indicate as follows:

> "QEII ER 2007/02/05
>
> Chief complaint: Laceration/puncture
> Triage time: 09:56 Triage notes: Pt. here with injury to L hand decreased ROM
> MD time: 10:45 Crush injury 5th digit left hand
> Laceration palm left hand size cca 2 inches, no active bleeding
> 5th digit left hand flexion PIP joint (proximal inter phalangeal joint)
> ↓ (decreased) extension active/passive
> Past history: No meds
> Allergy: Codeine, Morphine, Lactose intolerance
> Numbness ulnar side, two point discrimination +/ - normal
> Extension digits 2 – 4 normal
> Keflex 500 mg 1 QID start now
> TD booster up to date 3 years ago
> X ray review: comminuted impacted fracture proximal phalange

> Consult plastic surgery
> Diagnosis: Comminuted open fracture proximal phalange 5th digit left hand
> Time of discharge: 11:20"

285. Here again, Dr. Ross indicated that the writing on the chart was an amalgam of points noted by Dr. Osif, some of which arose out of their discussion. He testified that S.H. had a laceration and deformity of her finger. Dr. Osif ordered an x-ray which showed a comminuted fracture of the proximal phalanx.

286. Dr. Ross was concerned Dr. Osif did not consider whether there was any kind of nerve injury, any blood vessel interruption or tendon injury. He discussed that with her and she went back and conducted the examination indicated on the chart and referred S.H. to plastic surgery. Dr. Ross thought that in the setting of the Northside General Emergency Room, this examination should have been conducted before referral to a plastic surgeon.

287. The Committee is not convinced that Dr. Osif failed to demonstrate the appropriate assessment, request the necessary investigative tests, take the appropriate histories and have sufficient evidence available prior to reaching a diagnosis in this case. Unlike the Northside General Hospital, a plastic surgeon was readily available at the Queen Elizabeth II. We are not clear that Dr. Osif failed to make an appropriate assessment because Dr. Ross had to intervene so early in the interaction with the patient. We do not think that any proper assessment of her competence can be drawn from this particular example.

288. We are concerned however that Dr. Osif simply denied Dr. Ross's evidence that she had not done any assessment of the patient's neurovascular function and tendon function until he intervened to raise that with her. The Committee accepts Dr. Ross's evidence of this point. Dr. Ross was conducting an assessment to measure the clinical competence of Dr. Osif and testified very clearly and in some detail about their interaction with this patient. He gave his evidence in a very fair manner, we found him straightforward and credible. Even though we do not accept the charge against Dr. Osif, the evidence of Dr. Ross is much more consistent with the overall circumstances than Dr. Osif's bare denial.

c) A.D.

289. A.D. was an 18 year old woman with a basketball injury to her right knee. The notes on the chart indicate as follows:

> "QEII ER 2007/02/05
>
> Chief complaint: Lower extremity injury
> Traige time: 07:16 Triage notes: roll injury yesterday, R knee, medial side, selling, PMS (N), able to WB with pain
> MD time: 10:20 17 y/o girl basketball injury R knee yesterday
> Past History: No allergies, no meds, not pregnant
> Collided with another player. Went to floor, did not directly hit the floor with the knee; twisted injury. Walked with difficulties. Pain medial aspect R knee overnight worsening with movement.
> Skin warm/local swelling medial aspect R knee
> X-ray right knee/patella
> R ankle
> R foot
> No calf tenderness, peripheral pulsation present, popliteal, dorsalis pedis artery, perfustion R foot/toes intact
> No neurological deficit
> ↓ (decreased) flexion R knee, ↑ (increased) pain with passive movement
> No obvious mediolateral stability, Lachman test unable to perform due to pain
> Dr. Ross's writing: *Effusion P x-ray*
> *Ibuprofen 600 mg PO*
> *↑ ROM (range of motion) as tolerated. F/U with FD (follow up with family doctor) this week for recheck. Ice. Ibuprofen.*
>
> Diagnosis: *Sprain Knee MCL (medial collateral ligament) partial tear*
> Time of Discharge: 12:18"

290. Dr. Ross expressed his concern that there was some "jumping around" between the history and the physical, and some disorganization in the taking of the history and the physical. He thought that Dr. Osif documented a reasonably thorough consideration of neurovascular function and recorded a reasonable amount of information. Dr. Ross was concerned that Dr. Osif did not consider whether this patient's injury involved the knee joint itself, as opposed to an outside superficial problem. He indicated that the list of things to consider with this patient

ranged from a simple sprain to a fracture or a ligamentous injury that ultimately might even require some further investigation. He discussed this with Dr. Osif and then an x-ray was ordered. In cross-examination there was the following exchange between Dr. Osif and Ms. Hickey:

> "Q. And Dr. Ross gave evidence, Dr. Osif, that in your examination of this patient, you did not do the type of examination that would indicate whether the swelling was in the medial aspect of the knee or in the joint itself. Do you agree that you didn't conduct that type of examination?
>
> A. Still at this point I am not really sure what Dr. Ross had in mind, what type of examination, particularly what type of knee examination.
>
> Q. Let me rephrase it then. Until the time that Dr. Ross spoke to you when you were seeing this patient, did you feel that you had done a full examination that would indicate whether the swelling was from the medial aspect of the knee or in the joint itself?
>
> A. Well, I do have documented "local swelling medial aspect right knee."
>
> Q. Yes.
>
> A. Yeah. So I did examination to find out that there is medial aspect right knee swollen.
>
> Q. Did you do an examination to see whether the swelling was in the joint itself?
>
> A. Yeah. Yes, it was on the right aspect of the knee, of the right knee joint.
>
> Q. What does medial aspect of the knee mean, Dr. Osif?
>
> A. Inside of the leg.
>
> Q. And how does that relate to the joint itself?
>
> A. That the inside side of the joint.

> Q. Do you acknowledge, Dr. Osif, that if the swelling is coming from inside the joint itself, it requires consideration of other diagnosis and potentially treatment?
>
> A. Yes. It requires to take the x-ray, which I ordered and which was taken."

291. Dr. Osif's explanation, in the view of the Committee, indicates a lack of knowledge of knee structure. We agree with Dr. Ross that she did not appreciate the difference on physical examination between an injury external to the joint as opposed to an intra-articular injury. She did not order an X-ray until Dr. Ross made that suggestion.

292. In the opinion of the Committee Dr. Osif has failed to demonstrate the appropriate assessment, request the necessary investigative tests or have sufficient evidence available prior to reaching her diagnosis in this matter.

d) The Simulator Cases

293. Dr. Ross has indicated that he and Dr. Osif spent three hours at the Human Patient Simulator Centre which is the set of rooms in the basement of the Victoria General Hospital with a simulator used to train paramedics, medical students, residents and practicing physicians. In the case the simulator was set up as a simple out-patient emergency department setting with a stretcher and the necessary equipment that one would have for basic resuscitation. The patient in the simulator centre is a mannequin which is attached to monitoring devices, heart monitor, oxygen saturation monitor and other equipment.

294. There are two charges against Dr. Osif arising out of the use of the simulator on February 7, 2007. One was the six year old patient with a seizure, and the second was the 46 year old unconscious patient.

295. The Committee is not convinced that these assessments on a simulator fairly indicated the failure of Dr. Osif to adequately demonstrate appropriate assessment skills, take appropriate histories, request the necessary investigative tasks, or have sufficient evidence available prior to

reaching a diagnosis. In the opinion of the Committee the simulator may be a very useful teaching tool but that it is not an adequate or fair tool to assess Dr. Osif's clinical abilities.

e) B.S.

296. B.S. was a 55 year old man who had been found at the bottom of a set of stairs and brought to the Queen Elizabeth II Emergency Room in a confused state. Dr. Osif assessed him, along with Dr. Ross in the high acuity area of the Queen Elizabeth II Emergency Room. Dr. Osif's chart notes indicate as follows:

> "QEII ER visit February 8, 2007
>
> Triage time: 09:05 Chief complaint: confusion
> Triage Notes: Found at bottom of stairs this AM. Unsure as to whether fell or not. Confused at present. Medications: Alendronate 70 mg weekly, Citalopram 20 mg TID, ECASA, Calcium
> MD time: 10:10 Fell this AM, tripped on stairs
> Via ambulance to ER. Weight loss 20 lbs past 3/12, disheveled
> Asthenia habitus, feeling weak. Alert, oriented to place, person.
> Disoriented to time.
> Past History: Osteoporosis Ao stenosis Depression MKK pain R shoulder
> HEENT pupils equal, foto reactive No discharge. Posterior neck no tenderness. Chest A/E
> bilaterally good, rhonchi diffucely. HS irregular S1S2
> Abdomen soft, peristaltics + (present). No obvious mass. No pelvic/legs injury MSK pain shoulders bilaterally Impression Hx R shoulder ? adhesive capsulitis/Hx # (fracture) R humerus
> Nov. 2006
> X ray C spina/Thoracic spina R shoulder R humerus CXR Urine drug screen (marked cancelled)
> Calcium, Magnesium"

297. Dr. Ross indicated that this was a challenging patient. He observed that Dr. Osif's history taking and examination was disorganized and incomplete. He had to intervene, first of all to overcome communication problems between the patient and Dr. Osif by establishing a rapport with the patient and getting him talking and then by taking more history and conducting more examination and the ordering of x-rays which resulted in identifying a fracture of his right humerus, which did not look like it was healing properly. Dr. Ross thought that Dr. Osif's data

gathering process was really disorganized, and that Dr. Osif would likely have reached the proper diagnosis if she had come up with the fact that he had an earlier left shoulder fracture. The development of the history and the physical examination was scattered and disorganized.

298. Dr. Osif did not disagree with Dr. Ross's comments but explained in her evidence that it was very difficult to communicate with B.S.

299. The Committee has concluded that Dr. Osif failed to demonstrate the appropriate physical examination and history taking because of her failure to properly organize the taking of the history and the conduct of the examination. In the end the appropriate assessment was reached but the process of reaching it was flawed.

f) E.B.

300. Dr. Ross was assisted in his clinical evaluation of Dr. Osif by Dr. Todd Howlett who spent the day with her on February 6, 2007, at the Dartmouth General Hospital, where Dr. Howlett is the Chief of Emergency Medicine.

301. E.B. was an 84 year old woman who came to the Dartmouth General Emergency Room complaining of general weakness. She had previously had a heart attack in 2005, and complained of being short of breath for approximately two weeks when she attempted to walk any distance.

> "Dartmouth ER 2007/02/06
>
> Chief complaint: general weakness
> Triage time: 09:30 Triage notes: c/o SOB (short of breath) x 2 weeks Hx MI 2005 H/A this AM
> with weakness and feeling "shakey" Denies CP (chest pain) HR irregular
> Medications: ECASA, Hydrazide, Metoprolol, Synthroid, Metformin, Coversyl, Nitro, Alendronate, Paroxetine
> MD time: 14:00 84 y/o lady c/o episodes of SOB triggered … illegible
> Past history: MI 18/12/ago (myocardian infarct 18 months ago)
> Hx of palpitations 3/52 ago / Holter monitor done 2 x

> Denies chest pains. No obvious distress. Lying comfortable on the stretcher
> HEENT no focal infection. Chest A/E bilaterally good/no creps.
> HR regular S1S2 no S3
> Abdomen soft non tender, peristaltics +. No GI symptoms. MSK no peripheral edema.
> TSH 6.Oct. 2006 1.88 HgAIC 6.5
> Troponine Normal 6.7.06/normal renal screen/Hgb 127 g/1
>
> Dr. Hollett's writing:
> *PMX (past medical history) HOLTER TM? (Holter monitor) negative*
> *Diagnosis: r/o Angina (rule out angina equivalent)*
> *Equivalent*
> *Consult Dr. Gupta"*

302. After Dr. Osif had conducted her history taking and physical examination, she and Dr. Howlett left the examination room to discuss Dr. Osif's impressions. Dr. Howlett was expecting a differential diagnosis. However, he testified that Dr. Osif's assessment was the following:

> "But it was basically I think she's anxious and she may be depressed, which was … I was somewhat concerned about. And then I asked, well, what do you think, you know, we should do. And she said, well, I think she could go home.
>
> And at that point, I suggested that … well, I asked … I mean, I formed it in a question. I said: Do you think maybe she could be having an angina equivalent. And in explanation … I mean, this is an elderly lady who is diabetic, who is known to have ischemic heart disease or has had an MI who is now having shortness of breath when she exerts herself."

303. Dr. Howlett testified that Dr. Osif readily accepted his suggestion and was able to synthesize what should be done next, but left him concerned that she had not recognized and ruled out a cardiac problem before coming to her diagnosis.

304. Dr. Osif disagreed with Dr. Howlett's evidence and testified as follows:

> "Q. Can you describe to the Committee what you remember about this patient and how the process went in order to respond to the criticisms of Dr. Howlett?

A. So this was an elderly lady came to emergency room in Dartmouth General Hospital with her daughter. And their chief complaint was that she has episodes of short of breath when she's alone at home and when she's lying down, when she stand up, sits, is (?) out and she didn't have any chest pains, so like I … I took the history. I went through her symptoms.

I was aware that she's post-myocardial infarction 18 months ago, she had Holter monitoring just recently, that she is in the process of an investigation for angina, for ischemic heart disease like following the myocardial infarction. And when I finished the history, when I was taking the history and the physical examination at the bedside, at a certain point Dr. Howlett stopped me and take me out to the nursing station.

And here in the chart we see I was just writing the cardiac markers what she had on the previous attendance in emergency room when he took the chart and started asking differential diagnosis, so I told him what I … so far what I work out. And then he just interrupt me and he said, You don't think so it is angina equivalent? And this is what he wrote down. I just … he kind of stopped me when I was in the middle of the assessing of this lady.

Q. … be specific about where you were interrupted.

A. Yeah. So like I identified her symptoms, what is getting her worse, what is getting her better and …

Q. Go back to the starting gate now, Dr. Osif. Just …

A. Yes. This was elderly lady who had complain of symptoms of short of breath when she was lying at home alone, so the … she came with this to emergency room and I was going with the focus history and the physical examination for the symptoms. And my clinical conclusion at that point when I was just in the middle of the assessment with the cardiac markers from the previous visit was that she may have congestive heart failure because she is in lying position when she gets these episodes. And also depression, anxiety, she gets these episodes only when she's alone in the apartment.

And then Dr. Howlett interrupted me and he said that it was angina equivalent. Well, I said, Well, she does have the history of ischemic heart disease. The diagnosis is there, so like then he kind of labeled the chart. I didn't really finish. I don't even have

> differential diagnosis written there, that …. And he took the chart and continued by himself."

305. Dr. Howlett and Dr. Osif agreed that after further investigations, E.B. was discharged home after a specialist confirmed that she did not have angina.

306. The Committee accepts Dr. Howlett's evidence where it differs from Dr. Osif. Dr. Howlett was conducting a clinical assessment. In his evidence before the hearing he demonstrated the care and the rigor with which he approached this exercise. There is no reason why Dr. Howlett would record Dr. Osif's reaction to E.B. erroneously. He made a report shortly after this to Dr. Ross, which Dr. Ross recorded as follows:

> "Dr. Howlett also found that the history was incomplete in some cases. The differential diagnosis was too narrow or not clear – he felt he had to go back and clarify some details. In the case of an elderly woman with a well documented history of ischemic heart disease who presented with shortness of breath, there were significant 'rule out' questions omitted. A working diagnosis of anxiety/depression was reached. When Dr. Howlett suggested the possibility of angina she agreed and was then able to develop a reasonable plan for investigation and management."

307. Furthermore, Dr. Howlett's account is consistent with the approach that Dr. Osif has demonstrated in many of these cases. This has been described by several of the witnesses as her failure to make a differential diagnosis by identifying all the possible explanations for what has been observed in the history and physical examination and then ruling out options before reaching a final diagnosis. In this case, Dr. Osif is described as coming to a diagnosis of anxiety and depression without ruling out the possibility of a cardiac problem in an 84 year old woman with diabetes and a previous heart attack. This is what we have seen in the A.B. case, where a diagnosis of urinary tract infection was reached without the considering the possibility of appendicitis. It is similar to the M.S. case where on June 15, 2003, Dr. Osif concluded that M.S. had an ear infection without adequately considering the other more serious problems which later came to light.

308. Dr. Ross made similar observations of his assessment of Dr. Osif on Monday, February 5, 2007 in the Queen Elizabeth II Health Sciences Centre Emergency Room, which he summed

up as follows: "… There were no critical omissions, but I was left with the impression that early closure (ie. assuming a diagnosis too early) was occurring at times and had the potential to miss important details with other types of patients".

309. Given the evidence as a whole the Committee prefers the evidence of Dr. Howlett over that of Dr. Osif, and accordingly concludes that in the case of E.B., Dr. Osif failed to demonstrate the appropriate assessment, request the necessary investigative tests, take the appropriate histories and/or have sufficient evidence available prior to reaching a diagnosis.

2. The Clinical Assessment Overall

310. The clinical assessment conducted by Dr. Ross demonstrates an overall pattern of failing to take adequate histories or conduct organized examinations because of reaching a conclusion too quickly in these cases without considering the differential diagnosis adequately, and therefore not conducting an appropriate assessment and reaching conclusions without sufficient evidence.

3. Was The Clinical Assessment Fair?

311. Counsel for Dr. Osif argued in this hearing that all of the charges arising out of the clinical assessment by Dr. Ross should be dismissed because he was provided with a copy of the Complaint File Summary. We have already concluded above, the Complaint File Summary is misleading in respect of some of the matters summarized there. It is argued therefore that Dr. Ross's assessment was tainted and should be disregarded, and that any charges that arose out of it are unfair because of contamination from his reading the Complaint File Summary.

312. As we have stated earlier, our concern is whether Dr. Osif has had a fair hearing in this case. It is not our role and we do not have sufficient evidence before us to assess the fairness of the investigative process. On the other hand, Dr. Osif must be treated fairly in this hearing. She must have a full opportunity to respond to the charges against her, and that includes the right to

cross-examine the witnesses put forward by the College, to present her own evidence and to make submissions to us.

313. In this hearing, Dr. Ross was extensively cross-examined about the material that he received from the College and from counsel for Dr. Osif, and the impact of these materials upon his report and upon his clinical assessment. We conclude that he was not particularly influenced by the Complaint File Summary. We disagree that his assessment and his evidence were tainted or contaminated by this document provided by the College.

314. In the cross-examination of Dr. Ross, it was suggested that he was influenced by material in the Complaint File including a memo from Dr. Currie that is referred to on page seven of his report. He agreed that Dr. Currie was a friend, a work colleague and a business associate. It was suggested that the influence of that relationship created a bias. Having listened to the cross-examination of Dr. Ross, the Committee does not accept that he gave his evidence in a biased manner. He was a very fair witness. He acknowledged his relationship to Dr. Currie. He indicated that Dr. Currie's opinion resonated with his own.

315. We have determined that Dr. Osif failed to demonstrate the appropriate assessment, request the necessary investigative tests, take the appropriate history or have sufficient evidence available prior to reaching a decision with respect to W.P., A.D., and B.S. In each of these cases Dr. Ross conducted his assessment before he had read the Complaint File other than by flipping through it. There is no evidence that his assessment in these three cases was biased by any influence from Dr. Currie's opinions in memos in the Complaint File. The facts as reported by Dr. Ross are consistent with the observations of other witnesses in other cases.

316. In our view, Dr. Ross gave his testimony objectively in a manner which was fair and unbiased. Dr. Osif had the opportunity to call evidence and did testify herself about Dr. Ross's assessment. In our view, she has had a complete opportunity to answer the charges against her arising out of Dr. Ross's report.

317. The Committee sees no reason to dismiss the charges that relate to W.P., A.D., and B.S. on the basis that the College provided Dr. Ross with a Complaint File Summary or that counsel for Dr. Osif provided him with a Complaint File and Dr. Osif's comments on the Complaint File. From all the evidence, we do not see that these materials have affected Dr. Ross's assessment of these three cases. In the case of E.B., Dr. Howlett was the physician who assessed Dr. Osif's clinical skills. There is no evidence that he was influenced by anything other than his own observations.

PART XI - THE INAPPROPRIATE EXPLANATIONS TO A COLLEGE ASSESSOR

318. Counsel for Dr. Osif provided Dr. Ross and the College with a copy of Dr. Osif's comments on the Complaint File. As a result she has been charged with the following:

> "6. In a document provided to a College assessor addressing complaints ledged with the Cape Breton District Health Authority you provided an inappropriate explanation:
>
> (i) as the basis of your referral of a patient to a specialist on April 10, 2002;
> (ii) by diagnosing a patient on June 15, 2003 with otitis and stating "This complaint reflects unavailability of hospital beds"; and
> (iii) by stating in response to a complaint of a failure to locate and remove a foreign body in a patient's arm, "This was likely case of self administration of Oxycontin tablet intramuscular way. This method of drug abuse is known in this area, however I did not think about this possibility when this girl presented to ER."

319. These charges are based on Dr. Osif's comments on the Complaint File which was sent to the College in September of 2006. The College Assessor who is referred to is Dr. Ross. Dr. Osif's counsel sent Dr. Ross a copy of Dr. Osif's comments. These comments were then later sent by the College to Dr. MacLeod when he conducted his chart review. In Dr. MacLeod's chart review, he refers to Dr. Osif's comments in three of the cases. On the basis of Dr. MacLeod's assessment the College has charged Dr. Osif with providing an inappropriate explanation in her comments on these three cases.

320. The Hearing Committee is not convinced that Dr. Osif is guilty of these three charges. Her comments were appropriate for her own use and for the use of her counsel. Some of these comments are detailed and reflect access to the relevant charts; others are superficial and respond to very limited information in the Complaint File. None of these comments were made at the time of the assessment and treatment of the individual patient, but, in some cases years

later with limited information. We are not convinced that her comments should be the subject matter for charges given their very nature.

321. We reject the argument of counsel for Dr. Osif that Dr. MacLeod's report and evidence are contaminated in respect of these charges. Here again, the charges against her were clear and she was represented by counsel with the opportunity to cross-examine the College's witnesses and to present her own evidence. Nonetheless, we do not think that it would be fair to find Dr. Osif guilty of these charges because of the nature of the comments on which they are based. Accordingly, we dismiss the complaints relating to J.G., M.S. (as it relates to her comments on the Complaint File), and C.B.

PART XII – FAILURE TO COMMUNICATE EFFECTIVELY AND COURTEOUSLY WITH DR. L.S.

322. We have previously found that Dr. Osif failed to communicate with others in an effective and courteous manner in the case of A.B. and in the case of M.S. One additional charge related to her communications remains:

> "8. On a number of occasions you failed to communicate with others in an effective and and/or courteous manner, specifically you failed to:
>
> (i) uphold adequate professional courtesy to another emergency room physician on June 15 2003;"

323. S.M. was a 34 year old man who was brought to the Northside General Hospital Emergency Room on June 15, 2003. The physician in the emergency room on that day was Dr. G., who sent him for a CT Scan of his thoracic spine at the Cape Breton Regional Hospital. Dr. G. went off duty and Dr. Osif took over as the emergency room physician at the Northside General Hospital and became responsible for S.M.

324. Dr. Osif later received the report of the CT Scan and called the Cape Breton Regional Emergency Room and spoke to Dr. L.S., S.M. was at this time still in the CT Scan area across the hall from the Cape Breton Regional Emergency Room. He had been sent there directly from the Northside General and had not been dealt with in the Cape Breton Regional Emergency Room.

325. Dr. Osif wanted the Cape Breton Regional Emergency Room to look after S.M. Dr. L.S. thought that the appropriate way to do this was for her to contact the surgeon who would then accept responsibility for the patient at the Cape Breton Regional. Dr. L.S. thought that Dr. Osif was being impolite in the conversation, and worse, she hung up on him as they were speaking. Dr. L.S. called her back but nothing was resolved between them. Dr. L.S. prepared an emergency/outpatient record in which he noted "Dr. Osif got the report back but impolitely tried

to involve us without going through the proper channels. I tried to advise her that she had to call the orthopedic surgeon on call, but she was very rude and inappropriate hung up on us. This is certainly not a professional way to deal between emergency room and emergency room physicians".

326. Dr. Osif's account of the conversation was different. She said that Dr. L.S. initiated the contact because he wanted to send the patient back to the Northside General. She tried to explain to him that the Cape Breton Regional was the trauma centre and that Northside General did not have any specialists available, so it would be unreasonable to send the patient back to Northside. She denied being rude. She did acknowledge that no one ever mentioned Dr. L.S.'s complaint and she did not become aware of it until she received the complaint file in 2006. So the first time she had to recall the event was three years after the fact. Nevertheless, she was very emphatic that she was not responsible for this patient. She insisted that the physician in the emergency room at Cape Breton Regional Hospital who had accepted the patient for the C.T. scan was responsible.

327. We have no reason to doubt the account of Dr. L.S. It is consistent with the record that he made at the time. Dr. Osif is at a disadvantage in recalling the event because of the passage of time.

328. A normal prudent physician of Dr. Osif's experience and standing would know that Dr. L.S. was correct when he told her that she should contact the surgeon on call. Having taken over the Northside emergency room from Dr. G., Dr. Osif was responsible for S.M. until the surgeon at the Cape Breton Regional took over that responsibility. It cannot be uncommon for an emergency room physician at the Northside General to send a patient to the Cape Breton Regional for diagnostic tests and for there to be a shift change before the patient returns. The Committee is very concerned that Dr. Osif either does not understand or does not accept her responsibilities as a physician to her patients in these circumstances. However, Dr. Osif is charged with a failure to communicate not with a failure of professional responsibility so we make no finding on this point.

329. Professional courtesy is important and it certainly would be regrettable if a physician in these circumstances was rude or impolite to another physician. However, emergency rooms can be a stressful place. Patients come first. It would be surprising if there were not occasional stresses and strains between the physicians involved. We can certainly understand Dr. L.S.'s frustration, but we are not convinced that the conduct of Dr. Osif was sufficiently serious to be the basis of the charge against her relating to professional conduct or professional incompetence.

330. Accordingly, we dismiss the complaint relating to Dr. L.S.

PART XIII – PROFESSIONAL MISCONDUCT OR PROFESSIONAL INCOMPETENCE

331. We have found that Dr. Osif failed to exercise the degree of care and skill which could reasonably be expected of a normal, prudent practitioner with the same experience and standing in a number of the charges that have been presented to us. We have also rejected a number of the charges where we found that the evidence was insufficiently cogent or we were not otherwise convinced that the College had proved the conduct alleged in the charge.

332. We have concluded that the conduct proven by the College in these cases does not constitute professional misconduct except in the cases of A.B. and M.S. In those cases, in our view, Dr. Osif's conduct goes well beyond mere carelessness.

333. In the A.B. case Dr. Osif did not conduct a proper history and she did no physical examination but she recorded on A.B.'s chart that she did so. Her failure to conduct a physical examination is such a departure from elementary and accepted standards of a physician in Nova Scotia that it constitutes an abuse of the privileges granted to Dr. Osif as a licensed medical practitioner. The fact that Dr. Osif recorded a physical examination on her chart indicates to us that she knew that she should have conducted a physical examination on A.B. but deliberately did not do so.

334. Charting a physical examination which had not been performed is a deliberate departure from accepted standards, compounded by her claim to her supervisor, Dr. Currie, that she had performed a physical examination. Although Dr. Osif at one point acknowledged to Dr. Currie that she may not have performed a physical examination, she insisted throughout the investigative process of the College and in her evidence at this hearing, that she had done a physical examination. We find that providing an inaccurate account of an emergency room physical examination on the patient's chart constitutes deliberate misconduct. We do not draw any conclusion about Dr. Osif's explanation to Dr. Currie.

335. In the M.S. case, we accepted the evidence of K.S. that on June 23, 2003 Dr. Osif gave her father a quick once over, diagnosed a placement problem and told K.S. that she would call a social worker. She told K.S. to take M.S. home and someone would contact her. Given M.S.'s condition, he must have appeared gravely ill and in need of significant medical attention. Dr. Osif's dismissive approach to him, in our view, constitutes not just carelessness but indifference to his well being. Her conduct towards M.S. on June 23, 2003 was such a departure from the accepted standards of a physician in Nova Scotia that, in our view, it constitutes professional misconduct.

336. Accordingly, the Committee finds that Dr. Osif is guilty of charges 3(ii), 7 (in part) and 8(ii) and that her conduct constitutes professional misconduct. The same conduct is also part of a pattern of carelessness that constitutes professional incompetence.

337. In order to find professional incompetence there must be a pattern of carelessness not simply an isolated incident or incidents. We have found that the College has proved in a clear and convincing manner that Dr. Osif is guilty of the following charges:

1. Dr. Osif failed to demonstrate adequate skill and care on May 29, 2006, during the emergency room management of a fracture – dislocation of an ankle by failing to perform an immediate and effective reduction, and by failing to provide appropriate pain management;

2.(a) Dr. Osif failed to demonstrate adequate skill and care during the emergency room management of M.S. on June 15, 2003 by reaching an unsupported diagnosis of otitis and pharyngitis, by failing to perform a complete neurological examination and by failing to follow up adequately with M.S.'s family doctor.;

(b) Dr. Osif failed to demonstrate adequate skill and care during the emergency room management of M.S. on June 23, 2003 by failing to conduct an appropriate medical examination including a complete neurological examination, by failing to order x-rays and generally by failing to take seriously the reasonable concerns of K.S.; she failed to communicate with K.S. in an effective or courteous manner by failing to appropriately respond to those concerns;

3. Dr. Osif failed to demonstrate adequate skill care and knowledge during the emergency room examination of A.B. on December 13, 2005, and failed to take an appropriate history, perform an appropriate physical examination, properly analyze a urinalysis resulting in a misdiagnosis of a urinary tract infection, properly diagnose a serious medical condition and either refer A.B. to an appropriate expert or to establish proper follow up management;

4. (a) Dr. Osif failed to demonstrate an appropriate assessment, request the necessary investigative tests, take the appropriate histories, and have sufficient evidence available required to reaching a diagnosis in two cases on February 5, 2007, where she conducted examinations in the emergency department of the Queen Elizabeth Health Sciences Centre in the presence of an assessor, and in a case on February 6, 2007 at the Dartmouth General Hospital, and again in a case on February 2007, at the Queen Elizabeth II where she conducted a disorganized and incomplete examination in the presence of an assessor, of a 50 year old patient with an altered level of consciousness;

   (b) Dr. Osif failed to demonstrate the appropriate assessment, or have sufficient evidence available before reaching a diagnosis in the case of an 11 year old female complaining of asthma, who she diagnosed with pharyngitis, a three year old female with sore throat for three days, a temperature of 37.9 who Dr. Osif diagnosed with pharyngitis, a nine year old female with sore throat and temperature of 37.5 who she diagnosed with pharyngitis, a 14 year old male with diarrhea and vomiting and a temperature of 36.0 who she diagnosed with pharyngitis, an eight year old female with sore throat and a temperature of 37.4 who Dr. Osif diagnosed with pharyngitis, a two year old female with fever, sore throat and cold symptoms, a temperature of 37.8 who Dr. Osif diagnosed with pharyngitis and a 33 year old male with sore throat and cough for one week, a temperature of 37 and chest clear who she diagnosed with pharyngitis;

5. Dr. Osif failed to order or inappropriately ordered the appropriate or recommended first line of antibiotics in the case of a 9 year old female with sore throat and a temperature of 37.5, whom she diagnosed with pharyngitis and treated with Ceclor, a 2 year old female with fever, sore throat and cold symptoms, temperature of 37.8 who she diagnosed and treated with Zithromax, a 33 year old male with sore throat and cough for one week, a temperature of 37, and chest clear who she diagnosed with pharyngitis and treated with

Ceclor and a 26 year old female whom she diagnosed with urinary tract infection and treated with Noroxin;

7. Dr. Osif provided an inaccurate account of the emergency room physical examination of A.B. on December 13, 2005 on the patient's chart by recording an examination that she did not perform;

8. Dr. Osif failed to communicate with others in an effective and courteous manner by failing to appropriately respond to reasonable concerns raised by a family member of M.S., and to appropriately respond to reasonable concerns raised by a family member of A.B.

338. In determining whether or not Dr. Osif's conduct in relation to these charges amounts to professional incompetence, we exclude the charges of inappropriately ordering or failing to order the appropriate or recommended first line antibiotics. Although these charges have been proven by the College we are not convinced that they are part of a pattern of carelessness or incompetence. The evidence of the prescribing practices of Dr. Osif's peers in similar circumstances, in our view, makes it inappropriate to conclude that her prescription of antibiotics demonstrates incompetence.

339. Aside from the issues of Dr. Osif's prescribing of antibiotics, the other findings demonstrate a pattern of carelessness by Dr. Osif. She has been shown to come too quickly to a diagnosis without an adequate history or examination, a failure to consider the appropriate differential diagnosis and of making diagnoses not substantiated by the patient's chart. In some of these cases, specifically the case of A.B. and M.S., Dr. Osif's carelessness is very significant and is accompanied by a failure to respond appropriately to the concerns raised by family members. The overall pattern of carelessness, in our view, demonstrates a lack of insight into the quality of her care for the patients involved.

340. These patterns are substantiated by the clinical assessment at the Queen Elizabeth II Health Sciences Centre and the Dartmouth General Hospital where, in an assessment situation, she again failed to consider the appropriate differential diagnosis, move to early closure of her assessment and failed to make a thorough enough history and examination of her patients.

341. The pattern of carelessness in her own practice and as observed in her clinical assessment cover a period between 2003 and 2007. This pattern shows that Dr. Osif did not exercise the degree of care and skill which could reasonably be expected of a normal prudent emergency room physician, in a rural hospital with a Level III emergency room, after 15 years experience. Accordingly, the Committee finds that Dr. Osif is guilty of the charges listed in paragraph 337, except those of inappropriate prescription of antibiotics, and that her conduct constitutes professional incompetence.

342. The Committee has determined that Dr. Osif is guilty of charges relating to a disciplinary matter that is professional misconduct and professional incompetence pursuant to Section 66(2)(e) of the *Medical Act*. The College and Dr. Osif requested during the hearing that if there was a finding of guilt, the Committee reserve its decision on any further determination under Section 66 to enable the College and Dr. Osif to present evidence, and make submissions about any further determinations. We therefore reserve our jurisdiction to make any further determinations under Section 66.

343. In order to make any further determinations, the Committee requests the parties to provide it with evidence as to whether there are any realistic options that may be available to permit Dr. Osif to remedy her deficiencies and to demonstrate that she is qualified and able to fully meet the requirements of a licensed medical practitioner, whether under conditions, limitations or restrictions or otherwise. In requesting such information, the Committee does not wish to indicate that it has reached any conclusion on whether it is appropriate to impose any particular disposition including license revocation if that is indicated in light of the evidence presented to us and the submissions of the parties.

344. The Hearing Committee wishes to express its gratitude to counsel for the College and for Dr. Osif for their thoroughness and professionalism in presenting this case to us. It was a lengthy hearing involving serious charges; the Committee feels very well served by the quality of all four legal counsel who appeared before us.

This decision given at Halifax, this 18th day of January, 2008.

Raymond F. Larkin, Q.C. – Chair

Dr. William Acker

Dr. Leslie Whynot

Mr. Douglas Lloy

Dr. Jan Sundin

APPENDIX A

September 14, 2007

Via Facsimile

Ms. Marjorie Hickey, Q.C.
McInnes Cooper
1300-1969 Upper Water Street
Purdy's Wharf Tower II
Post Office Box 730
Halifax, NS
B3J 2V1

Mr. Thomas Donovan, Q.C.
Cox & Palmer
Purdy's Wharf Tower I
1100-1959 Upper Water Street
Halifax, NS
B3J 3N2

Dear Counsel:

College of Physicians and Surgeons of Nova Scotia – Dr. Stani Osif – Pre-hearing Motion to Permit the Introduction of Expert Evidence at the End of the College's Case

This is the decision of the Hearing Committee appointed under the *Medical* Act, S.N.S. 1995-96, c. 10, to hear charges relating to a disciplinary matter against Dr. Stani Osif which have been referred to the Committee. A Notice of Hearing was prepared on August 28, 2007, listing a large number of allegations about the conduct of Dr. Osif and alleging that that conduct amounts to professional misconduct and/or professional incompetence. Counsel for Dr. Osif has made a pre-hearing motion to permit him to introduce an expert report at the hearing without providing to counsel for the College a copy of the report 10 days in advance of the hearing as required by subsection (1) of Section 59 of the *Medical Act.*

Due to the constraints of time, the decision of the Committee and brief reasons are being provided in this form and the Committee expects to provide more complete reasons in its final decision in this matter.

Counsel for Dr. Osif has indicated that he intends to disclose two expert reports as required by Section 59(1) but wishes to be relieved of the obligation to file a third report 10 days in advance of the hearing. This report deals with evidence which is the subject of another preliminary motion which will be made to the Committee on September 27, 2007. In that motion, Dr. Osif

will request the Committee to exclude certain evidence and to dismiss the charges flowing from that evidence. If the Committee agrees to the motion to exclude that evidence the expert report will become irrelevant and will not be introduced. If the Committee rejects the motion to exclude the evidence after considering the motion on September 27, 2007, Mr. Donovan proposes that he be permitted to disclose the report at that time and to have the report admitted into evidence despite non-compliance with Section 59(1).

Dr. Osif's request is opposed by the College which says that it will be prejudiced by not having access to the expert report in a sufficiently timely way to appropriately prepare its case.

Section 59 of the *Medical Act* provides as follows:

> **Notice of certain evidence**
>
> 59 (1) The following evidence is not admissible before a hearing committee unless the opposing party has been given, at least ten days before the hearing,
>
> (a) in the case of written or documentary evidence, an opportunity to examine the evidence;
>
> (b) in the case of evidence of an expert, a copy of the expert's written report or if there is no written report, a written summary of the evidence; or
>
> (c) in the case of evidence of a witness, the identity of the witness.
>
> **Power to allow evidence**
>
> (2) Notwithstanding subsection (1), a hearing committee may, in its discretion, allow the introduction of evidence that would be otherwise inadmissible under subsection (1) and may make directions it considers necessary to ensure that a party is not prejudiced. 1995-96, c.10, s.59

Subsection (1) of Section 59 makes inadmissible an expert report which is not provided to the opposing party at least 10 days in advance of a hearing. However, subsection (2) permits the Hearing Committee to allow the introduction of evidence which was not disclosed as required by subsection (1) and empowers the Committee to make directions that it considers necessary to ensure that a party is not prejudiced by the failure to disclose in advance of the hearing.

In exercising its discretion on whether to allow the introduction of an expert report at the hearing or which has not been disclosed to counsel for the College as required by subsection (1) of Section 59, the Hearing Committee is mindful of its duty to ensure that the hearing is fair and workable. Dr. Osif is entitled to a fair hearing and to have the hearing conducted in accordance with the recognized principles of natural justice and administrative fairness.

In this case, Counsel for Dr. Osif says that she is prejudiced by the requirement to provide this expert report to the College in advance of the hearing because the disclosure gives an advantage to the College. It will allow counsel for the College to identify problems in a factual matrix being

presented or the professional opinions being delivered in a way that deprives Dr. Osif of a full answer and defense to the charges against her. Mr. Donovan argues that that the disclosure of this expert report would give the College a strategic and tactical advantage by providing it with material from which it could build or strengthen its case. He says, further, that this prejudice to Dr. Osif will be magnified if the Committee finds the evidence upon which these experts relied in making their report is deemed inadmissible at the hearing as he will argue on September 27, 2007.

The Committee does not accept that, as a general proposition, it is unfair that a member be required to disclose expert reports in advance of the hearing. Indeed, Mr. Donovan does not take his argument that far and will be providing other expert reports in advance.

The purpose of Section 59 is to ensure that both the College and the charged physician get full disclosure in advance of written or documentary evidence and of expert reports as well as the identity of the witnesses to be called. In our view, this disclosure in advance is appropriate to the hearing of charges relating to a disciplinary matter against a member of the College. Disclosure in advance by both the College and the member will ensure that neither party is taken by surprise at the hearing and that adjournments resulting from that surprise or lack of preparation will be avoided. This applies to both disclosure by the College and disclosure by the member.

This is a process of assessing a complaint of professional misconduct not a criminal trial. Although the potential consequences of a disciplinary hearing are very serious to a member, it does not subject the member to criminal penalties. Requiring Dr. Osif to disclose expert reports in advance will not deprive her of an opportunity to defend herself against the allegations against her and to answer those allegations by presenting evidence in her favour.

Although subsection (2) of Section 59 allows the Committee to make exceptions to the general requirement of disclosure by parties in advance of the hearing, in our opinion, the general principle of disclosure is not itself unfair or unjust to Dr. Osif. Indeed, Dr. Osif does not argue that, in general, such disclosure prevents a fair hearing. She is prepared to disclose two expert reports as required by subsection (1) of Section 59. Disclosure in advance is consistent with a fair and workable hearing.

Mr. Donovan ultimately argues a fairly narrow point. The specific prejudice to Dr. Osif is that the evidence upon which the experts rely on in their report may itself be deemed inadmissible in the hearing. He argues that if the Committee accepts the motion to exclude that evidence, the expert report need never be disclosed because the charges relating to it will be dismissed. He implies that the content of the experts report may give an advantage to the College in relation to the remaining allegations.

It is not clear to the Committee how this would prejudice Dr. Osif more than the pre-hearing disclosure of the other expert reports. Actually the Committee thinks that more information would have been helpful. It is apparent that the College is aware of the disputed evidence and intends to rely on that evidence in the hearing. An expert opinion based on that evidence may give the College greater insight into its significance but no more than any other expert report provided to counsel in advance of the hearing.

On the information before us at this stage, we cannot conclude that the disclosure of this expert report will cause any greater prejudice to Dr. Osif than the disclosure of the other reports. If we accept the motion to exclude certain evidence and, therefore, dismiss certain allegations, the report may become irrelevant. If so, it will not be admissible before us. If it is relevant to the remaining charges, it will, no doubt, be provided to the Hearing Committee. Like any other expert report that is relevant to the remaining charges, it should be disclosed in advance as required by subsection (1) of Section 59.

If, as the hearing progresses, it becomes apparent any unfairness results from the pre-hearing disclosure of this expert report, the Hearing Committee will consider objections at that stage and take the necessary steps to ensure that Dr. Osif has every opportunity to defend herself against the allegations against her and to answer the evidence presented by the College.

We have not found it necessary at this stage to decide whether or not the *Charter of Rights and Freedoms* applies to this issue. The Hearing Committee is a tribunal created by statute and subject to the *Charter*. We expect that the application of the *Charter of Rights* will be argued fully before us in the motion which will be presented by Counsel for Dr. Osif on September 27, 2007.

The motion of counsel for Dr. Osif to permit him to introduce an expert report at the hearing without providing a copy to counsel for the College 10 days in advance of the hearing as required by subsection (1) of Section 59 is rejected. We do not exercise our discretion to allow the introduction of that evidence if it is not produced as required by subsection (1) and Section 59. In our view, counsel for Dr. Osif must disclose to counsel for the College any expert report upon which it wishes to rely at the hearing.

Yours truly,

Hearing Committee
per: Raymond F. Larkin, Q.C.

rlarkin@labour-law.com

RL/cc

cc: Mr. Doug Lloy, (via email)
Dr. Leslie Whynot (via email)
Dr. J. Sundin (via email)
Dr. William Acker (via email)