MEDICINE IN ONTARIO NEEDS "GLASNOST"

A Report to the Government and the People of Ontario
Prepared by Doctors and Patients
September 2001

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"The subject truly loyal to the chief magistrate neither consents to nor advises arbitrary measures." Junius

I. INTRODUCTION

The following submit this report to the Government and the people of Ontario:

Ontario Medical Association's Section on Chronic Pain (OMA Pain)
Ontario Physicians' Alliance (OPA)
Citizens for Choice in Health Care (CCHC)
Voices on Healthcare Concerns and Accountability (VOHCA)
Research Advocacy & Information Network on Environmental Toxins (RAINET)
Ontario Chelated Patients Association (OCPA)
Environmental Health Group (support organization for Dr. J. Krop, Mississauga)
Patients and Friends of Dr. F. Adams (Kingston)
Patients and Friends of Dr. S.S. Kooner (Windsor)

The information, concerns, and recommendations contained in this report constitute a statement of solidarity offered by doctors and patients committed to excellence in medicine. Following the review of Ontario's health care legislation, the final HPRAC Report entitled "Adjusting the Balance", has been received by the government. As the HPRAC exercise nears its end, we would like to call for the protection of fundamental principles. This report draws attention to a pattern of serious problems identified at the *College of Physicians and Surgeons of Ontario* (CPSO). We view all of these problems as potential violations of Canada's *Charter of Rights and Freedoms*. We invite the Government of Ontario, the Minister of Health, and the public to consider our analysis and our recommendations for fundamental change to the CPSO's mandate and processes.

This report relies upon many sources most of which are provided in the separate Appendix volume available upon request. Our sources are:

a. The government-ordered July 2000 KPMG report released by the Ministry of Health in April 2001. It is available through the Ministry of Health at 416-327-8890).
b. Transcripts of some disciplinary hearings held at the CPSO during the last decade.
c. Relevant excerpts from CPSO council meetings and from their *Members' Dialogue*.
d. The full text of the CPSO's submission to the HPRAC Review, December 1999 (available through the Ministry of Health at 416-326-1550 or the CPSO at 416-967-2600)

e. The submissions made to the HPRAC Review by some of the medical and patient advocacy groups listed above (available through them directly; see **Guide to Authors** at the end of this report).
f. The in-depth analysis of several CPSO disciplinary cases undertaken during 1998/99 by Mr. Michael Code (criminal and *Charter* law expert and former Assistant Deputy Attorney General of Ontario)
g. The series of articles published in *The Toronto Star* since May 2001 on the CPSO's mishandling of public complaints. (Available on the internet through www.thestar.com - "medical secrets")
h. The information provided by "whistleblowers" - i.e. long-time employees at the CPSO - in extensive interviews, and from the documents they made available.
i. Various reports made by dissenting members of the CPSO council and expert witnesses at disciplinary hearings.
j. Transcripts of CBC *Fifth Estate* and Michael Enright's CBC radio interviews
k. Interviews with physicians who had been subjected inappropriately to the CPSO's disciplinary procedures.

We firmly believe that Charter violations may be involved in the actions of the CPSO discussed in this report. For that reason we have retained the Ottawa-based law firm *Raven, Allen, Cameron & Ballantyne* to evaluate our contention that human rights issues are involved.

The Charter issues we feel may have been, and are being, violated in CPSO processes are:

Section 2: freedom of conscience, belief, opinion
Section 7: right to life, liberty and security of the person
Section 11: right to a fair trial in all its many aspects, protection from arbitrariness
Section 13: protection against self-incrimination
Section 15: equal rights in its various forms
Section 36: guarantee of essential public services of reasonable quality

As we feel it is of vital importance that our submission be supported by verifiable evidence, the Appendix to this report is extensive. Only three of the documents are also attached to the report itself. The entire Appendix is available upon request; call 519-927-1049. One portion of this Appendix constitutes the December 7 and 8, 1995 cross-examination of Dr. J. Carlisle, the then Deputy Registrar of the CPSO and the current interim acting Registrar. This document is almost 100 pages and of central importance to the problems raised in this report and, therefore, is quickly available by e-mail upon request by calling 519-927-1049.

We chose the word “glasnost” in the title of this report in order to convey the idea that doctors and patients in Ontario are currently facing a situation as serious as the former Soviet Union faced on the larger scale of the state, when Mikhail Gorbachov diagnosed his nation’s antiquated totalitarian regime as suffering from a systemic lack of “glasnost”, a Russian term that means both transparency and openness and implies that accountability is the remedy.

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II. EXECUTIVE SUMMARY

Several physician and patient groups as well as concerned individuals joined forces and have pooled their information bases in order to inform the government and the people of Ontario of their concerns about the manner in which doctors and patients are treated by the *College of Physicians and Surgeons of Ontario* (CPSO). The consensus is that the CPSO may be violating the human rights of both doctors and patients through the arbitrary interpretation and misuse of the existing legislation governing medical practice in this province. It is agreed also that the manner in which the CPSO conducts its complaints and disciplinary processes to a large extent serves to retard medical progress in Ontario, discussed in Section VI. We provide our view of the current crisis in the CPSO’s handling of the complaint process in Section IV.

This consensus is supported by the findings of the KPMG Report of July 2000, commissioned by the Ontario Ministry of Health in 1998 and by the legal opinion of criminal and *Charter* expert Mr. Michael Code of Sack Goldblatt and Mitchell, Toronto. His analysis was requested by a group of doctors, patients and concerned individuals called *The Committee for the Investigation of the College* which was founded in 1998. Mr. Code analyzed several physicians’ discipline cases, some of which were the subject of many media reports; they are summarized and presented in Section V. Mr. Code concluded in 1999 that

> **In at least one case “there was *prima facie* evidence that CPSO officials may have committed the criminal offence of obstructing justice by repeatedly misleading the Executive Committee as to the true state of the evidence in this case”. In the remaining cases Mr. Code found “evidence of abuse and misuse of power”, “systemic unfairness and repeated abuse and misuse of power”, and “a consistent pattern of unfairness”.**

In addition to the presentation of these discipline cases studied by Mr. Code, this report also provides information and documentation received from "whistleblowers" from amongst the CPSO staff on aspects of the problems identified with the CPSO's handling of complaints and discipline. We also rely upon exhaustive interviews with many physicians affected by the disciplinary process, and the records of aggrieved patients; some of them had their stories covered in the investigative reports on the CPSO commenced in *The Toronto Star* in May of 2001.

A focus of this report is on the submission made by the CPSO in December 1999 to the HPRAC Review. In their submission, the CPSO requests changes to the existing legislation which, in the opinion of the authors of this report, are insupportable because they demand an unacceptable increase in powers and open up even more opportunity for violations of human rights. An analysis of the CPSO submission - their "wish list" - to HPRAC follows in this report in Section VIII and our specific recommendations for the inclusion of safeguards against future abuses of power and process are found in Section X. It is our belief that the existing legislation lacks adequate safeguards. We also comment on the HPRAC Report, "Adjusting the Balance".

Our recommendations deal with

1) general recommendations,
2) a suggested test for public accountability in all CPSO handling of complaints and discipline, and
3) specific recommendations for changes (safeguards) to the *Regulated Health Professions Act* and the *Medicine Act*.

To place the Ontario situation in context the experience with parallel problems in the UK and in New Zealand is discussed in Section VII. Those countries' solutions are briefly discussed also and recommended for consideration when making changes to health care legislation in Ontario.

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II. LOOKING BACK OVER THE PAST DECADE

Recently, the Health Professions Regulatory Advisory Council (HPRAC) evaluated the responses of the various colleges and the public to a range of questions including: "Has the 1991 *Regulated Health Professions Act* provided a system that is effective, efficient, flexible, fair and equitable?" While there is always room for improvement in any legislation, our view is that, by and large, the Act itself is not the cause of the problem.

Instead, we are deeply disturbed by the alarming betrayal of the Act's intent and the great number of instances where its provisions have been, and are continuing to be, mishandled. The government, in acting on the HPRAC Report, must first and foremost address legislative change designed to prevent such abuse in future. We intend to demonstrate that the most serious and (unintended) failure of the current legislation governing health care in Ontario is due to insufficient safeguards, which are needed to prevent abuse.

The existing legislation was written in good faith and assumes good faith. That assumption has proven to be unwarranted in many instances. It was most instructive indeed to attend the public HPRAC meetings. None of the other colleges appear to have such bitter criticism leveled against them, either by their members or by the public. The ongoing *Star* series on the CPSO's mishandling of public complaints supports this view. We do not hear of hundreds of people rushing to the newspapers to complain about their experiences with any of the other colleges.

For thousands of patients and for many doctors in various specialties, the past decade has been a human, scientific, and public health disaster because of the CPSO's idiosyncratic and arbitrary interpretation of the existing legislation.

The CPSOs interpretation appears to be based on fundamentally flawed assumptions about its role and its responsibility to the public. The CPSO administration (not necessarily its membership) appears to believe that they alone are in charge of medicine in this province, and that it is their mandate to determine which direction medical evolution is to take in Ontario, irrespective of the rest of the world. In the 1860's that assumption may have had some merit when political and social hierarchies were fundamentally different from today. Today's pluralistic society and global scientific community live in an exponentially increasing information pool accessible to everyone. Often the CPSO appears to conduct itself in a manner more suited to the imperial and parochial notions of the past.

Partially in response to public concerns in 1999, the Ministry of Health commissioned KPMG to investigate the complaints and disciplinary processes at the CPSO. Unfortunately, the mandate did not allow KPMG to look at Discipline Committee files (KPMG report p. 33) or to look at Section 75 investigations - areas in which there have been numerous procedural improprieties. Section 75 investigations are not based on patient complaints but on circumstances in which the Registrar and Executive Committee decide they have "reasonable and probable grounds" to initiate an investigation. However, despite these limitations in their mandate, the KPMG report has many insightful criticisms which we discuss in detail.

We are in agreement with the authors of the KPMG Report whose authors state ***"Public services and public institutions are undergoing fundamental change in all major democracies around the world. The public interest is being defined more specifically, and a higher degree of accountability is expected from public institutions … This new accountability standard is also characterized by a greater attention to ethics and the responsiveness of organizations to changing public values and social norms. The College of Physicians and Surgeons, like all other public bodies is expected to meet these new expectations."***

It is important to note that the KPMG authors observed:

"When questioned specifically about the alignment of the CPSO processes with current social norms and public expectations, several senior officials and committee members demonstrated little understanding of current public values, or expectations, and did not see how these might have a role in the complaints and discipline process." (KPMG p.39 and 41)

We, doctors and patients, feel that there must be room for diversity of opinion in medical practice. The democratic process is expected to protect this diversity. Indeed, the *Medicine Act*, 1991, s.3 states: *"It is* ***the duty of the Minister*** *to ensure that* ***the health professions are regulated and coordinated in the public interest;*** *that appropriate standards of practice are developed and maintained; that individuals have access to services provided by the health care professions of their choice; and that they are treated with sensitivity and respect in their dealings with health care professionals, the colleges and the Board."* (Emphasis added.)

Indeed, the recent passage of the so-called "Kwinter Bill" (Bill 2) on December 17, 2001, with the unanimous support of the Ontario legislative assembly, demonstrated that the legislature recognizes how important choice is to people in this province and that such choice is central to the direction medicine takes. Significantly, the record shows how strongly the CPSO objected to this Bill's passage right up to the time of the third vote and how thoroughly this body misunderstood both the Kwinter Bill and their own mandate.

In a recent speech in the Legislature (April 30, 2001), the Hon. T. Clement, Minister of Health, affirmed this principle when reiterating statements made in the Speech from the

Throne (April 19, 2001) elaborating on them further: **" … government is the servant of the people, not its master. Citizens are more than 'customers' or 'clients'. The entire public sector belongs to them. And accountability means setting expectations against which we can all be measured. And that will be manifested in transparency and openness with the public. Citizens are entitled to transparency in the operation of public institutions…"**

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III. CREDIBILITY CRISIS AT THE CPSO: THE COMPLAINTS PROCESS

In view of the fact that the purpose of medicine is to serve humanity and ease suffering, it is appropriate to focus first on patient complaints. The recent and still ongoing series of articles published in *The Toronto Star* details the astounding acts of CPSO with regard to patient complaints. This investigative series is still ongoing, and more revelations can be expected as the year progresses.

The *Star's* excellent investigative reporting rests to some extent upon the data made available to the *Star* by several of the patient advocacy groups who also are submitting this report. Some of us were involved in the research period, prior to the publication of this series, starting May 5th, 2001. The Star had the opportunity to speak with CPSO whistleblowers. Because legislation protecting whistleblowing in this province does not yet exist, the identity of these informants must be kept confidential. These whistleblowers have years of experience working in the CPSO and held key positions. They also provided documentary evidence to back up their descriptions of the complaints and disciplinary processes.

Finally, all the hotly debated public issues regarding the CPSO's antiquated attitude towards pain and environmental medicine, certain types of orthopedic therapies, chelation therapy, and complementary medicine - which provoked the public to call for this investigation by KPMG, were also outside the scope of the investigation (KPMG p.3).

Even though the KPMG investigation was rather like asking a doctor for a check-up and refusing to be examined from the neck on down, KPMG's evaluation of the handling of the complaints process at the CPSO turned out to coincide with the views of this Committee. Most of their recommendations are good.

In fact, the few points of disagreement that we have with the KPMG recommendations, as will be detailed below, are due to the fact that KPMG had a somewhat different information base than ours and, therefore, came to some different conclusions as well. Significantly, the subsequent *Star* reports perfectly complement KPMG's findings.

In summary, there are four sources of information on the CPSO's handling of **complaints** on which this report is based: the KPMG report, the CPSO whistleblowers, *The Star* articles, and our interviews with patients and physicians. A discussion of all of the above follows.

The KPMG critique of the CPSO complaint process

Looking at the percentages, KPMG found

1. 64% of complainants and 77% of physicians rated CPSO communication as poor or very poor
2. 75% of complainants and 88% of physicians did not think the time required to process a complaint was justifiable
3. 70% of complainants and 46% of physicians did not feel that the Complaints Committee gave an adequate rationale for its decisions
4. 81% of complainants and 67% of physicians did not feel that the complaints process reflected the CPSO responsibility to protect the public interest
5. 77% of complainants and 56% of physicians did not feel the process reflects current public expectations and social values (p.21-22)

These percentages show clearly that this sample of the public and the profession shows deep dissatisfaction.

In May the CPSO published in their bi-monthly *Members' Dialogue* the results of a survey undertaken by them through *Decima Research*. The aim was to find out how the membership feels about the CPSO and whether the public supports self-regulation. Since the extremely critical KPMG review had become available around that time also, it is difficult to see this action as anything else but an attempt at public relations. The CPSO effort was based on a database of some 250 physicians which, in statistical terms, is hardly representative of Ontario's doctors. The questionnaire was superficial and left no room for explanation. The elaborate pie charts and analytical tools reproduced in the *Dialogue* remind of the framed statement that hangs on the wall in the office of a U of T statistics professor: "If you torture the data long enough, they will confess to anything."

A specific and very serious problem identified by KPMG was with regard to the file review. The reviewers found that the CPSO files were **"incomplete, not well-organized and not amenable to audit"** (p.24). The extraordinarily long time the processing of complaints takes, in spite of major recent improvements, was discussed in exhaustive

detail. The average time taken for an investigation is now about one year; it used to be two to three years (p.28-29). KPMG noted the existence of "information silos" which showed that information is not being shared **"creating intra-organizational silos**" which are **"barriers to effective management"** (p.31). Therefore KPMG found that **"transparency is compromised in a number of ways":**

1. **a copy of the final investigation report is not given to the complainant and the physician before going to the Complaints Committee**
2. **oral and written cautions do not appear on the public record, nor does the complainant get much information about the results**
3. **the Quality Assurance process, upon which the CPSO is relying to meet its responsibility to protect the public, is completely secret, and the results do not appear on the public record (p.35).**

This use of the QA process was not intended by the legislators and many believe it constitutes abuse of power.

The KPMG authors were critical of the fact that **"the CPSO still does not provide a rationale for the decisions of the Quality Assurance Committee"** and did not agree with the CPSO's view that this cannot be helped due to the confidentiality provisions of the RHPA, suggesting that the CPSO chooses to interpret this provision "very rigidly" and could use other ways to demonstrate accountability. Indeed, we agree with KPMG that **"it is not sufficient for public bodies to simply do the right thing. Public accountability now requires that public bodies communicate publicly how they are in fact fulfilling their obligations"** (p36). However, our experience has been that secrecy appears to be the preferred approach of action at the CPSO.

KPMG's authors found that **"Some fundamental elements of an accountability framework … are missing"** and that therefore **"the program lacks transparency - a key element of public accountability"**. They found the following elements to be missing entirely:

1. no stated philosophy to guide the program
2. no published criteria for the Complaints Committee
3. no objectives against which to evaluate the program.

Given all of the above, KPMG advised that" **"the CPSO must ensure that the root cause of the problem, that led to the complaint, is understood".** (pp.36-38) This is, however, not possible when the entire decision making process is fundamentally flawed because Complaints Committee members "**do not have explicit criteria and/or decision making tools",** nor does the staff. In fact, "the reviewers found no evidence that [internal memos dealing with such criteria] were included in procedural manual." (p.41)

As for the central issue of the public interest, the KPMG reviewers found nothing with which it would be possible for staff and committee members to establish just what is in

the public interest**. "There was no evidence in the written decisions in the files, or any other significant criteria, or values that influenced the decisions. The content analysis of the communications and Complaints Committee decisions found no references to the public interest, public protection, or public accountability… the CPSO told the reviewers that there is no test for assessing whether something is in the public interest."(**p.41) Our own proposal for such a test is provided in our recommendations as item no. 1.

KPMG's conclusion is that the CPSO has failed to recognize that times have changed: **"the health care delivery system is moving from a physician-centered model to a patient-centered model. To ensure public accountability, the CPSO decision making model must follow that direction"** as otherwise there simply is no "earned trust". (p.43)

Of particular importance is the fact that KPMG cites the case of *McIntosh v. CPSO 1998* in which Justices Southey, Rosenberg and Cusinato seriously criticized the CPSO for their erratic handling of a complaint, finding it to have been a violation of natural justice and procedural fairness for both the complaining patient and the doctor against whom the complaint was lodged. The unfairness included not notifying the physicians for four and a half years after the complaint was made, not dealing with the complaint in the mandatory period, allowing the complainant to turn the investigation on and off several times, and not providing reasons for any of the above. The judges stopped the investigation and admonished the CPSO, stating that once a complaint has been lodged, the process must begin and be handled as required by law.

The *Toronto Star* articles

The *Toronto Star* articles, which commenced on May 5, 2001, and are still ongoing, can be obtained through the internet at *www. thestar.com*. (go to "medical secrets"). Most of the problems identified by KPMG are found in them as well. Some of the stories concerning nightmare-doctors shielded by the CPSO will be part of the discussion below, as will be the comments made by the CPSO President, Dr. R. Gerace in his letter to *The Star* (on May 9th).

A whistleblowers' view of the CPSO complaint process

Although we know that the following material cannot be corroborated directly through documentary evidence, we nevertheless include it for two compelling reasons: first, these informants' reports are consistent with the documentary evidence that does exist as well as with the findings of KPMG, even though they were reported to some of us long before the KPMG report became public and before we were able to introduce them to *The Star* for the investigative series. Second, the informants spoke to *The Star* and us separately, independently of each other, and their reports were consistent with each other. Their

information could be tested if the government wishes to do so. The informants from the CPSO provided the following insights into how complaints are frequently handled.

Central to the complaints and discipline process appears to be the chosen fields of interest identified by the Deputy Registrar Dr. John Carlisle. It is common knowledge at the CPSO, the informants told us, that Dr. Carlisle disapproves of certain medical specialties and has for more than a decade now concentrated financial resources and staff time to the pursuit of these areas by punitive means, especially through the invocation of Section 75 of the RHPA.

The medical specialties Dr. Carlisle disapproves of are the following

a. chronic pain therapy, especially with opiates
b. environmental medicine
c. prolo therapy (a form of orthopedic medicine)
d. chelation therapy (for cardiovascular disease)
e. certain forms of psychotherapy

This list stands in sharp contrast to the nature of complaints actually lodged against doctors. For example, the CPSO whistleblowers provided us with a list dated June 8, 1993, which was compiled for Deputy Registrar Dr. John Carlisle. This list is the result of an analysis of the most frequent complaints received from patients. Of the 12 most common complaints 6 were gynecological and obstetrical misadventures. The rest concerned missed gastro-intestinal cancer diagnosis, inappropriate handling of psychiatric problems, missed or untreated bone fractures, missed AIDS and other infectious disease diagnoses, missed appendicitis diagnosis, and a few consent issues, especially perceived invasions of privacy. In short: very basic medical mistakes and ethical issues are what concerns patients most - not entire medical specialties, none of which have anything to do with the list provided above. The important point is that the *Star* reports support the observation that these are still the main concerns 8 years later.

However, as the documentary evidence shows, this does not appear to be merely a personal agenda, but resonates with other individuals' prejudices in the administration and on the executive; if this were not so, the internal memos on these issues would not be expected to meet with approval and, subsequent confirming action. That the executive almost always goes along with Dr. Carlisle's recommendations has been amply confirmed. Examples of documentary proof, much of it in the public record and some provided by our informants, is part of this submission.

The informants stated, that Dr. Carlisle keeps files on doctors working in these medical areas, until something can be found that might be turned into a disciplinary procedure.

Inspectors are instructed to gather information in these areas and on these doctors, including marital problems, private as well as OHIP financial information, and interviews with patients are also often initiated. This will be discussed in more detail in the following section. The complaint process is thus undermined by the irrelevant priorities at the CPSO's executive level which do not reflect the public's priorities.

Doctors who have no complaints against them are subjected to an inappropriate amount of CPSO time and funds in an effort to find something on them to remove them from practice, while serious complaints about doctors, who may be found deficient, are not dealt with expeditiously, if at all.

This situation goes a long way towards explaining how some complaints can take 4 years to be dealt with, and why so many absurd discipline cases have been in the public eye over the past decade.

Another disturbing statement made by the informants was, that on occasion the reports CPSO investigators are required to write for the Complaints Committee frequently have to be rewritten several times - not because errors needed to be corrected, but to ensure that the slant was such that the Committee would rule accordingly. This so bothered one of the investigators, an informant told us, that this person made sure that all four versions of a report came before the Committee; the ensuing confusion and discussion ensured that this complaint was looked at very carefully and dealt with more fairly than it would have been otherwise. It is important to note, in this context, that the KPMG investigators found that a **"few years ago, the Complaints Committee changed its policy and requested to see the entire investigation file in each case, rather than the summary."** (p.35).

An informant related how one of the Complaints Committee members noticed the following in the early 1990's: the copy of the list of complaints cases under review in the hands of the inspectors was coded on the left hand margin, while the same list provided to the committee members did not have such codes on the margins. When the surprised committee member asked what those codes meant, he learned that they indicated the probable outcome of each case (i.e. dismissed, cautioned, reprimanded, sent to discipline etc.). This deeply disturbed that committee member, since the outcome of each case was yet to be determined by the Complaints Committee. Examples of such lists with their codes were provided by the informants and shown to the *Star* reporters.

Another way by which the complaints process appears to be frequently subverted arises from the following effort: in order to find something useful to initiate a prosecution on a doctor practicing in a field Dr. Carlisle disapproves of, an attempt will be made even to

turn even a letter of commendation from a grateful patient into a complaint if at all possible. Thus, for example, in the case of Dr. J. Krop, the informant stated, a letter from an especially grateful patient, writing to the College about the life-saving treatment received from Dr. Krop after no success with many previous physicians, was scrutinized carefully by Dr. Carlisle. The inspector, our informant stated, was then instructed to contact the patient and see if there was some way in which this letter of commendation could be turned into a statement of concern, if not outright complaint. It proved unsuccessful, of course, completely confused the patient and demoralized the investigator.

One major complaint made by the informants was that the entire complaint process is flawed because all deliberations by the Complaints Committee are recorded only in minutes. There are no transcripts possible. Neither the doctor nor the complainant has any way of verifying the facts on the basis of which the Committee arrived at a decision. Hence, it is not surprising that the KPMG report notes that there seems to be no way to understand how the Committee arrives at their decisions.

The informants felt that one reason the complaint intake procedures causes such problems is because of the assumption inherent in the system is that any complaint might end up as a full fledged disciplinary investigation. This, they felt, was the primary reason for the immense backlog. In actual fact, they felt, the vast majority of complaints could be settled very quickly and easily.

Since neither doctor nor patient, after the initial input, is allowed to be involved in the complaint process, often simple misunderstandings in non-life-threatening situations cannot be cleared up to speed up the process. This, as one informant put it has resulted in "a bureaucratic nightmare".

This nightmare may now become chronic, as Alternate Dispute Resolution (ADR) has been terminated. The *Globe and Mail* reported earlier this year (Nov.29, 2000), that several investigators were fired at the CPSO. Most of them happen to have been primarily working in ADR and they were told that their "positions no longer existed". The KMPG investigators noted that no ADR cases were active (p.35). The chief difference between Quality Assurance and ADR is, of course, that <u>ADR is that the patient is present for the proceedings involved.</u> Secrecy as a policy has increased in the last two years, not decreased. Possibly this attitude is what prompted the ADR investigator Rozmin Dossa to say to the *Globe and Mail* about the College's management: "The fish stinks at the head." More about this below.

One informant described in detail how attempting to resolve a complaint amicably resulted in Dr. Carlisle severely reprimanding an inspector and placing the subsequent thank-you letters, received at the CPSO from the complainant and the doctor, into that inspector's file as a recorded reprimand. Dr. Carlisle instructed that inspector that the job was not to resolve a case, but "to get doctors!"

Complaints coming against high profile doctors, especially those teaching at universities and who are recipients of large research grants, the informants told us, are taken right out of the hands of the investigators and very few people know what happens to them, as they are handled by Dr. Carlisle personally before delegating the case to employees of his choice. This might explain why CPSO employees interviewed by KPMG reported on "**information silos**" creating information barriers; they also told KPMG **"that more could be done within existing legislation to create an organizational culture that supports greater information sharing and integrated activity between departments."** (p.31)

These examples provide a glimpse into the mind-set at work in the CPSO which supports the general impression received by the KPMG investigators who wrote**: "The practice of medicine is now a shared responsibility between patients, physicians, government, other professions, the public, and health care agencies …. The organizational culture of the CPSO has not incorporated this fundamental shift. The organization still operates in relative isolation from the broader health system and society."** (p.45)

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IV. CREDIBILITY CRISIS AT THE CPSO: THE DISCIPLINE PROCESS

Two different routes can bring a doctor into discipline: a complaint process or an investigation initiated by the CPSO under Section 75 of the RHPA. Section 37 of the RHPA is another serious process to which doctors may be subjected; it is invoked as an extreme emergency measure and allows the Registrar to suspend a doctor's license immediately with a hearing following later. For the KPMG investigators looking at Sections 75 and 59 was outside their mandate and their report is silent on this matter. They were also not permitted to see the full documentation on those discipline cases that had been initiated through a complaint, because the CPSO cited confidentiality legislation as a reason. However, the KPMG authors do record that it was felt **"that the College being the prosecutor, judge, and jury [does] not seem ethically nor legally sound"** (p. 23). We absolutely agree. This legal anomaly is what prompted us to seek a legal opinion in terms of the *Charter*, as stated earlier.

It is instructive to look upon the flow chart provided in the KPMG report on page 14. If one did not know that the Section 75 provision exists, one would naturally come to the conclusion that disciplinary hearings are one possible outcome of the complaints process. That is, of course, how it should be and how the public would like it to be, because it implies that the process is patient-centered and outcome-dependent. Thus, one would expect that a negative patient outcome would be examined and then either found to be unavoidable, a genuine mistake, or a misunderstanding - any of which could theoretically be resolved without the need for disciplinary action. On the other hand, in a serious case of criminal negligence or assault, the process would ensure that a full investigation would take place and disciplinary action taken as appropriate.

However, the black box at bottom right, identified as QUALITY ASSURANCE COMMITTEE, is as KPMG pointed out and critiqued, entirely secret. That means, the decisions made may or may not serve the patient and the public interest. There is no way of ever finding out if they did serve the public interest.

Secondly, the box on the bottom left, identified as DISCIPLINE COMMITTEE, is the one that may deal with legitimate complaint-driven investigations of physician practices. In fact, however, this is where we also find those horrendously costly Section 75 cases, that have over the past decade brought so much negative publicity for the CPSO, and which have, probably more than anything else, helped to bring about the passage of the Kwinter Bill.

These are the College-driven "fishing expeditions" which are initiated under Section 75; they can be misused in a way that does not serve the public or the evolution of medicine. They can ruin the life of the doctor involved, and have done so in several cases. It is highly unusual that even people under criminal investigation in prison attempt suicide, yet we know of four doctors who committed suicide while under CPSO investigation. None had patient complaints against them.

In the final analysis, Section 75 cases, when misused, carry the additional terrible cost of compromising the health of these doctors' patients. They either lose his or her services entirely, or find that the doctor's license has been restricted specifically to exclude the very therapy they sought (usually in utter desperation). As will be shown here, the central problem in the Section 75 abusively used disciplinary cases is the fact, that patient outcome is explicitly disregarded. In this way the CPSO becomes an instrument for the retardation of medical progress and harm to patients while also sending messages of professional intimidation to its members. Thereby the CPSO creates its own quasi-laws, instead of going through the legislative process. The human drama involved in these Section 75 cases cannot possibly be overstated - they are every bit as heart breaking as those tragedies described in the *Star* series.

The Section 75 witch-hunts, and the CPSO mishandling of patient complaints, both demonstrate the CPSO's failure to understand that patient outcome is of central importance in medicine.

Most readers of *The Star* series (and the authors of this report) agree with Dr. Rocco Gerace, president of the CPSO, who was quoted in the May 6th *Star* article, **"The doctors hate us because they think we are out to get them, and the public thinks we are an old boys' club."**

In view of the letter by Dr. Gerace, subsequently published in *The Star* on May 9th (A25), it seems clear that he and the CPSO administration, simply do not get it - namely, that giving the CPSO more power through legislative change is not the answer to this public scandal they are responsible for.

An old boys' club will not be rejuvenated and democratized by more power. Similarly, the deep distrust of the members will not be healed by giving the administration more punitive toys to play with.

The KPMG authors very astutely pointed out that: **"Organizations need to start from an understanding of public expectations, social norms and values, and then interpret the law in light of these… it can no longer be assumed that the values of the members of the CPSO (or the CPSO council) are the same as the values of society."** (p.44) In that context they also made the very important observation that goes, in our view, a long way towards explaining the problem identified, but not understood, by Dr. Gerace. They stated**: "Professionals in particular are susceptible to the belief, that if the individual professional is ethical, the organization will be as well. In fact this is not the case. A more deliberate process and comprehensive structure are required to ensure that organizations give sufficient weight to ethics and public values in all their processes, decisions and systems."** (p.44) Indeed, it is our submission that the CPSO is very poorly representative of the medical profession in Ontario. This misalignment, so well brought out in the government-ordered KPMG report, is what this government has the power to rectify.

The vast majority of Ontario's 26,000 doctors are dedicated physicians committed deeply to the welfare of their patients and the advancement of medical science. Consider especially the fact that this report is the result of so many physicians joining forces with so many patient groups (all of which arose from the determination to protect patient-centered medicine, save specific doctors and entire medical specialties from the CPSO's destructive interference). We feel that Dr. Gerace's observation highlights the problem and that KPMG's statement explains it: the CPSO administration is out of touch with

reality. Having considered the evidence supporting this statement in the complaint process, we now turn to the evidence in the discipline process.

Abuse of complaint-driven discipline cases

It has been our experience, that complaining to the CPSO is largely a futile exercise. For example, formal complaints filed with the CPSO against negligent or abusive doctors by some two hundred patients, who are among the members of VOHCA, were treated with such uniform lack of interest, that this experience is what launched the formation of the organization and quickly brought it to national attention in the mainstream media. VOHCA's experience struck a resonant chord nationwide.

Furthermore, there is no mechanism by which patients can complain to the CPSO about the CPSO. In the most recent cases of the clinical ecologist (environmental physician), Dr. J. Krop of Mississauga, the allergist, Dr. S.S. Kooner of Windsor, and the internationally renowned pain expert, Dr. F. Adams of Kingston, their patients literally send thousands of faxes of protest and hundreds of formal letters of complaint to the CPSO about the handling of these doctors' discipline cases. Even formal demands for the investigation of the Registrar Dr. John Bonn's competence were filed. The mainstream press reported on all of this extensively. Dr. F. Adams and Dr. F. Ravikovich were the subjects of a CBC *Fifth Estate* programs and they were interviewed on CBC radio by Michael Enright. The transcripts of which are found in the Appendix (items 10,13,14,17 and 17). These latter two doctors had patients who were totally dependent on their treatments. Not only were their protests and formal complaints ignored by the CPSO, but these patients' requests to the CPSO to help find them another physician, after Dr. Adams' license had been suspended and Dr. Ravikovich's quality of asthma treatment had been specifically prohibited, were met with the reply that it is not the CPSO's job to find doctors. How horrific this situation is in human terms for patients is graphically described by Dr. F. Adams in his statement to the press (see transcript of March 28th press conference, item 21 in the Appendix).

This needs to be considered in the light of the observation KPMG reports: **"… It has been recognized for some time in health policy circles, and indeed by the courts, that there is an inherent unequal power relationship between patients and physicians. Members of the public who come forward with a complaint face a similar unequal power relationship with the CPSO and the profession of medicine…. The reviewers did not find that the CPSO accepted this principle or incorporated it into its decision making frameworks."** (p42)

KPMG discussed this in context of their observation that patients losing the services of a doctor they have formally lodged a complaint against. KPMG noted that CPSO officials did not recognize that a serious problem arises especially in many underserviced areas of Ontario were unwilling to address the issue (p.43). We suggest that KPMG's

observation about this ethical problem of power imbalance applies also to the way in which they deal with their membership.

The CPSO is not, in our opinion and experience, an even remotely democratic organization. Indeed, a serious human rights issue arises when the CPSO takes out of circulation doctors, or specific treatments, upon which often hundreds of people desperately depend: in those instances, the CPSO's power turns into an autocratic menace.

Furthermore, consider the following: Dr. E. Leyton of Kingston tried to find out by what formal mechanism he might be able to complain about the CPSO's handling of the discipline proceedings against Dr. F. Adams, as he himself was one of Dr. Adams' pain patients now left without a doctor. Dr. Leyton had followed the disciplinary proceedings closely and agreed with hundreds of fellow patients and the public that this was a case of abuse of process and power.

At the CPSO he was told that a formal complaint was actually not possible. Persisting, he finally filed his formal complaint with Dr. P. McNamara, who is in charge of disciplinary investigations at the CPSO. Dr. Leyton pointed out to Dr. McNamara that this was somewhat peculiar, in fact rather "incestuous", to have to lodge one's complaint about the prosecution with the prosecution. Dr. McNamara acknowledged that this was logically a correct observation, but was not sure just what he could do about that. He did say that he would try to bring this complaint to the attention of the Council, but made it clear, that there is no guarantee whatsoever that council will, in fact, consider this member's complaint. A letter to that effect went out from the CPSO to Dr. Leyton dated May 23, 2001.

The possibility that the membership might want to complain is not envisaged in the CPSO's available mechanism. One might say, that if the membership doesn't like the way their self-governing organization is run, they are free to vote accordingly. That is, however, only possible if all of the members are actually fully informed about how their professional organization is run. The membership also needs access to the records on whatever proceedings they are unhappy about.

The KMPG Report supports the assertion that there is a serious problem of communication and information flow between the membership and the administration. We feel that this problem is not primarily a matter of communication, but a matter of administrative impropriety.

Given the widespread secrecy in the CPSO's very structure and the thick blanket of double-speak that characterizes all communications between the administration and the membership a palace revolt is difficult to bring about. The *Ontario Physicians Alliance* characterized the CPSO as "dehumanizing in tone towards doctors, projecting blame, coercive, unresponsive to physician concerns, hostile, unfair and aggressive". They also accused the CPSO of selling information on doctors, actively supporting legislative moves to erode patient confidentiality, running "kangaroo courts", and mishandling complaints (not informing the doctor, losing files etc.).

This "Glasnost" report, however, is endorsed by a broad range of doctors and constitutes an attempt at initiating reform through CPSO members and supporters of decent medicine. Consider also the fact that the OMA Section on Chronic Pain and the OMA Section on Complementary Medicine were in part formed because its members realized, that only united and organized could they begin to stop the systematic persecution they had been subjected to by the CPSO.

The Star eloquently described the fact that patient complaints can, and all too often do, disappear into the Quality Assurance (QA) process, which is totally secret - a fact the KPMG reviewers were deeply critical of. Its procedures allow the CPSO to protect their own, if they wish, or to get a tight and coercive grip on those they wish to control, while the patient whose complaint brought the matter to their attention, finds out nothing or very little about the result. This allows the CPSO to effectively bury any complaints they do not wish to pursue - and concentrate their resources on those they do want to pursue, <u>in secret</u>.

How greatly the CPSO prefers this secret process becomes evident by the fact that the Alternate Dispute Resolution process (ADR) has disappeared. The KPMG report notes that by May 2000 there were no active ADR cases at all (p.37). The CPSO told the KPMG reviewers that they had found the QA process more effective, since in ADR a doctor cannot be forced to take further training. As the KMPG reviewers did not have as much information available to them as we do, they cannot be faulted for not being aware of the deeper problem involved. **In ADR the patient is central and the two parties are expected to hammer out a mutually agreeable solution to a dispute.** In ADR the patient stands a chance at being on equal footing with the medical establishment, and the doctor stands a chance of clearing up problems if they turn out to be minor. From the point of view of the CPSO this is far messier than QA where the CPSO is not accountable to the patient and cannot be contradicted by them. ADR may be costlier, and since a disproportionate amount of the funds available for "protecting the public" go into the extremely costly Section 75 cases, there may very well be little left for ADR or QA.

To explore this problem of secrecy further, we need to consider what the whistleblowers have said about the complaint-driven discipline process. The most glaring example is the case of **Dr. Kenneth Bradley** reported in the May 5th *Star* cover story. What is especially interesting about that story is the fact, that eventually the discipline process did kick in and did the right thing, but the disciplinary panel's decision was, for some mysterious reason, not carried out.

It is absolutely astounding that a doctor is brought into discipline, investigated, found guilty, has his license revoked - and then the sentence is not carried out. The failure of Deputy Registrar Dr. John Carlisle (who coordinates disciplinary matters) to implement the discipline panel's order is inexplicable, given the rules governing discipline.

This is what the CPSO whistleblowers suggested as an explanation:

Shortly before Dr. Bradley came up for the second disciplinary investigation (completed in November1996), which quite properly resulted in the panel ordering his license to be revoked, he was asked to come to the CPSO office in Toronto. The informant said that Dr. Bradley walked into Deputy Registrar Dr. Carlisle's office where he remained for about an hour. When Dr. Bradley came out, he was followed by Dr. Carlisle "treating him like royalty". After that, the Bradley file was removed from that department and taken into Dr. Carlisle's office. As *The Star* reported, the revocation never was actually carried out, and Dr. Bradley continued to work, which opens the shocking question: Who is in charge at the CPSO? The CPSO informants, who had observed this event, were naturally amazed; the Bradley case was notorious amongst all investigators already ever since the 1987-discipline proceedings. In fact, they couldn't believe that Dr. Bradley was still working when he appeared for this visit in 1996. This case is unique and sheds light on serious administrative impropriety that ought to be investigated.

Possibly the case of gynecologist **Dr. Errol Wai-Ping,** now the subject of a huge class action suit involving the CPSO and others, may have a similar component. Indeed, if the latest *Star* report (June 12, 2001) is correct, the fact that the CPSO's initial decision to move his case into Quality Assurance, instead of Discipline, means that the secret route is, once again, preferred over the route of public accountability: QA means the public cannot observe the proceedings as would have been the case with Discipline. QA also assumes that his license will not be revoked, and that only certain terms, limitations and conditions can be imposed for at most one year. Discipline, on the other hand, has the power to impose even more serious limitations on a license or revoke it outright. It is noteworthy, that the right to public hearings in discipline cases had to be won by court order under a constitutional challenge in the early1990s launched by *The Globe and Mail*. If this challenge had not occurred, discipline hearings would still be secret.

Dr. Bradley subsequently opened a practice in Virginia, USA. CPSO president, Dr. Rocco Gerace, is quoted as saying that Dr. Bradley's Canadian CPSO record would have been made available to Virginia, if a request had been made by the American authorities, adding, "I am not sure we are allowed [to do so]". This is an astounding statement from the College president. Consider the following facts:

1. when Dr. F. Adams had his license temporarily suspended in October 2000, the CPSO lost no time in informing the state licensing boards of California, Texas and New York (Dr. Adams was licensed in all three) that his license had been revoked - which was not the case. His lawyers provided those state boards with the correct information - temporary suspension, not revocation. Upon learning of the details, the Texas authorities renewed Dr. Adams' license immediately because they did not consider themselves bound by the CPSO. The standard of pain medicine the CPSO wished to establish through their suspension had become obsolete in Texas close to a decade earlier. The state of New York held a formal hearing in June 2001 and completely rejected the Ontario handling of the Adams case. This is discussed in more detail below.

2. when Dr. C. Dean, who was working in medical research in New York City, had her license revoked in absentia in 1993, the CPSO immediately informed both New York State and California of the revocation, and she spent considerable time, effort, and money on providing the full information which - again - resulted in both states disregarding the Ontario decision. She still has her US licenses.

What is astonishing is the fact that as per an internal memo prepared by Deputy Registrar Dr. John Carlisle in July 1993 the CPSO is obliged to inform the rest of Canada, the USA and Europe of license revocations of Ontario doctors. Why does CPSO President Dr. R. Gerace not know this? Why did the CPSO inform other jurisdictions in the cases of Dr. Adams and Dr. Dean, but not in the case of Dr. Bradley?

Abuse of College-driven discipline cases: Sections 75 and 59 of RHPA

In 1998 a group of deeply concerned doctors, health care advocacy groups, one lawyer, and one investigative medical journalist decided to form a group called *Committee for the Investigation of the College.* The Committee retained Mr. Michael Code of *Sack, Goldblatt & Mitchell* and provided him with all the available documentary information on a group of 9 Ontario physicians 7 of whom had been subject to disciplinary proceedings under Section 75 and one under Section 59. Over the course of a year, Mr. Code provided his considered opinion on each case. The executive summary of this opinion is to be found in the Appendix as item No. 1. (The full text of this document is

being provided to Premier Harris, the Minister of Health, the Attorney General, and the official Health Critics; it is available to any reader upon request from the Committee whose contact information is given at the end of this report.)

Mr. Code found

1. **That in the case of Dr. M. Smith of Almont "there was *prima facie* evidence that CPSO officials may have committed the criminal offence of obstructing justice by repeatedly misleading the Executive Committee as to the true state of the evidence in this case". In the remaining cases Mr. Code found**
2. **"evidence of abuse and misuse of power"**
3. **"systemic unfairness and repeated abuse and misuse of power" and**
4. **"a consistent pattern of unfairness"**

As Mr. Code had no prior experience with the CPSO or with doctors' cases, he came to this task unbiased and viewed the evidence from the point of view of criminal law. He was sufficiently disturbed and concerned about his findings that he spoke at a press conference held in Queen's Park on May 30th, 2000, where he described in more general terms the cases he had examined. The transcript of that statement is item No. 2 in the Appendix.

Mr. Matthew Wilton, who specializes in medical law, provided an overview, based on many years of personal experience with doctors in Section 75 disciplinary proceedings. His statement is item No. 3 in the Appendix.

At the outset of his in-depth analysis in the March 12, 1999 document, Mr. Code makes the important point, that Section 75 is characterized by its "very high standard of 'reasonable and probable' grounds'. This is the normal standard in criminal cases, for example, for the issuance of a search warrant, for the arrest of a suspect, or for the laying of a charge. It has been described as a standard of 'credibly-based probability' and it is clearly intended to prevent weak and unsubstantiated state intrusions on the individual's right to be left alone. It is a standard that does not ordinarily apply in non-criminal contexts… Presumably, the Legislature chose the high standard of 'reasonable and probable grounds' under s.75 because of the high privacy interest that attaches to medical records and doctors' offices."

A Section 75 order goes out over the signature of the CPSO's Registrar. Mr. Code points out that "it is noteworthy that the s.75 power to launch an investigation is not given to the Registrar alone. Rather, the Registrar must seek the approval of the Executive Committee … in other words; the provision operates like a warrant requirement. It is a form of prior authorization…. This statutory scheme is, again, consistent with the Legislature's desire to erect some degree of protection around the exercise of a power to search a doctor's office, akin to the protections found in the criminal law."

The point is clear; that the authors of the RHPA were aware of the need for safeguards and used those that experience had shown served well in the extreme situation of criminal offences. One might, therefore, assume that reasonable people would invoke such powers when convinced that activities akin to criminal behavior might be suspected - the kind of actions described in *The Star* in connection with Dr. Bradley, for example. In short: the kind of action that hurts, maims and kills people. It is, therefore, all the more surprising to find that the CPSO, whose Registrar and Deputy Registrar both are trained in law and medicine, has managed to abuse this provision in so many cases where there was no demonstrated harm to any patient.

One reason why such abuse can occur has to do with the fact that the CPSO seems to possess greater power than the police.

Mr. Code points out, that there is a major - and disturbing - difference between the police and the CPSO: "… once the Registrar establishes the existence of 'reasonable and probable grounds' to the satisfaction of the Executive Committee, an authority to investigate is granted. The right to enter the doctor's office without a warrant and seize any relevant material, the right to apply for search warrants authorizing entry into and search of any third party premises, and the right to compel testimony pursuant to the *Public Inquires Act* are extraordinary powers. **The first and third of these powers are not possessed by the police."** (Emphasis ours.)

Prior to the 1991 RHPA coming into effect, the comparable clause in the Health Disciplines Act was Section 64, the current Section 75. A well-known case, *Bernstein and the CPSO,* was heard in the Ontario High Court in 1977. It became the gold standard for establishing "reasonable and probable grounds" in medical-legal cases. Justices O'Leary, Steel and Garrett stated that "the degree of proof required in disciplinary matters of this kind is that the proof must be clear and convincing and based upon cogent evidence … the seriousness of the charge is to be considered by the tribunal in its approach to the care it must take in deciding a case which might in fact amount to a sentence of professional death against a doctor."

Before reporting on the results of Mr. Code's analysis, the reader's attention is drawn to page 33 of the KPMG report in which its authors discuss the *Bernstein 1977* case also. There is an inadvertent error in that discussion which turns out, in fact, to be the source of an important - correct - insight. Mr. Wilton drew attention to the fact that the *civil* standard is "balance of probabilities" which means that the prosecution does not have to bend over backwards to give the accused the benefit of the doubt as is required in criminal cases. By contrast, the *criminal* standard of "reasonable and probable grounds" (defined specifically in doctors' cases in *Bernstein 1977* as "clear, cogent and convincing evidence") puts a much greater burden of proof on the prosecution. Indeed, the criminal standard **is** higher, and if that is what the CPSO officials told the KPMG reviewers, they were right. The KPMG writers were under the impression that in discipline cases the civil standard would apply and that "reasonable and probable grounds" constitute the civil standard, which is not so.

The core of the misunderstanding appears to be the notion of what "higher" means. In law "higher" might usefully be described as "handle evidence with extreme care because lives are at stake", or, put another way: "you must give the accused every benefit of the doubt to avoid a possible miscarriage of justice". The prosecution is expected to be terribly careful because so much is at stake, hence the judges in *Bernstein 1977* make the strong point of the possibility of "professional death".

This misunderstanding is interesting because the KPMG authors arrived at a valid and significant critique. They observe, after reporting that they were told the CPSO must uphold a higher standard than the civil one, **"It is not clear why the CPSO has interpreted the standard more strictly than the judgement reads. However, this interpretation can be expected to influence the decisions that the CPSO makes in the complaints and discipline process. It provides some explanation why some CPSO decisions have been publicly criticized, as the CPSO is clearly using a different standard than other observers believe is appropriate." (p.33)**

The KPMG writers appear to misunderstand "higher" as meaning, "zero tolerance". They state that they read the *Bernstein 1977* and *McIntosh 1998* decisions (which, incidentally, are extremely critical of the CPSO's handling of discipline cases and even more scathing in their critique of the complaints process).

It is unlikely KPMG did not notice the extensive publicity on some of the high the profile cases that were in the main stream media throughout 1999 and 2000 (e.g. **Dr. J. Krop, Dr. F. Adams, Dr. S. Kooner** etc.), which is what they appear to refer to. As the extensive quotations from the KPMG Report, provided earlier, have shown, the KPMG reviewers had found that the CPSO's standards of evidence, patient care, procedure, external and internal communication, handling of complaint-driven discipline cases, and guidelines for interpreting the law were characterized by systemic arbitrariness. Thus, the KPMG authors' misunderstanding of the legal definition of civil and criminal standards resulted in bringing into clearer focus the CPSO's systemic pattern of arbitrariness.

To provide an overview of the Kafkaesque nature of the Section 75 abuses, and the effect these abuses have had, and are and are continuing to have, on medical care in Ontario, summaries of some of these physicians' cases are given below. The names of those doctors whose cases are in the public domain are given; identifiers are used in those cases that are not in the public domain or where the documentation was provided to us by CPSO whistleblowers. As the whistleblowers commented on some of these cases, their comments are included where applicable.

Dr. X.
See item no. 6 in APPENDIX

The documentation on this case was provided by one of the CPSO whistleblowers, and as this doctor's case did not enter the public domain, his identity is not given here. As item 4 shows, this is an internal CPSO memo from Deputy Registrar Dr. John Carlisle to the Registrar, then Dr. M. Dixon; attached to the memo is a letter Dr. Carlisle received from the CPSO legal counsel, Mr. Donald Posluns. Mr. Posluns informed Dr. Carlisle on February 5th, 1995, that an ongoing discipline case under Section 75 was running into problems as far as the prosecuting CPSO was concerned.

The doctor in question was being investigated since 1988 under Section 75 because of the death of a patient. The doctor was using therapeutic methods typical for a medical specialty known as prolo therapy (or sclerotherapy, a form of orthopedic medicine). The College was aware that the cause of death was "speculative" and that it was highly unlikely that it could be proven that Dr. X's therapy caused the death. The patient had suffered from serious pre-existing conditions which the coroner was unable to connect to the therapy she had received from Dr. X. for her back pain. Nevertheless, Dr. Carlisle had advised the Complaints Committee on January 28, 1988, to "investigate the man's entire practice" (note the long stretch of time involved). In Mr. Posluns' February 5th memo to Dr. Carlisle he states also that "the cause of death is unknown". This same memo shows that, the CPSO, having decided to use this event to prosecute prolo therapy starting in 1988, found itself now in the position of having to abandoned this Section 75 case because of the following development:

Mr. Posluns wrote to Dr. Carlisle: "Near the end of September, 1994, the defense disclosed two expert opinions which, in essence, say that (1) prolo therapy is acceptable and useful and (2) Dr. X. followed conventional prolo therapy practices. One [of these] experts is a RCPSC-certified internist who has published the North American magnum opus on orthopedic medicine, and the other is a locally trained physician who won many academic awards in medical school and has an impressive record of local service both to the medical and general communities."

Mr. Posluns then explaining the legal implications of such impressive witnesses and the fact that it would not be possible to prove lack of consent, and that nothing else could then really be found against Dr. X, "The question now is," he concluded, "whether to proceed with such a case or dispose of it by some alternative method." He observes that the doctor's defense is essentially "complete" because "the doctor followed a school of thought that is accepted by respectable peers". Furthermore, "in order to prove that the physician failed to provide sufficient information for an informed consent, the College would need to prove that the physician failed to warn of *known* risks of the recommended treatment. Prolo therapy has no known *specific* risks and the *general* risks are quite small." (Emphasis his.)

Logically, Mr. Posluns concluded "If the College prosecutes a case of prolo therapy and loses, then it will find *it almost impossible to pursue any subsequent case of prolo therapy.* At the present time the College is still in a position to insist that *prolo therapists (and other unconventional practitioners*) warn patients of the unconventionality of their treatment….. If a statutory body like the College maintains a prosecution against a physician which is certain to fail, the College is liable to the physician in a civil action for malicious prosecution." (Emphasis ours.)

Having acknowledged that the doctor's defense is complete due to the stature of the defense's expert witnesses, Mr. Posluns, nevertheless, goes on to assert that prolo therapy is one of those "unconventional" practices that the CPSO wants to keep an eye on. One must assume that everybody privy to this information agrees in principle with a policy of using the disciplinary process to establish arbitrary standards of practice.

Upon receipt of this advice, Dr. Carlisle sent a memo to the Registrar on February 6, 1995, the following day. In it he made the point several times that a Section 75 is a very expensive process and that this fact should be taken into account. He asked the Registrar to inform the Executive that Mr. Posluns' advice should be considered, namely to drop the case by getting the doctor to enter into some sort of agreement with the College.

Dr. X did not know that the College had no grounds to prosecute him and did not learn of the reasons for the abandonment of his case until we told him and sent him a copy of these documents. He was absolutely astounded and also informed us that he had now (200-2001) been put into Peer Assessment, but the tests he was about to take at McMaster University Medical School were the ones given to GPs; he felt he was being set up for mediocre results if not outright failure since he had not practiced as a GP for at least three decades, his practice being almost exclusively devoted to prolo therapy. Since Peer Assessment is part of the essentially secret Quality Assurance process, there is no way for Dr. X but to play along as he is told to. He also told us, that the College insisted (six years after his Section 75 investigation was abandoned) that they would not recognize prolo therapy and, therefore, would not provide him with a peer, as Dr. X had requested.

We have in this case all the elements of bias, impropriety, disregard for scientific fact, and harassment as well as collusion amongst the key people running the CPSO. The reason Mr. Posluns advised the College to drop the case against Dr. X was merely based on the fact that it had become too hot to handle, not because the defense witnesses were acknowledged (in the spirit of professional collegiality) as representing sound medicine. Worst of all, the legal counsel for the CPSO and the Deputy Registrar, Dr. Carlisle, are both fully aware of what they are doing, namely using the disciplinary process to establish arbitrary standards of medical practice. What the membership expects, however,
is that rudimentary scientific consensus and a proper treatment of evidence informs the policies of self-governance.

CPSO Legal Counsel Mr. Posluns and Deputy Registrar Dr. J. Carlisle seem to know they are within the range of abuse of law. Their memos give one the impression that two people are gauging how much they can get away with. The Registrar, to whom all of this information is being provided, must be seen as equally aware of what is going on, since there seems to be no hesitation on the part of Dr. Carlisle to include the Registrar in the discussion. Even more astonishing is the fact that the Executive Committee seems to be part of the same mindset, as they were the ones to whom all of this material is addressed for purposes of action. Legal Counsel and Deputy Registrar have no fear at all of being asked what on earth they are doing with this member.

Everybody in the administration appeared to follow this policy knowingly. In this case the stated excuse for improper use of disciplinary powers is the tragic death of a patient. However, as the cases below will illustrate, whether a patient dies or is cured, whether the patient is injured or vastly improved against all odds, all has little bearing on how the CPSO pursues a discipline case, if the therapeutic methods or medical specialty in question happens to be in disfavor in the CPSO administration. This disfavor is not based on membership consensus, nor on science, as Mr. Poslun's discussion of the expert witness indicated. Our position is that this amounts to an unacceptable violation of the spirit and the letter of Ontario's health legislation.

Dr. R. KIDD
Part of item 1 in the APPENDIX

The CPSO disciplinary action began against Dr. Kidd on the basis of what might reasonably be called a "snitch-line" type of action. A colleague, who happened to disapprove of orthopedic medicine (in which he is not trained) chose to ignore the positive patient outcome recorded in a consultation note he accidentally received through a secretarial error on one of Dr. Kidd's patients. The note should have gone to the referring doctor instead, but rather than forward it to the proper recipient, he sent it to Deputy Registrar Dr. John Carlisle at the CPSO. Action commenced in the absence of patient complaint or a negative clinical outcome and without Dr. Kidd knowing why. Dr. Carlisle never informed Dr. Kidd of how the case against him began, Dr. Kidd eventually found out himself through colleagues working in the same hospital, and all of this material was later provided to Mr. Code.

The second item of fact provides insight on how investigation reports are sometimes done.

The CPSO inspector's report on Dr. Kidd's practice was written and filed before Dr. Kidd had the opportunity to provide the medical literature that investigator had specifically requested from Dr. Kidd for the report on this practice. The time frame was less than a week.

When this premature report was filed with the CPSO and it had, thus, become clear that natural justice was not going to be afforded to Dr. Kidd, his lawyer doggedly persisted, in letter after letter to Dr. Carlisle, in demanding that "reasonable and probable grounds" be provided before commencing with disciplinary hearings. It appears, the CPSO got tired of that determined approach, or was too busy with other, possibly more promising, cases. In 1996 Dr. Kidd's case was shelved. Nothing has happened to date, but the case is still not officially closed or resolved.

Mr. Code' in his analysis of the case, stated that "there is nothing in the Minute or the letter [from the CPSO] about the existence of reasonable and probable grounds to believe that Dr. Kidd is incompetent or has engaged in professional misconduct. Dr. Kidd had written a powerful and persuasive rebuttal to Dr. Jones' [CPSO inspector] flawed and hurried report. Section 65 [the current Section 75] is not a vehicle to simply gather further information about a doctor. It requires an objectively based belief in probable guilt of professional misconduct or incompetence. As in so many of the other doctors' cases, the record in Dr. Kidd's case shows a complete failure by CPSO officials to direct their minds to the relevant statutory test before exercising their significant legal powers." (Emphasis in the original.)

Dr. F. RAVIKOVICH
Part of items no. 1 and 5, see also items 7, 8, 9 and 10 in the APPENDIX

Dr. Ravikovich, a graduate of the Leningrad Medical Institute, worked for many years at a teaching hospital in the former Soviet Union. He earned his specialization degrees in allergy and internal medicine. He came to Canada as refugees in the early 1980's. During the Cold War, medical science progressed in different directions on either side of the Iron Curtain. Most notably, the development of pharmaceuticals was prevented by the Communist regimes of the east block, which resulted in medical research focusing on what we would call "alternative" ways of treating disease - often with extraordinary success. Hence, Dr. Ravikovich brought with him knowledge and research into the treatment of allergy, and especially asthma, which had been validated in medical science and clinical application in the former Soviet Union. He lectured widely, including at the annual International Congress of Allergy and Immunology and attracted the attention of researchers at Stanford University in the US. In 1992 the University of Tel Aviv, Israel, asked Dr. Ravikovich to join an Israeli research team at Hadassa University in a large double-blind study of histamine treatment for asthma. He had to abandon that project because he was brought into discipline by the CPSO - on what basis is still unknown.

No patient complaint is on record against Dr. Ravikovich. Yet, to this day the CPSO web site states that the action taken against this physician is based on five patient complaints. Numerous efforts at correction, even by Dr. Ravikovich's lawyers, have been unsuccessful.

Initially, the CPSO asked questions in 1988 about his practice, which Dr. Ravikovich misunderstood to be interest in a new and effective asthma treatment with which he had a vast experience. He has reported in the international literature the results of histamine treatment with some 1,500 patients. Naively and enthusiastically, Dr. Ravikovich provided the CPSO with 200 files voluntarily for purposes of discussion. He quickly learned that, instead, he was the subject of a Peer Assessment. While he continued to be under the impression that he was to be peer assessed, Mr. Code's analysis shows the following had actually happened:

"The initial s.64 Order against Dr. Ravikovich was made by the Executive Committee on December 12 and 13, 1989. The appointment of inspectors under s.64 did not occur until September 13, 1990 [i.e. 9 months later]. In between these two dates, Dr. Carlisle, the Deputy Registrar, wrote to Dr. Ravikovich, by letter dated February 6, 1990, and elicited information about Dr. Ravikovich's use of histamine therapy. Dr. Carlisle did not inform Dr. Ravikovich that the Executive Committee had already made a s.64 Order against him two months earlier. Indeed, Dr. Carlisle's letter is positively misleading on this subject, as he states: The *Executive Committee has not reached any conclusion on this matter, but invites your comment*. This letter should have been written before the s. 64 Order was made. It was unfair and less than frank to write such a misleading letter after the s.64 Order had been made. The conduct of CPSO officials, in this aspect of the matter, provides further evidence of a number of themes that we have seen in the other cases."

Mr. Code concluded that "this case does support and confirm the pattern of abuse and misuse of its disciplinary powers by CPSO officials." This abuse is further compounded by the fact that it is completely improper to transmute a Quality Assurance case into a disciplinary one - leave alone without telling the physician that the second is already approved while pretending that it is the first that is in progress.

The s. 64 Order against Dr. Ravikovich is based on a "histamine challenge test" which the CPSO Executive correctly identified as being obsolete for at least 30 years. (See item 7 in Appendix) Dr. Ravikovich never used this test which, incidentally, requires equipment no longer available. He invited the CPSO inspectors to see his office and confirm his statement. The disciplinary process ended in June 1995. This original stem allegation, which it was incumbent upon the CPSO to prove, was never mentioned again, no arguments were made, no witnesses called, and Dr. Ravikovich's assertion that he never used such a test was not dealt with in any way whatsoever. Indeed, the basis of the entire disciplinary action against Dr. Ravikovich mysteriously transformed itself on

September 13, 1990, when the allegations against him changed from the original alleged use of the "histamine challenge test" to the use of histamine as a therapeutic agent. Proof that the Executive Committee had, in fact, approved this change of direction, was never provided despite Dr. Ravikovich's lawyers asking for it repeatedly.

No patient complaints existed either, instead the proceedings became focused on whether or not Dr. Ravikovich's work was "scientifically valid". The CPSO provided only one published medical paper in the prosecution's support which was an article published by the *British Society of Allergy and Immunology*. This article asserted that the basis for clinical work should be a) double blind studies and b) clinical experience and personal judgement. The CPSO prosecution did not mention point b in their legal arguments and in the exhibit cited only point a. When the defense drew attention to this selective quoting, the prosecution withdrew its one and only piece of supporting evidence completely. The case proceeded without expert witnesses, without discussion of patient files, and without consideration of the 200 (!) scientific papers provided by the defense, and without discussion of the stem allegation in the Notice of Hearing. Originally, the CPSO sought revocation of license, but the near total lack of any material on which to base anything at all, may have forced the Discipline Panel into changing the penalty to a reprimand - and a most peculiar restriction on his license.

The Sentence of June 23, 1995 provides for the following penalty: "1. Dr. Ravikovich is to be reprimanded and the fact of the reprimand is to be recorded on the Register. 2. A restriction on Dr. Ravikovich's Certificate of Registration is to be imposed for an indefinite period, prohibiting Dr. Ravikovich from employing histamine for purposes of diagnosis or therapy…. Dr. Ravikovich is not to employ any biological material which contains histamine." The Penalty concludes:" The Committee believes that the public is protected by the Order it made, in that it prohibits Dr. Ravikovich… from using histamine as a diagnostic or therapeutic tool when there is no scientific or medical validity to use it."

The irony of this Penalty is that histamine is a substance that does not require a doctor's prescription and is required to be on hand in every allergist's practice for various emergency situations or as a control substance.

A significant procedural impropriety occurred in this case as well: item 8 in the Appendix is the copy of a scientific paper published by Dr. Ravikovich in which he reproduced a table of facts concerning the biological activities and effects known to science about histamine. It is derived from publications of a world-renowned expert on histamine, S. Holgate. Additionally, a similar table from the then current textbook on allergy (used also at the University of Toronto medical school, while this case was being pursued at the CPSO) was appended to Dr. Ravikovich's article. That textbook then was *Allergy*, edited by A. Kaplan, 1985. Both these tables were central to the defense's documentation because they provided the summary of the internationally accepted basis for the medical use of histamine. These two tables were missing in the files provided to the Discipline

Committee. Repeatedly attention was drawn to the importance of these documents and the demand was made to correct the error - but it was not corrected.

In sum, the case has an unknown origin, was initiated secretly on the basis of an erroneous allegation concerning an antiquated testing process, proceeded as an argument about scientific validity without the benefit of the published science involved, and was concluded without supporting scientific or patient-outcome evidence. The prosecuting CPSO failed to prove anything, but asserted that they were protecting the public from potential harm, which was neither discussed nor proven. The Ravikovich case has the characteristics of a phantom.

Item 9 in the Appendix is a letter dated November 8, 1992, by Dr. Ravikovich to Deputy Registrar Dr. J. Carlisle asking him what to do with his desperate asthma patients. No reply was ever received. Asthma, especially in children, has increased four fold in the last decade and is identified by the World Health Organization as one of the most serious health problems. Far from experiencing themselves as the protected public, hundreds of these desperate asthma patients went public, resulting in a *Fifth Estate* TV program aired March 16, 1993, the transcript of which is provided in item 10 in the Appendix.

An important question is raised here: does the passage of the Kwinter Bill renders this absurd CPSO decision against Dr. Ravikovich's asthma treatment obsolete? Many asthma patients in Ontario are waiting for an answer breathlessly.

Dr. J. KROP
Part of item no.1 and items 11 and 12 in the APPENDIX

This case is possibly the longest running discipline case in medical history. It began in 1988, the investigation itself commenced in 1991, and the Notice of Hearing went out in 1994. A total of 37 hearing days took place between 1995 and 1998 with a hiatus of no activity or hearings in 1996. This hiatus is one of the many mysteries of this case. Presumably a disciplinary hearing is supposed to serve the public interest and such a delay requires explanation. The delay was caused by the CPSO, not the defense. The case cost over $ 1 million to defend, most of it raised by public donations through the efforts of the *Environmental Health Group* which is a sponsor of this submission. The cost to the CPSO was likely close to double that. Deputy Registrar, Dr. J. Carlisle observed in an internal memo of September 1988 to the executive committee: **"This will be a costly and lengthy process, but may be the only way of finally, once and for all, dealing with these clinical ecologists".**

The CPSO's then legal counsel, Mr. Richard Steinecke, recommended in a memo of September 17, 1993, not to proceed on the grounds that "such cases [note the plural] cannot succeed unless one has either 1) an angry, exploited patient, or 2) actual harm to a patient." He went on to say, "In order to succeed, we will have to prove that his defense experts are not reputable or credible. In my view the College does not have a solid case at this point, and the matter should not be referred to a hearing. As you know, there are additional reasons for caution as this case has a high publicity potential." But the case went forward with another lawyer, Mr. Robert Armstrong of Tory & Tory.

Every effort was made to find a patient who would side with the prosecution. An internal e-mail memo from an investigator to the then chief of investigations, Mr. Ed Singleton, of March 3, 1994 is seen in item 11 in the Appendix. It states that "**interviews have been conducted with potential witnesses. All of whom are very supportive of Dr. Krop. We have been unable to locate others and attempts are continuing in this regard."** This memo is signed "thanks, Ed [Singleton who was chief of prosecutions then]". An estimated 200 patients of Dr. Krop's were sought out for interviews by the CPSO inspectors - without success.

One person was persuaded to testify against Dr. Krop. This former patient did not file a formal complaint. During cross-examination this patient's testimony fell apart and had to be withdrawn by the prosecution. This case is briefly referred to a "complaint" in Mr. Code's opinion given below where the context of his remarks is that moment in time where the prosecuting CPSO attempted to make this patient into a complainant. Interestingly, just prior to coming on the stand, this person claimed disability for repetitive motion injury after having worked in a flower shop for three weeks. She received this pension shortly after, following her testimony before the CPSO, during which she referred to the CPSO lawyer, Mr. Robert Armstrong, always as "Bob". The details are in the transcripts and available upon request.

The procedural improprieties and peculiarities in this case are so numerous, that only a few can be mentioned here. For example, during a disclosure meeting at the CPSO offices, Mr. Armstrong slammed a wooden gavel on the table and exclaimed, **"You are not entitled to disclosure, your only aim is to destroy the College."**

Furthermore, the charges were formulated after the inspectors had taken patient charts and commenced the investigation. Dr. Krop also did not know why and by whom he was accused of what. In response to Dr. Krop's lawyer insisting on knowing why an investigation was being initiated, Deputy Registrar Dr. John Carlisle replied on February 19, 1989**,"We understand that Dr. Krop is presently participating in a research project proposal at the University of Toronto, and it is partly in response to that knowledge that we believe these preliminary inquiries are necessary."**

Since this reasoning parallels the approach taken with Dr. Ravikovich, one gets the impression that the discipline process is used to establish medical standards such as to prevent medical developments from occurring.

The hearings proceeded without a mandatory report on Dr. Krop's practice presumably because the original report, provided by Dr. McFadden, even after several re-writes, was so unacceptably full of errors, the CPSO prosecution could not use it. Instead, a report by Dr. McCourtie (who had also done a report on Dr. Ravikovich) was circulated among the members of the Discipline Panel, but Dr. McCourtie had never set foot in Dr. Krop's practice and had not had the opportunity to review the files taken by the inspectors. Because of his stated bias against environmental medicine, Dr. McCourtie's report also had to be withdrawn when the hearings finally began.

The record shows that the prosecution's expert witnesses all admitted in their testimony that they were unfamiliar with environmental medicine. The extensive peer review done by the *American Academy of Environmental Medicine* (AAEM), an international medical association that trains physicians in environmental medicine, was not considered by the CPSO: Deputy Registrar Dr. John Carlisle stated in a memo to the Registrar, on this issue, that allowing the opinion of a peer would be **"like sending the fox to guard the hen house."** The American Medical Association recognizes the AAEM, of which Dr. Krop is a fellow. AAEM courses are accredited in the USA, and a considerable number of their members also hold university positions at medical schools in the US, Canada, and Europe. Germany has since 1995 incorporated environmental medicine into the curriculum of every medical school in the country.

Virtually all medical literature (much of it double-blind and placebo-controlled studies from around the world) published after 1990 was simply ignored by the CPSO in their deliberations and final Decision. The Notice of Hearing was served in 1994. Ignoring the material available in the international literature between 1990 and 1994 suggests deliberate bias. This means, that the explosion of scientific information from universities around the world dealing with the impact of environmental agents on health was effectively ruled out. The CPSO's discipline panel observed in their 1998 Decision with the sophistry of a latter day revival of the Spanish Inquisition, that all the evidence submitted by the defense was found **"lacking in the authority of acceptable scientific evidence".** The Decision handed down in 1998 stated that "**the central issue has to do with the use of an unscientific hypothesis"** concerning various environmentally induced conditions and various treatment modalities.

Patient outcome was of no consequence. In the transcripts, the then Registrar, Dr. Michael Dixon, stated in cross-examination in December 1995: **"that fact that patients are benefited is not necessarily information that's terribly helpful".** Being asked at this time also whether he agreed with Dr. Carlisle's assertion that this disciplinary investigation was intended to be an example to all doctors practicing environmental medicine (clinical ecology), so that it would "deal, once and for all, with these clinical ecologists", he replied **"Yes."**

Seeking originally revocation of license, for some mysterious reason, the CPSO downgraded the penalty to a reprimand. The Sentence stated that Dr. Krop was free to continue all those very therapies which the decision had judged to be sub-standard. Dr. Krop was asked to accept a reprimand because his diagnoses and therapies were "lacking in scientific validity". In addition, a Byzantine amendment to the consent forms was ordered: Dr. Krop is to tell his patients that whatever he is diagnosing and whatever treatment he offers is based only on his "personal opinions and beliefs, not scientifically substantiated medicine". Dr. Krop is appealing because he is not willing to allow his patients to be treated as fools and to be party to untruthful assertions. The numerous legal improprieties also demand an appeal.

Mr. Code studied the Krop case and focused on the many legal improprieties of which only a couple are discussed here.

In his June 9,1999, analysis of the Krop case, Mr. Code observes further: "The allegations against Dr. Krop, from beginning to end, involved the simple assertion that he was practicing an experimental form of medicine (known as Environmental Medicine), whose practices and premises have not yet been rigorously tested…. Nevertheless, the core of this form of medicine appears to be the rather unremarkable proposition that environmental toxins influence our health." Mr. Code points out that after ten years of investigation, "the Discipline Committee concluded that Dr. Krop's experimental medicine pactices 'did not harm them [his patients] in any physical sense."

Mr. Code is especially shocked by the following impropriety: "The only records we have, as to whether senior CPSO officials formed these requisite beliefs [about whether reasonable and probable grounds for an investigation actually existed] is the September 27, 1989 memo from Dr. Carlisle to [Registrar] Dr. Dixon, and the October 6, 1989, Minutes from the Executive Committee. Neither document appears to reflect any real attempt by Dr. Carlisle or Dr. Dixon to direct their minds to the proper statutory test. Dr. Carlisle's memo states: **'In all the circumstances, the Department is of the opinion that Dr. Krop's practice should be subjected to an investigation under s.64 and if anything is needed to form a basis for that, the complaint of Mrs. C. will do. All the other complaints may be seen as in aid of this'**. [Emphasis added by Mr. Code.]"

Mr. Code then observes," Dr. Carlisle's memo to Dr. Dixon is particularly shocking, in my opinion. It reveals a very casual, almost cavalier, approach to the very serious task of formulating reasonable and probable grounds. His statement *if anything is needed the C. complaint will do*, suggests outright contempt for the strict process enshrined in statute. At a minimum he has failed to direct his mind to the requisite test in law, as set out above, namely, an objective basis for a belief in probable guilt."

Mr. Code discussed the various documents in which Deputy Registrar Dr. Carlisle and Registrar Dr. Dixon express deep bias against virtually anything connected with clinical ecology and Dr. Krop's practice. The most serious evidence of bias appeared in their not reading the material provided by the defense and submitted by the defense at the request

of the prosecution, specifically by Deputy Registrar Dr. J. Carlisle himself in his correspondence with Dr. Krop's lawyers. The full details are found in the cross-examination of Dr. Carlisle in item 12 of the Appendix. The full cross-examination is provided so none of the context is lost in the reading.

Mr. Code stated: "In my opinion, Dr. Carlisle and Dr. Dixon could not fairly and impartially carry out their statutory duties under s. 64 in this case without reading and considering the materials submitted by Dr. Krop …. **When a judge decides a case without considering evidence tendered by the defense that is relevant to a material issue, we say that there has been a miscarriage of justice because the decision 'is not based exclusively on the evidence and is not a true verdict'. This what happened in Dr. Krop's case, in my opinion."** (Emphasis ours.)

Mr. Code was especially disturbed by the following quote from a letter by Deputy Registrar Dr. John Carlisle to Dr. Krop's lawyer: **"We are, with respect to Dr. Krop and his patients, not interested in receiving affidavits from patients who are satisfied nor any other form of testimonial … We do not for a moment mean to suggest that these parties are not telling the truth or are exaggerating their statements, but merely that testimonials are of no value in establishing scientific principles.** (Emphasis added by Mr. Code.)"

In conclusion, Mr. Code observes: "The proceedings against Dr. Krop would, therefore, appear to involve the *Alice in Wonderland* proposition that doctors are to be disciplined on the basis of some pure scientific principle that has no regard for actual harm and no regard for the satisfaction or dissatisfaction of the patients. That CPSO would spend ten long years, from 1988-1998, pursuing this kind of enormous expense through endless disciplinary processes would seem, at a minimum, show inappropriate judgement and over-zealousness."

Dr. Krop has appealed the CPSO Decision because, in addition to the procedural abuse he experienced, he rejects the reprimand which is based on arbitrary assertions about science and requires, through the consent procedures, that patients agree with the arbitrary CPSO view. Thus the Decision essentially condemns a number of diseases recognized internationally, researched at the world's top medical schools, and recognized by the *World Health Organization.* It also condemns treatments which are based on rigorous scientific research published in peer reviewed medical journals the world over. The appeal is going to be heard in the Divisional Court in December 2001.

Dr. F. ADAMS
See items 13 through 21 in the APPENDIX

Dr. Adams, formerly of Kingston, is a neuropsychiatrist and a diplomate of the American Academy of Experts in Traumatic Stress, American Academy of Pain Management, and the Royal College of Physicians and Surgeons of Canada. He has taught at Queen's University in Ontario, the University of Texas, and the University of Toronto. He established the pain service at the University of Texas at the world's largest cancer care center. His research was central to the recent major changes made by the US medical licensing boards and the guidelines for pain management formulated by the World Health Organization; Dr. Adams was involved with both during this process. He originally developed several of the standard tests used by neurospychiatrists worldwide also. He has directed many pain management centers for the US and in Canada. His CV of 19 pages provides information on his many publications in the world's peer reviewed medical journals on the editorial boards of many of which he also served.

Without a single complaint or known clinical misadventure he was brought into discipline by the CPSO in May 1998. No disclosure was ever given to Dr. Adams or his lawyer as to how this case commenced. Seven months later a report was provided by CPSO investigator Dr. A. McFarlane, who is not a neuropsychiatrist or even a pain specialist. The factual errors were so numerous, the CPSO withdrew the report. A new report was commissioned by the CPSO from Dr. D. Moulin. It was written without interviewing Dr. Adams or the patients whose charts were the basis of the report. The report was ready in July 1999. Before even commencing the hearings, the CPSO imposed restrictions on Dr. Adams' license.

None of the files taken for the investigations showed a single instance of harm done to a patient, not one instance of addiction having developed, lack of appropriate tests (such as liver function monitoring when potentially toxic drugs are used). Because of the exceptionally good results Dr. Adams had achieved in some of the most severe cases of chronic pain, and which the prosecution used as evidence for proving incompetence, the suggestion had been made by the editors of the Canadian pain journal, *Pain Research and Management,* that these cases should be prepared for publication.

Eight hearing days took place in September 1999. The defense introduced voluminous pain management literature, including Dr. Adams' own papers. One of his expert witnesses was the internationally renowned pain expert, Dr. Harold Merskey, professor emeritus of the University of Western Ontario and editor of the above-mentioned medical journal. The prosecution introduced as their primary evidence the Alberta Pain Management Guidelines. Since the CPSO's own were not completed until December 2000, they might have introduced the international guidelines adopted by the World Health Organization. That would have meant, however, judging Dr. Adams by guidelines he had helped to create. The authors of these Alberta Guidelines had some time previous to this disciplinary event submitted their document to Dr. Adams for review. Following his assessment, the authors of this review had declared their guidelines obsolete. This

fact is not in evidence in the Decision rendered in April 2000; instead, the Decision states that by not following the Alberta Guidelines Dr. Adams was proven to be falling below the standard of medical practice. The transcripts of the hearings on September 9, 1999, provide the following interesting passage:

"The idea of standards [of practice] is to avoid trouble," Mr. Donald Posluns, acting for the prosecution, stated. "The College doesn't have the burden to show you that patients are dead or disabled or actually toxic; the College is obliged to demonstrate that at the time the doctor did or didn't do something …. Not that there were some adverse consequences….certain patients showed improvement, that's true, but that's not the question."

The approach taken by the prosecuting CPSO here is once again one of the requiring a member to follow an arbitrarily imposed and selectively chosen standard of practice unrelated to recorded, empirical results and the needs and choices of the specific patient, in contravention of the spirit of the RHPA.

The CPSO's expert witness, Dr. Moulin, complicated the situation for the prosecution because he did not feel that Dr. Adams should lose his license. Even more astonishing was the following development:

A member of the CPSO Council who also sat on the Discipline Committee, Dr. Ellen Thompson of Ottawa, herself a pain specialist, submitted her protest against these proceedings in writing to the Executive Committee and then went public as well on the subsequent CBC television *Fifth Estate* program devoted to the Adams case. She declared the CPSO's attitude as being "in the pre-Cambrian era when it comes to pain management". This prompted censure from the then Registrar, Dr. J. Bonn, who faulted Dr. Thompson for not being a "team player". Indeed, the Adams case took place at the same time during which the US medical licensing boards declared pain the Fifth Vital Sign, which must be treated on par with the other four.

Dr. Thompson, then a CPSO Council member, stated publicly that the discipline's process, in her experience as one of the Discpline Committee members, is "often fishing expeditions, which they [CPSO] abandon only if they can't find what they are looking for in the first place."

Because so many severely ill patients were affected by the Adams case, a storm of public protest arose. More than 8,000 (eight thousand) faxes and letters were sent to the Registrar by patients and family members of those patients. The media featured the case prominently (see items 13,14,15 in Appendix). Formal complaints were also lodged against the Registrar and the Deputy Registrar by both patients and doctors.

In support of the prosecution's desire to revoke Dr. Adams' license, CPSO lawyer Mr. Posluns produced during the summation phase of the proceedings a quotation from a *Medical Post* article. In it, some years ago, Dr. Adams passionately criticized pain management in dying cancer patients in Ontario's hospitals as being no different than Nazi medicine, i.e. merciless.

Mr. Posluns declared that Dr. Adams "is incorrigible" and that nothing less than revocation of license was indicated because, in order "to change his ways he tells you he would have to become Nazi, which he will not do, so we have here a clear case of ego-centricity compounded by grandiosity". Mr. Posluns stated that "the CPSO cannot take responsibility for Dr. Adams like for a slightly retarded and unruly elementary school student who is lacking in prudent judgement." Only revocation of his license would ensure compliance, since Dr. Adams had made it amply clear that he did not intend to adopt the pain management ideas the CPSO wanted him to agree to. (July 21, 2000).

The context of Dr. Adams newspaper statement is important: Dr. Adams was commenting on the fact that Ontario palliative care wards were spending more and more money on physical restraints to keep thrashing and screaming patients under control, instead of providing full and readily available sedation. These circumstances, incidentally, led to the federal government's first Senate report on pain management in 1995. And indeed, at the same time that Dr. Adams' case was being heard at the CPSO, Senator Sharon Carstairs and her committee issued their second (July 2000) report severely criticizing the lack of pain management in Canada once again. One of the members of that committee, Dr. Helen Hayes, who was awarded the Order of Canada for her palliative pain work, made a point of writing to the CPSO expressing her criticism of the Adams prosecution and commending him for his outstanding contributions to pain research and management.

Presumably due to the escalating public protest covered throughout the mainstream media for months (e.g. *Macleans* magazine, *CBC Fifth Estate* and CBC radio's Michael Enright items 13, 14, 15) the Discipline Panel did not pursue revocation, but imposed a temporary suspension and ordered skills upgrading as well as long-term restrictions of such a nature that Dr. Adams found it was impossible to practice in Ontario.

At the same time, the then Registrar, Dr. J. Bonn, took the unprecedented step of devoting an editorial in the CPSO's *Members' Dialogue* (Appendix item 16) to the Adams case, assuring the membership that this had nothing to do with the use of opiates. However, his assertions did not reflect what happened at the hearings nor did it harmonize with the content of the Penalty. The contradictions are listed in item 16.

The Penalty states that its purpose is "to send a message as a general deterrent to all physicians". As the case centered specifically on the use of opiates, the "message" can only be about their use.

Then Registrar, Dr. J. Bonn stated on CBC radio (Appendix item 14) that the CPSO had to prosecute Dr. Adams because he was not following any guidelines at all. In fact he was following the international guidelines already accepted in several provinces in Canada. The full story of the Adams case was well researched and presented by CBC's *Fifth Estate* (transcript in item 17 of the Appendix).

Significantly, the Federation of Medical Licensing boards of the USA and the federation of Canada's medical colleges have been formally affiliated with each other for many years. Part of that affiliation requires mutual recognition of each other's standards. Dr. Bonn's statement was, therefore, incorrect in many respects. In theory, Canada ought to recognize the US (and therefore also the international) standards on pain management and hence ought not to have prosecuted Dr. Adams at all.

Dr. Adams was ordered to take re-training and to be assessed by the CPSO-appointed preceptors at Queen's University. (They were surprised, as they felt that he should be teaching them pain medicine.) The report that was issued by Queen's University (see Appendix item 18) stated unequivocally that Dr. Adams' license should be restored and all restrictions lifted. However, then Registrar Dr. J. Bonn, without referring this matter back to the Discipline Panel or the Executive Committee for reconsideration, instructed Dr. Adams' lawyer that the license would be reinstated only if Dr. Adams guaranteed to abide by those very restrictions for the next three years (Appendix item 19).

Shocked by the rampant impropriety of this case, Dr. Merskey was joined by CPSO Council member Dr. E. Thompson, and they produced an analysis of the Adams case which actually does reflect the facts from the hearings and the Decision (Appendix item 20) and provided it to the media at a Queen's Park press conference on March 28th, 2001.

Unable to work in his field, Dr. Adams decided to leave Canada and return to the US where his license in Texas was renewed with that state licensing boards full knowledge of the actions taken against him in Ontario.

Prior to his departure, Dr. Adams spoke at that same press conference. (Transcript in Appendix item 21.) Dr. Adams made two significant points. Regarding the first he outlined that the CPSO had ordered him to see his most severe pain patients every 15 days for prescription renewals. Besides being medically not indicated and causing enormous inconvenience to these very sick people coming from all over the province, the financial implications were astounding for the province as well.

He said:

"Every 15 days to see [these] patients would have been a financial windfall and I would have become quite wealthy over the next three years [the period for which this restriction was in place]. I calculated that I would have grossed better than $ 1.5 million billing the way the College wishes me to bill. Premier Harris is continuously upset by the burgeoning health care budget and has repeatedly asked physicians to bill responsibly … the College chooses to overlook that and has now not only mandated but actually commanded that, in essence, what I do is commit OHIP fraud for the next three years."

Because the Adams case is seen by the OMA Pain Section members as setting a precedent, the financial implications indicate a possible annual increase in OHIP spending of roughly $ 120 million, if the 300 pain doctors in the province have to accept the Adams Decision's deterrent. Lawyer Mr. Matthew Wilton, who specializes in medical cases, sees this as a very real possibility. (Appendix item 3.)

The second important point Dr. Adams made concerned the terrible human cost of his prosecution. **"I hold [Dr. Bonn and Dr. Carlisle] morally culpable for the incredible amount of physical pain that they have created in this province, when they suspended my license, and for the two hundred and some patients who then went without medication. I kept the office phone going for some time after my suspension… However, it was very difficult, no matter who you are… to tolerate hearing people on the other end of the phone screaming, crying, gagging, actively vomiting, describing a litany of symptoms and a litany of despair because they were out of medication."**

The main reason Dr. Adams, now 5 months without an income, left Canada was that the restrictions effectively stopped him from continuing to serve his patient population as he had done before. They were unable to receive from him, or any other doctor, the treatments that had worked for them and which are internationally accepted. Those patients who called the CPSO asking for help in finding a pain doctor were told that it was not the CPSO's job to find doctors for them. Other pain doctors either refused to take on former Adams patients, or told them outright that they feared being brought into discipline as well. In fact, the CPSO asked for reports on all Adams patients from those doctors who did take them on, without the knowledge of those patients.

To put pain medicine into perspective, Dr. Thompson told the media that the waiting list at most Ontario's pain clinics is about three years. At any time about 75,000 pain patients are without care. According to the *National Chronic Pain Association*, the suicide rate among chronic pain patients is 10 times higher than in the general population, and they tend to succeed on the first try. The cost to the public of <u>not</u> treating chronic pain is enormous: under his care the patients of Dr. Adams went off the public purse and returned to managing their work and families, which they were unable to do before. Some, who were suddenly cut off their pain medication following Dr. Adams'

suspension, very quickly ceased to be able to function at work. (See the *Star* article on this specific issue of September 10, 2001.)

In June 2001 the medical licensing authorities of the State of New York commenced a formal hearing into Dr. Adams' case, as he is licensed there as well. The result of that board's deliberations, which oversees the largest medical jurisdiction in North America, was issued on July 10 (Appendix item 22). It states, that "findings of misconduct made other than in New York are binding in this hearing only if they constitute misconduct in New York." Following their review of all the documents and evidence which was the basis for the CPSO's decision, the New York authorities concluded:

"The Hearing Committee is, to put it succinctly, dubious as to whether the standard utilized by the Ontario College [to assess Dr. Adams] are comparable to the applicable standards prevalent in New York."

They proceed to critique the CPSO's view that Dr. Adams was guilty of falling below the standard of practice because he did not do complete physical exams by agreeing with the Dr. Adams' defense experts. The defense had pointed out that psychiatrists do not do full physical exams when these have already been done several times over by the referring doctors.

The New York medical licensing authorities noted the lack of pain management standards in Ontario at the time of the disciplinary proceedings and concluded: "This is not a case where it is appropriate to equate standards applied in a foreign country, especially in such a controversial and evolving area as pain management, with those prevalent here, without any proof as to what the latter standards are." Dr. Adams' New York license was renewed.

Since the Adams case, the CPSO has commenced with disciplinary hearings against yet another pain doctor discussed below.

Dr. G. GALE
Part of item 1 in APPENDIX

These Toronto pain specialist's disciplinary hearings commenced on June 20th 2001. He has no patient complaints against him. Dr. Gale has the unusual distinction of having **two** Sections 75's invoked against him as well as a Section 37 which places immediate restrictions on his practice - none based on patient complaints or harm done. The reason for the second Section 75 and the Section 37 is due to the fact that Dr. Gale responded to a call for help and assisted in the case of a colleague's patient going into cardiac and pulmonary arrest following a nerve block treatment for chronic pain.

Thus, the CPSO invoked a second Section 75 against Dr. Gale on the strength of his mere association. During the hearings, it has already become clear in testimony that the primary responsibility for the patient lay with another doctor, but the hearings against Dr. Gale are continuing anyway.

The only explanation for this procedural overkill seems to be that Dr. Gale practices pain medicine of the kind that Deputy Registrar Dr. Carlisle disapproves of, according to the CPSO whistleblowers. The supreme absurdity is found in blaming the wrong doctor in what appears to be an all-out effort to discredit a particular type of treatment, namely nerve blocks. The report ordered on Dr. Gale's practice is written by a CPSO-appointed physician who is a pain doctor specializing in a very different type of pain management; she also subscribes to a very different philosophy of main medicine. Interestingly, the second Section 75 as well as the Section 37 (generally an emergency measure) were invoked 2 years after the cardiac arrest incidence occurred.

Mr. Code's observations on the case of Dr. Gale are specific to the first Section 75, as the second one was invoked after Mr. Code had completed his analysis on the first Section 75. Starting with the first Section 75, Dr. Gale kicked up a great deal more of a fuss than most doctors we know about and used every legal means open to him to question the CPSO's authority. As a result, a most unusual story unfolded.

In the case of the first Section 75, Mr. Code observed that **"sweeping and unqualified"** orders were made and that such a **"broad and unqualified authorization makes a mockery out of the statutory requirement of reasonable and probable grounds" because "there is no indication as to what kinds of misconduct or what kinds of incompetence are to be investigated"; furthermore "there are no dates specified in order to control and focus the investigation." Mr. Code concludes that "A broad unqualified general warrant like this permits fishing expeditions, at the discretion of the individual investigator armed with the warrant, and undermines the statutory scheme of prior authorization based on reasonable and probable grounds."**

Mr. Code also commented on "the extraordinary dilatoriness of this investigation". Over the course of almost a year, information was supposedly received at the CPSO regarding Dr. Gale's prescription patterns. Mr. Code observed that "if meritorious grounds actually

do exist to believe that a doctor is incompetent, or has misconducted himself, the delay would also be harmful to the public interest. The CPSO obviously regarded this case as one of little urgency." All the information amounted to, was that Dr. Gale was "prescribing large amounts of narcotics and controlled drugs to many individuals." Mr. Code observed, "Given that Dr. Gale is a specialist working in a pain clinic, large amounts of narcotics would presumably be normal." In Mr. Code's opinion, invocation of a Section 75 for a complete investigation of Dr. Gale's practice would "at a minimum" require "some kind of expert opinion … to be provided to the Executive Committee to the effect that the amount of prescribed narcotics was abnormal in the context of Dr. Gale's specific practice, before it could be said that there was credibly-based probability as to incompetence or misconduct." (Emphasis in original.)

A peculiarity of the Gale case is the shifting ground of the sources upon which the CPSO relied to invoke Section 75. On March 29, 1998 Dr. Gale's lawyers were informed that "the basis of [the case] was information received from the Bureau of Drug Surveillance". When Dr. Gale's lawyers informed the CPSO that this office had ceased to collect data on doctors' prescription patterns some three years prior, the CPSO responded on July 28, stating that they "did not receive the prescription information through the Ottawa office, but rather through a regional office locally." When Dr. Gale's lawyers informed the CPSO that no such local office exists, the CPSO wrote back on August 13 that it was actually "pharmacy information". The assertion that the formerly cited offices don't exist was simply ignored and treated with silence. Finally, the CPSO provided an affidavit on October 30, 1998, in response to a demand in a judicial review, stating that the information came from a Drug Control Unit of Health Canada located in Scarborough." Not surprisingly, Mr. Code found this series of events "somewhat suspicious".

Dr. Gale subsequently questioned also the search warrants the CPSO acquired. The basis for this warrant was provided in a statement made by the CPSO's Associate Registrar Dr. P. McNamara, the chief of investigations. He stated that a search warrant was necessary because **"the quantity of narcotics [they expected to find in Dr. Gale's office] could exceed recommended daily dosages and could be considered excessive and hazardous and therefore could form the basis for a finding of professional misconduct."** (Emphasis by Mr. Code). Mr. Code reports that Dr. McNamara "acknowledges that he does not know what underlying circumstances or medical conditions, if any, exist to justify Dr. Gale's … manner of prescribing narcotics." Yet, all of this was offered by the CPSO to the Justice of the Peace as grounds for needing a search warrant.

Mr. Code is blunt in his observation: "In my opinion, this above process of reasoning is completely improper and is an illegal usage of s. 75 powers…. It is simply a fishing expedition to find out whether the prescriptions were proper or improper." He quotes a Supreme Court decision of 1984 by Justice Dickenson: "… an applicant's reasonable belief that relevant evidence may be uncovered by the search would be to define the proper standard as the possibility of finding evidence. This is a very low standard and would validate intrusion on the basis of suspicion and authorize fishing expeditions of

considerable latitude. It would tip the balance strongly in favor of the state and limit the right of the individual to resist only the most egregious intrusions."

Mr. Code concluded his study of Dr. Gale's first Section 75 by stating, "that once again the CPSO is abusing and misusing its statutory powers" and provides "cause for grave concern as to the levels of professionalism and competence within this body."

In connection with the opinion being prepared by Ms S. Ballantyne on the potential abuses of Charter rights of patients and physicians by the CPSO, she wrote in a preliminary statement made to the Committee on July 9, 2001, as follows:

"In my opinion, the argument could have been advanced that the granting of the Section 75 Order was improper, and was contrary to the principles of fundamental justice, since the statutory precondition of 'reasonable and probable grounds' for its issue were not met. A second though related argument is that the authority given to the investigator by virtue of the Appointment was so extraordinarily broad that the very grant of it was in violation of the principles of fundamental justice."

This case is currently being heard before the CPSO.

Dr. S. S. KOONER
Items 22 and 23

Dr. Kooner practices in Windsor specializing in asthma and allergies. He is exceptionally successful with children suffering from asthma; patients consult him from all over the province. Trained originally in India, he received his medical fellowship from the University of Saskatchewan. He is also trained as a clinical ecologist (environmental physician) and is a member of the *Pan American Allergy Society*, a medical organization with member physicians throughout the world many of whom teach at universities. The treatments developed by them are included in current medical textbook chapters, some of which were introduced by the defense in Dr. Kooner's discipline hearings in 2000. These treatment modalities are recognized by the Canadian

federal government. The CPSO tacitly approves their use as "complementary" through their 1997 policy on complementary medicine (even though these asthma therapies were developed at mainstream universities as far back as the 1940's and are hardly complementary).

In 1996 a patient had an anaphylactic reaction (not anaphylactic shock! there is a significant difference) during testing, a very common occurrence. The full protocol published by the *Anaphylaxis Network of Canada* (distributed by the Ontario Ministry of Health) was immediately used and the patient was revived within a minute. Because of its frequency, allergists' offices are equipped with the instruments needed to deal with anaphylaxis. However, Dr. Kooner took the extra precaution to send the patient by ambulance to the hospital for observation and investigation. The boy was released within an hour and went back to school the next morning. As cases of anaphylaxis are registered with the *Anaphylaxis Network*, this case came to their attention.

For reasons unknown so far, one of the doctors associated with this registry contacted the mother of this boy about a year after the incident and suggested to her that she should lay a complaint against Dr. Kooner, so that "this does not happen again to anybody." The CPSO did not tell the mother that this is a common occurrence, which probably happens dozens of times daily in medical practices throughout Ontario. She was also not told that the standard protocol had been followed to the letter, and as there also was no demonstrable or lasting harm, there could be no substance to a complaint. Instead, a protracted cat-and-mouse game began during which Dr. Kooner was asked by the CPSO to make some adjustments to his letterhead, change his consent forms and the like. A Section 75 was at first not even mentioned.

Then, suddenly in January 1997 Dr. Kooner was informed of a Section 75 disciplinary proceeding, but instead of starting this accordingly, nothing happened for 3 and ½ years, until August 2000 when hearing dates were suddenly announced even though the negotiations with his lawyers were then ongoing, leading his lawyer to believe that the Section 75 investigation would be dropped. Thus, the e defense lawyer, Ms Kirby Chown, was surprised, objecting that no time was allowed to get expert supportive opinion, that no full disclosure had been given, and that important evidence was still missing without the repeatedly requested explanation for their disappearance: the tapes done by the CPSO interviewing Dr. Kooner had been lost. She also questioned the very legitimacy of the invocation of Section 75 because every item the CPSO had asked for had already been complied with.

At this point, the CPSO offered Dr. Kooner a sort of last chance: he was asked to voluntarily stop all asthma work - or else go to discipline. He refused and the hearings began on October 2, 2000, with the CPSO seeking revocation of license. The defense's position was that every possible, universally agreed upon, standard protective measure had been observed in this simple case of an adverse reaction to allergy testing. However:

Mr. Posluns, speaking for the prosecuting CPSO instructed the Discipline Panel as follows: "The outcome of treatment is not a useful concept. Even if he [Dr. K.] had killed somebody, it would be irrelevant … doctors can have bad outcomes. If we want to get into how many died and how many benefited, well this is not a murder trial and it is unfair to judge outcome. Only standard of practice is to be evaluated. You set the standards in Ontario, you have never heard of the *Pan American Allergy Society* and its treatment modalities, therefore you have to find the member guilty".

Dr. Kooner's patients organized a patient group and unleashed an intense public protest campaign with press conferences, town hall meetings and the like. Hundreds of letters of protest went to the CPSO also. One of his patients whose children had also been treated by Dr. Kooner was a character witness during the hearings. He stated flatly, "We are deeply offended by these proceedings against Dr. Kooner" and suggested the CPSO was conducting kangaroo courts. At the press conference held in Queen's Park the media was joined by many MPPs and MPP. Items 23 and 24 are letters from the Official Opposition to the CPSO asking for clarification in this case.

Two months after the hearings began, the Kwinter Bill was passed which specifically prohibits penalizing doctors for practicing unconventionally as long as patients are not hurt. In the Kooner case nobody was hurt and the defense provided plenty of judgements showing that even before the Kwinter Bill became law, the courts do not support preferential endorsement of one type of therapy over another, if both have published scientific support. The Discipline Panel did not take notice of the passage of the Kwinter Bill, but on July 11, 2001, gave their Decision, finding him "incompetent" , "unfit to continue practicing", or "that his practice should be restricted" under s.52(1) of the Health Professions Procedural Code. The Decision is full of inaccuracies and irrelevancies, such that several people involved with this and other cases as well as with the preparation of this report, observed that the CPSO Decisions have the quality of "cookie-cutter" productions: the individual case's facts are simply kneaded into the dough and the same type of Decision is rendered regardless of the case.

Dr. Kooner's patients are terrified that the treatment they have received and which works for them (unlike the treatments they used to get) may suddenly be no longer available. As most of Dr. Kooner's asthma patients are children, the situation is serious. Dr. Kooner's Sentencing is to take place November 14 of this year.

Dr. C. DEAN
Part of item 1 and see item 24 in APPENDIX

On April 29, 1993, Dr. Carolyn Dean received an "admonishment" from the CPSO on the basis of a complaint received from the *Sugar Institute of Canada* (see item 25). The Institute was unhappy about the fact that Dr. Dean, who frequently spoke on television and had written numerous books, mentioned the universally known fact that refined sugar has adverse health effects especially for diabetics who have to avoid its consumption.

In the city of Banting and Best, two doors down from where they discovered the action of insulin and the cause of diabetes, the medical licensing authority of Ontario upheld the *Sugar Institute's* complaint and admonished Dr. Dean by stating that Dr. Dean's "sensational and scientifically unsubstantiated comments to the media" would "potentially arouse concern in the viewing public." This "sensationalistic" behavior was deemed "inappropriate for a professional". This admonishment went out over the signature of Dr. David Walker, then the CPSO's chairman of the complaints committee and now the current Dean of Queen's University's medical school.

For good measure, the CPSO censured her also for allegedly "advertising" her then most recent book about which she was being interviewed on the Dini Petti show. Here our whistleblowers have some interesting information to offer: They stated, that they were fully aware of the fact that Dr. Dean had "done nothing to harm anybody" and that she was strictly "one of Dr. Carlisle's cases." The whistleblowers also provided us with a copy of the *Complaints Coding Guide* with which inspectors and staff were working at that time. It reveals on page 10 of Version D that "anything related to advertising" such as "signs, phonebook, magazine/newspaper articles/ads; endorsements; appearances on TV/radio; etc." is to be interpreted as evidence for failing to meet the standard of practice and constitutes the proper subject of a complaint. The immense latitude for punitive action provided here would make it impossible for doctors to publish anything or ever say anything in public. Yet, medical science is a public good by definition.

Following this admonishment, a patient complained to the CPSO that she had failed to provide a homeopathic remedy and suggested he should drink less beer. The CPSO instituted a Section 75 investigation upon that complaint. Dr. Dean had been appointed to a research position in New York City prior to these events. When the discipline hearings began, several years later, she did not receive information of their commencement. The notice had been sent, strangely, to an old address even though, for several years, all the CPSO mail, including invoices for membership renewals, had been sent to New York. Each time Dr. Dean went to a conference or on vacation to California,

she checked with the CPSO by telephone as well as in writing, always being assured she would be told as soon as a date was set for the hearings.

Finally, in 1995, the hearing began. A sworn affidavit was provided to the Discipline Panel by Julia Martin of the CPSO's law firm Porter, Posluns & Harris. It stated that they "telephoned her several times in California and left messages on an answering machine. Dr. Dean did not respond to my telephone messages or my letter." The affidavit asserts that faxes were also sent to that California address in November 1993 notifying her that the hearing would be held from July 4 through 7, 1995, and that she did not respond. In fact, during those two years plenty of correspondence went on between the CPSO and Dr. Dean, always telling her that the date had not yet been set. If the affidavit is to believed, the CPSO knew two years in advance when Dr. Dean's hearing would be scheduled, which contradicts the actual correspondence between Toronto and New York during that two-year period which repeatedly asserted that no date had been set.

Dr. Dean's license was revoked in absentia and she did not find out about this for almost a year. She provided affidavits and actual post-marked envelopes showing that the CPSO knew her correct address and phone number in New York City all along. She also provided proof in the form of affidavits of the fact that the place the CPSO lawyers supposedly telephoned and faxed, did not then and never has had an answering machine or a fax on which any messages could have been left. She was only temporarily at that California location, prior to November 1993.

Upon reviewing the CPSO disciplinary case, the medical licensing authorities in New York State and California were fully persuaded of their absurdity, and her licenses have remained valid in those states.

Dr. M. SMITH
Part of item 1 in APPENDIX

This case is treated last, but it is the most troubling in terms of its human tragedy as well as in terms of its legal implications.

It is this case that allowed Mr. Code to assert that it provides "***prima facie*** **evidence that CPSO officials may have committed the criminal offence of obstructing justice by repeatedly misleading the Executive Committee as to the true state of the evidence in this case".**

In the early 1970's, Dr. Michael Smith was one of the first physicians to introduce acupuncture into Canada after rigorous training in China. He also practiced bioenergetics therapy. As a member of a taskforce of the Ontario Medical Association charged with evaluating primary health care in Ontario in 1972-1976; he was the lead author of a report which was exceedingly critical of primary health care in Canada. It was his view that 95% of western medicine was unable to handle chronic illness. In 1992 he found himself the subject of a Section 59 proceeding under the *Health Disciplines Act* based on "complaints" which alleged him to have engaged in serious sexual misconduct. This story became the subject of a Queen's Park press conference in May 2000, at which Mr. Code spoke about it also (Appendix item 2).

Dr. Smith's widow summarized this tragedy with the words: "We never had pornography in the house until the CPSO brought it to us."

Dr. Smith was arrested in front of his clinic at 9 am early in 1992 and briefly incarcerated for 12 hours. Simultaneously, the Children's Aid Society appeared at the Smith's home and questioned their children. Dr. and Mrs. Smith did not know why in both instances. The CAS's social worker, after having met with the children, realized that there was something sinister involved and apologized. Dr. Smith was released after 12 hours and informed that a Section 59 had been invoked against him. As the list of procedural improprieties is so very long in this case, only the briefest summary is possible.

The "complaints" the CPSO had received were altered substantially so as to change the nature of the entire case; these complaints may have been actually based on CPSO solicited interviews. The affidavits submitted by those same complainants (within days of the Section 59 having been invoked), denying ever having accused Dr. Smith of wrong-doing, were never submitted to the Executive Committee or the Discipline Panel. One of them, Ms Margot Haug, spent years and a lot of money in an attempt to correct the statement she is supposed to have made about Dr. Smith. She was also deeply disturbed by the summary of her case which was provided to the Discipline Panel. It was never proven that this summary, which was full of the grossest inaccuracies, was actually based on Dr. Smith's original chart. Ms Haug also spoke at the May 2000 press conference. None of the alleged complainants were ever cross-examined. Dr. Smith's license was revoked and he appealed. By that time, his family's financial situation was dire. Dr. Smith shot himself, as he knew that there was an insurance policy (about which his wife knew nothing) that would be paid even in the case of suicide, and it would help his family to get re-established. Interviews with his patients and his widow showed how deeply Dr. Smith is missed even now.

In discussing this case, Mr. Code explains that Section 59 "is akin to the power, in a criminal case, to take away the accused's liberty at a bail hearing pending trial" and that it "empowers the Executive Committee of the CPSO to take away a doctor's license, on the basis of a report from the Registrar and a response from the doctor, pending the hearing of a disciplinary complaint before the Discipline Committee." It is a very serious action

designed "to determine whether the doctor should be deprived of his/her livelihood on the basis of hearsay disciplinary allegations that have not yet been tested at an evidence hearing."

Mr. Code's analyzed the four factual bases of the Registrar's report to the Executive Committee (November 10, 1992) which led to the invocation of Section 59. Mr. Code found all of them to be "misleading". Each reported case of misconduct, Mr. Code shows to be substantially altered from the original report. As a result, the specific descriptions of Dr. Smith's actions with each patient takes on the nature of outright sexual assault, while the original is open to harmless interpretations of a non-sexual nature. Furthermore, there is no evidence that the original interview reports were ever made available to the Executive Committee - apparently, only the doctored versions were.

Mr. Code stated:" My conclusion concerning Dr. Smith's case is that it reveals a pervasive pattern of acts by the CPSO officials which were very likely misleading the Executive Committee, in a material way, as to the real nature of the evidence against Dr. Smith. [Then Registrar's] Dr. Dixon's report to the Executive Committee itself is consistently misleading in relation to all four of the CPSO factual bases for the S. 59 proceedings. In addition, the failure to provide Dr. Smith's lawyers and the Executive Committee with the three complainants' actual statements had the effect of ensuring that the misleading report would not be corrected. Therefore, it is my opinion that there is a reasonable case in relation to the *actus reus* of obstruct justice, namely that acts were committed which had a tendency to obstruct or pervert the course of justice at Dr. Smith's S. 59 hearing."

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We have on file many more cases illustrating how far the CPSO, as a professional self-governing body, has moved from being a collegial body of professionals.

For example, **Dr. B. Gray** committed suicide in 1998, shortly after a meeting for the second time with Deputy Registrar, Dr. John Carlisle at the CPSO offices. Information on this case is based on interviews with CPSO whistleblowers and with his surviving partner. His partner informed us that on both occasions Dr. Carlisle "screamed, ranted, raved and shouted at him incessantly, walking up and down behind his chair, threatening him with the most incredible things." Having heard about such treatment of doctors before (independently of Dr. Gray), we were interested to know if corroboration would come from our CPSO whistleblowers. Indeed, questioned about this case, they readily

concurred that this behavior was "typical of Dr. Carlisle" and that "he goes up one side of the poor doctor and down the other and absolutely shreds them emotionally." They reported that many doctors walk out of the CPSO from such a meeting shaking and in tears.

Dr. Gray's lawyer, Mr. Peter Newcombe, Q.C., of *Gowlings Strathy & Henderson* in Ottawa, wrote to one of us on February 17, 1998: "It should be remembered that at the time of his death, Brian Gray was a duly licensed physician in the Province of Ontario. Accusations of incapacity had been made against him but had not been substantiated, and in my opinion, would not have been substantiated."

Dr. N. Sutherland of Pembroke is a Harvard trained general surgeon who has been the subject of much harassment by the CPSO over a period of 17 years. The significance of his case is found in the methodology employed by the CPSO investigators. For example, inspector Nan visited Dr. Sutherland's office ostensibly to discuss whichever matter in a general way. However, unbeknownst to Dr. Sutherland, Inspector Nan was wired with a recording device. When the inspector would not take off his coat even in the heat of that July 23rd (1987) day, Dr. Sutherland suspected he was being taped and, eventually obtained the transcripts of that interview through the CPSO lawyers Tory & Tory. It took several years to get it, though, and probably only because of an important Supreme Court ruling. On January 25, 1990, the Supreme Court ruled in *Duarte and Wiggins that* it was unlawful to "bug" people without their knowledge. Previously, this had been legal, as long as one of the two parties consented. The Supreme Court upheld Section 8 of the Charter and it is now required to inform people of any such recording activity, including body packs used by police.

Among our documents and interviews we also have a case of a physician who was coerced into admitting a drug problem this person never had in order to have the license to practice reinstated. At issue was, once again, the use of opiates for chronic pain patients. Yet another doctor, at that time teaching also at a Canadian university, voluntarily gave up his license to practice out of sheer frustration and went into business. The College did not approve of this physician's approach to hormone replacement therapy in menopausal women: he tested their hormone levels more frequently and kept the estrogen dose very low because of its well known carcinogenic effect. The CPSO was not interested in the biochemistry and documented science involved.

The case that now promises to become a major public event is that of **Dr. Barry Armstrong** of Dryden. A general surgeon with the Canadian army for many years it was Dr. Armstrong who blew the whistle on the murder-by-torture incidents perpetrated by some Canadian peace keeping units in Somalia. The most recent of many harassments he endured comes from the CPSO: a section 75 has been invoked without patient complaints or known medical misadventures. A patient support group is fighting for him, the only general surgeon in a vast area. The press has begun reporting on this case already, notably the *Globe & Mail* which suggested political motifs already. An especially

unusual aspect of this case is that his hospital privileges were revoked first and a Section 75 initiated much later. Hospital privileges are almost never revoked unless there is a CPSO investigation involving Section 75 or incapacity issues first. In situations where this was attempted in the past, the doctor concerned almost always won under section 7 of the Charter.

A petition by some 2,500 patients - an impressive number coming from such as small place as Dryden - has gone to the Minister of Health on behalf of Dr. Armstrong. He is very popular with his patients and the area is seriously underserviced medically.

Interestingly, the CPSO whistleblowers informed us that a high ranking member of the military visited Dr. John Carlisle, on or about July 17th (i.e. after Registrar Dr. J. Bonn had already been dismissed) and demanded to know what was being done to "get that troublemaker Dr. Armstrong."

In summing up the cases Mr. Code examined, he stated, "… there appears to be serious misuse, mismanagement or incompetence by the CPSO in relation to their very substantial powers. Our clients should seriously consider what steps should be taken in this regard. In particular, some approach to the relevant government authorities should be considered in my opinion."

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V. CREDIBILITY CRISIS AT THE CPSO: MISREPRESENTATION OF MEDICAL SCIENCE

In the physicians' cases presented above one find a common theme: the CPSO's use of science as a tool of control instead of as a shared method of inquiry. The prosecution

blatantly picked and chose whatever *it* considered scientifically valid and condemned whatever weakened the prosecution's predetermined case. While it will probably never be known what agenda this way of proceeding serves, it is of utmost importance to the public that such a manner of handling medical science is not tolerated. As we have seen in the cases of Dr. Dean and Dr. Adams, the US jurisdictions of Texas, New York and California dismissed the Ontario CPSO views on these physicians as absurd and renewed their licenses. The Ontario CPSO is becoming an international embarrassment. Closer to home, this manner of handling science becomes a legal and public scandal when it is used to mislead the Ministry of Health of Ontario. One example of this is the case of chelation therapy. The report made by Dr. Edward Leyton of Kingston to Mr. Michael Code is discussed below.

Dr. E. LEYTON's report on Chelation Therapy
Part of item 1 and also see item 4 in APPENDIX

Dr. Leyton was president of the *Canadian Holistic Medical Association* in 1987. He learned that chelation therapy was being outlawed by the Ontario government. In fact, an order in Council finally did outlaw this therapy under Section 4 of the old *Health Discipline Act*.

This therapy was originally developed by the US government's military doctors in the early 1940's to remove life-threatening levels of lead from sailors of the US navy, many of whom had been poisoned through the lead-containing paint used then on war ships. Subsequently, it was refined to be developed for removal of mercury and of the plaque in the arteries of heart patients already too sick for open-heart surgery; it was also adapted to ease diabetic neuropathy in severe cases of diabetes. Doctors using this treatment must be trained and certified by the *American Academy for the Advancement of Medicine*.

In the mid-1980's the CPSO presented information to the Ontario Ministry of Health in support of the CPSO's wish to have chelation outlawed in Ontario. This was a unique move, as a specific therapy, developed and maintained by the mainstream medical establishment, has never been actually outlawed anywhere. Without consultation with the CPSO membership, as required by the by-laws of a self governing health profession, the Ministry of Health was given this report which was so damning of chelation therapy, that it was, indeed, banned (Section 4 of the old Act). Dr. Leyton describes in his report what actually happened, how the scientific literature cited as "evidence" in the presentation to the Ministry was misrepresented, and how he and his colleagues were treated when they objected to this attitude towards the membership and scientific facts.

A few years later, when the new RHPA came into effect, Section 4 was dropped without debate. The CPSO found out after the fact that this section was no longer in effect. During the time that it was outlawed, inoperable heart patients and patients with diabetic neuropathy had to seek out chelation doctors in the US, or Alberta and BC, where many

doctors practiced chelation then, and still do so. In fact, chelation became a medical-political issue in Alberta when MLA Roy Bressard met people whose lives had been saved by chelation therapy after they had been given up by cardiovascular surgeons. One such person was the husband of a fellow MLA. Mr. Bressard brought in bill 209, the equivalent later of Ontario's Kwinter Bill. The Alberta legislature passed it, amending their *Medicine Act* accordingly, with unanimous consent in 1996.

In Ontario, doctors did not know that chelation was permitted after the new RHPA came into effect. Nobody was informed by the CPSO that this prohibition was no longer in effect. Desperate and angry patients around the province formed the *Ontario Chelated Patients Association* (OCPA) in 1997 under the leadership of one such patient, Mr. Gene Dopp of Orangeville. Within months it was 700 members strong. They concentrated their efforts on education and the support of the Kwinter Bill. They educated doctors trained in chelation by bringing attention to the fact that Section 4 did not exist on the books anymore. However, the CPSO continued to pretend that the prohibition against chelation still existed and severely harassed doctors who practiced it. Ironically, chelation doctors in Ontario who were offering this therapy on conscientious grounds did not know that they were legally using chelation therapy. The OCPA can provide the names of the harassed doctors. Evidence of the fact that the CPSO continued to try to make it appear that keep chelation was not legal is provided in the copy of the CPSO council minutes attached to Dr. Leyton's report (Appendix item 4).

The significance of this case is that the CPSO misled the government by misrepresenting scientific fact and bypassing the mandatory debate with its own membership. In addition to being improper in every way, this action has had significant financial and human fallout. Item no. 5 in the Appendix is an article by Cynthia Ramsay, a journalist who specializes in medical economics, published in *The Fraser Forum.* In addition to her discussion of various persecuted doctors (some of whom are discussed above), she provides the astonishing financial analysis of chelation therapy: it is enormously cheaper and safer than open-heart surgery. As for diabetic neuropathy, there is no treatment other than chelation or conventional pain relief - and how <u>that</u> treatment is viewed by the CPSO was seen in the earlier presented case of Dr. Frank Adams.

At stake here is the fundamental right of freedom of choice and the right to reject a therapy - as the *Helsinki Accord on Human Rights,* and indeed the Kwinter Bill affirm.

Mr. Code studied Dr. Leyton's submission even though it was not a Section 75 case. Mr. Code's comment on the chelation issue was, in is July 26, 1999, submission: "… it illustrates the extraordinary bias of CPSO officials towards unconventional practices. It also provides further evidence of the willingness of certain CPSO officials to mislead the Executive Committee and to treat CPSO members (and their patients) unfairly in pursuit of an apparent institutional goal of stamping out unorthodox medical practices."

As for misleading the Ontario Ministry of Health, consider the following: Eight years after chelation became legal in Ontario and two years after the CPSO's Walker Report on Complementary Medicine was published, the then Minister of Health, Hon. E. Witmer, responded to the many letters from Ontarians protesting the harassment of doctors offering chelation by the CPSO. A form letter went out to many citizens demanding an explanation. The Minister wrote (February 2, 1999):

"I want to assure you that this government supports freedom of choice for patients with a range of care options, as long a people are not put at unnecessary risk…. The College of Physicians and Surgeons governs the medical profession in Ontario … and has assured the ministry that there is no substantial, scientific evidence that chelation therapy has any value in treating cardiovascular disease. Indeed evidence of risks associated with chelation therapy, including allergic reactions, kidney failure, heart failure, aggravation of diabetes and skin disorders, have been found. It would be inappropriate for the government to ignore the advice given by this body of experts."

Among the groups submitting this report is the *Ontario Chelated Patients Association*. They know from personal experience that chelation restored their health or greatly improved quality of life, after mainstream surgeons had told them to make their Wills. Many of them went from total incapacity to playing golf - without bypass surgery, for which they were no longer eligible because their condition was too advanced. Many of them had their painful diabetic neuropathy reversed and thus had limbs saved from amputation. There is not a shred of evidence to support this nonsense that the Minister of Health had been given by the CPSO.

Indeed, as Dr. Leyton's report shows, it appears that the CPSO considered it necessary to misrepresent the evidence in the medical literature to persuade the Ministry to outlaw chelation therapy.

The reader is also referred to item 5 in the Appendix, the article by C. Ramsay. The problem is that the status of the CPSO ("this body of experts") is such that there is no reasons why the government and the Minister of Health should doubt the veracity of statements coming from their administration. Government, as most business does assume that people and organizations tell the truth at least much of the time. The CPSO has abused its authority thoroughly.

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VI. THE INTERNATIONAL PERSPECTIVE

It is our view, whatever changes the government intends to make as a result of this HPRAC review, they ought to include a **reduction of power** for the CPSO. Transparency - **Glasnost** - is what is needed most urgently if the health budget is to be

manageable, patients are to have access to care of their choice, and doctors are to be free to be involved in medical progress. To achieve these ends the very principle of self-governance and the application of administrative law to issues of medical care require discussion and re-interpretation.

As Mr. Code observed in conversation once, a person accused of murder in Ontario has more rights before a provincial court than a doctor accused of professional misconduct seems to have before a CPSO discipline panel. Indeed, the courts observe the rules of law and the CPSO often does not. For the patient approaching the CPSO with a complaint or an accused physician there is no guarantee that rules of fair conduct will be observed, as our stories and the case histories in the *Star* reports have shown. Many of the submissions made by other groups to the HPRAC exercise support this observation also. The constitutional experts we consulted were astonished to find, when reading Mr. Code's opinion, that the current legislation governing the health professions in Ontario could, in fact, be abused this badly.

Before turning to our analysis of the CPSO's submission to HPRAC, it may be useful to look briefly at the international perspective. Our experience in Ontario is by no means unique. As we share an imperial history with many other English-speaking countries, it comes as no surprise that we share similar problems. It is also instructive how creatively they are dealing with them.

The situation in the UK

The CPSO's Members' Dialogue reported in their July/August 2000 issue on the visit of Mr. Finlay Scott, the Registrar of the UK's General Medical Council, the counterpart to the CPSO in Ontario. The UK had been plagued by medical scandals ranging from 28 babies who died after botched cardiac surgery in Bristol to the murders by Dr. Harold Shipman . Mr. Scott stated in the Dialogue: "The antagonism is absolutely relentless and there doesn't seem to be an easy way to staunch the flow." The public, the doctors and the government, he explained, all distrust the GMC, and the Prime Minister has demanded reform.

One such reform measures proposed by the GMC was "revalidation" whereby physicians required a regular 5-year assessment to maintain their licenses. Mr. Scott explained that as the GMC sees it, "For the first time in our history, our register will be more than simply a record of qualifications… it will be a positive statement on a physician's fitness to practice." However, the UK doctors reacted to this proposal with a vote of no confidence, stating that this measure was "potentially intrusive and threatening."

What the *Dialogue* does not state is that the UK is experiencing the same problems as Ontario, namely extensive witch hunts of doctors with innovative treatments and no patient complaints against them. Browsing the internet we find more than 20,000

patient complaints many of which tell the same sort of stories as the ones we presented here: not taking complaints seriously where they are serious, and prosecuting doctors who have no complaints against them. As a result, the UK became mired in a huge backlog of complaints and faced an increasingly angry public.

One very important measure undertaken in the mid 1990s was legal reform. The Lord Chief Justice of England and Wales, Lord Wolf of Barnes, an internationally renowned expert in administrative law, was appointed to review the situation. On October 30, 2000, Lord Woolf addressed the Medico-Legal Society in Toronto. He made three important points which are relevant to the Ontario situation.

1. **The Woolf report suggested easier accessibility to the courts, but with the view specifically to avoid civil litigation which frustrates all concerned**
2. **increasing the effective use of expert witnesses, and**
3. **increasing the use of alternate dispute resolution (the very ADR mechanism that was effectively killed in December 2000 by the CPSO) which should be central to all legal remedies being sought**

Lord Woolf made the point that when both sides put all their cards on the table before litigation commenced, the process worked far more efficiently and both sides were much more satisfied with the results. However, as we shall see in the next section, the requests made by the CPSO to HPRAC do not appear to consider the British approach.

The approach in the UK initiated by Lord Woolf has the effect of defusing the power of the General Medical Council: the courts decide who is an expert witness, medical misadventures are treated like assault and negligence situations, and the accused and the aggrieved have the opportunity to hammer out their factual and perceived differences through an ADR process. Most importantly: all processes are essentially public and removed from the secrecy of the Old Boys' Club system.

Apparently, this system is working effectively and helping to reform the medico-legal process in the UK. It would be important for the Ontario Ministry of Health to study the Woolf Report and see how its recommendations might apply to our very similar situation here in Ontario.

The experience of New Zealand

In 2000 the government appointed Helen Cull, Q.C., to produce a review of the processes concerning adverse medical events. In March 2001 the resulting report was published. While New Zealand has its own distinct problem areas, the parallels with Ontario and the UK are significant.

Thus, the Cull report shows that there was an 81% increase in public complaints between November 1999 and November 2000. The issues were also similar: large backlogs in dealing with patient complaints, "patronizing and insensitive behavior" in dealing with complaining patients, lack of guidelines, inconsistency in the discipline's process, biased medical tribunals, etc. The solutions proposed are:

The Cull Commission focused on "consistency" and "accountability" and suggested that having lawyers on panels, tribunals and disciplinary bodies would be helpful. These legal advisors would be different ones in each situation, not drawn from an existing roster (as is the case with the CPSO).

With regard to discipline, the recommendation is as follows:

> **"The Disciplinary Tribunal would be a Court or Tribunal presided over by a District Court Judge (not retired), together with an equal number of professional persons of the relevant peer group, and equivalent number of lay persons who are appropriately trained. In hearing any disciplinary proceedings, it will be mandatory, not an option, that the tribunal comprise the Judge, the professional persons and the lay persons." (Cull C. p.109)**

This recommendation emphasizes successfully the need for accountability and transparency in the legal process as well as in the manner in which specialized evidence (medical procedures and diagnoses and patient experience) must be treated. We will use this recommendation from New Zealand as our guiding principle in the recommendations we have provided. First we need to examine the CPSO's wish list for HPRAC.

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VIII. THE CPSO's WISH LIST FOR HPRAC AND COMMENTS ON THE HPRAC REPORT'S RECOMMENDATIONS

Considering the CPSO's submission to the HPRAC Review, we find - alarmingly - that the CPSO wants "**whatever tools the regulatory body may feel are required to investigate**" (p.i). A tall order indeed. In our opinion, the investigative tools available to the CPSO ought to be no different and not exceed those available to the courts in murder and negligence cases. Most importantly, we feel both the existing legislation and the CPSO wish list for changes must be carefully scrutinized in terms of the *Charter*. The analysis of this issue will be submitted to the Ontario Government, as stated earlier, in the Fall of this year.

In the name of organizational efficiency and flexibility, the CPSO is asking for sweeping changes to the RHPA that would greatly increase the College's power and flexibility which would remove from legislation specified procedural powers. Given the cases of abuse of power already cited, we are alarmed by the greatly increased possibility for abuse that these changes would create. Therefore, we are especially concerned about the potential increase in human rights abuses such additional power could generate.

On the CPSO Submission to HPRAC: Thirteen Areas of Concern

Virtually all the changes to the HPRAC the CPSO suggest have to do with gaining more control over the membership and over the way medicine is practiced in Ontario. The first notion amounts to an interpretation of self-governance that may be open to a *Charter* challenge; the second amounts to a misinterpretation of the role of the CPSO, as no CPS can be the sole guardian of a worldwide enterprise with constantly shifting goals and parameters.

The changes that the CPSO would like to see to Ontario's health care legislation appear to be based on the assumption that a physician's primary responsibility is to the CPSO - that is: to the profession as interpreted by the CPSO's executive. The responsibility to patients and the public seems to be subordinate to the notion of corporate duty of loyalty. Significantly, the question of individual conscience does not arise at all, except negatively in the CPSO's request to have their powers increased to enable them to control "ungovernable" physicians.

Consider the parallel situation of a government civil servant whose duty of loyalty to the employer (the government) is based on an oath and was, until recently, assumed to be the primary guiding principle. On September 5, 2000, federal court Justice Tremblay-Lamer handed down a landmark ruling on this point, which we feel, is relevant to our deliberations about the CPSO. This ruling re-interpreted administrative law to exclude the imposition of uniformity and included individual conscience as relevant.

The issue had been that two Health Canada senior scientists, Drs. Shiv Chopra and Margaret Haydon, had gone public on CBC radio on June 11, 1998, and told the Canadian people that our food supply was not safe. They accused the federal government of pressuring Health Canada scientists into approving known carcinogenic and endocrine disrupting substances, such as bovine growth hormone (which was subsequent to this radio appearance not approved). Health Canada reprimanded the scientists and placed a gag order on them. These punitive measures were being challenged under the *Charter*.

The government argued that Drs. Chopra and Haydon were bound by their duty of loyalty to resolve differences of opinion internally. Justice Tremblay-Lamer found for these scientists and against the federal government, and her judgement has remained unchallenged by appeal. She wrote, **"Where a matter is of legitimate public concern requiring public debate, the duty of loyalty cannot be absolute to the extent of preventing public disclosure by a government official … the public interest outweighs the objective of an impartial and effective public service."**

As some of the doctors' cases presented above have shown, the CPSO expected compliance with the CPSO's interpretations of medical science and validity of treatments, regardless of the physicians' clinical experience and observed, documented patient outcome. The CPSO's interpretation of these issues was, in each case, revealed through the discipline process and enunciated by the prosecuting CPSO's lawyers, or also through the correspondence from Deputy Registrar Dr. J. Carlisle. The transcript of his cross-examination clarified his view of himself as guardian of medicine in Ontario. The only reason given in support of such a demand for compliance was the simple assertion, that the collective body of the CPSO, as represented by the Discipline Panel and the

Deputy Registrar's stated opinions, sets the standard of practice in Ontario. That standard, the prosecution insisted, is to take precedent over patient outcome, public demand for the treatment concerned, existing scientific research supporting it, and the doctor's personal conscience. In the peculiar Penalty Decision in the case of Dr. J. Krop, his dissent is tolerated only as long as he tells his patients that whatever he does is only his own opinion and belief, not that of the CPSO. The CPSO's opinion is tacitly assumed to be identical with Science. All of the above applies equally to the problem of patient complaint which was effectively addressed by the KPMG Report.

Instead of interpreting its role in society as performing a duty to the public, the CPSO was shown to follow its own, usually secret and unsubstantiated, agenda. We believe that seen in the light of the *Charter*, the CPSO may be seen as violating the human rights of patients. KPMG's author specially noted the CPSO's poor grasp of what constitutes public interest (KPMG p.39-46)

Indeed, with this recent federal ruling in mind, we asked for an opinion on the CPSO's submission to HPRAC, in light of the *Charter*, and the legislation itself. It will be provided to the readers in the Fall.

With this consideration in mind, we now turn to the specific wishes for legislative change made by the CPSO. We have identified 12 areas of concern the first of which was not discussed or even acknowledged by the authors of the HPRAC Report; we acknowledge the wisdom inherent in their silence. However, as the CPSO was so keen on this particular issue in their submission to HPRAC, we will discuss it nevertheless, because it highlights the attitude of this College:

1. The CPSO wants the RHPA to **"create a positive duty for members to report other members whose level of capacity or competence puts patient welfare at risk"** (p.14);

Currently, the CPSO is unable to manage the complaints and discipline processes. Not surprisingly, the CPSO is once again in the red and forced to increase membership fees substantially. The discipline cases under Section 75 have indeed proven to be terribly costly exercises of enforcing idiosyncratic standards of practice. From CPSO informants we know that inspectors have caseloads of more than 135 complaint cases each, which they admit nobody can manage. The misinterpretation of its mandate has caused a situation in which the CPSO is having difficulty being a medical licensing authority as well as a self-styled para-legal police force.

It does not take much imagination to foresee, that adding a positive duty to report a fellow member would cause administrative havoc: if only 10% of the membership comply, that would be 2,600 cases more annually added to the existing workload. Fear could easily generate such a response. The KPMG Report shows that the vast majority of doctors are unhappy with the CPSO.

Ethically, this proposal may be a violation of the *Charter*. It is instructive to note that when the Germany was re-united, the legally mandatory duty to report fellow workers/colleagues (of central importance to the secret police, the STASI) was among the first to be repealed by the new united German government. In Canada such "reporting" could degenerate into a legal nightmare, because doctors are not trained to think like lawyers, detectives and police; nor does any one doctor understand all of medicine, and being human, is likely to suffer from various unconscious prejudices. The spurious communications provided by some doctors to the CPSO, for example, in the cases of Drs. Krop, Kooner and Adams which in part were responsible for starting those investigations, support our concerns.

Significantly, this proposed snitch program differs substantially from the already existing duty to report sexual and child abuse. In abuse cases, the suspicion is based on the doctor's personal, clinical judgement and personal examination of the patient which provide the bases for judgement - not extraneous motives which can cloud the act of reporting.

A snitch program allows for abuses because it is not designed to be open, measurable and based on legal tools of evidence - it turns subjectivity into a tool of potential prosecution. The basic right of knowing who is accusing you of what is violated, unless this right is explicitly made part of such a program.

Worst of all, one wonders how such a mandatory snitch program is to be enforced. Does this mean that a gynecologist brought into discipline by any other route, automatically generates the disciplining of all other colleagues in that same area for not having followed their duty to report? Again, this is eerily reminiscent of the former East Germany's STASI, which would automatically charge and interrogate all teachers in a school where one staff member was suspected of having engaged in state-subversive activities.

2. **In "member-specific issues" the authorization by the Executive Committee should no longer be required** (p.51 under 6.j).

The role of the Executive Committee, especially in discipline cases (via complaints or Section 75), was one of providing a check, of being a procedural safeguard. Mr. Code explained this point at the outset to his analysis.

The elimination of this function provided by the Executive Committee would result in the various sub-committees and the Registrar making key decisions, while giving themselves simultaneously the permission to make those decisions, and then act on them, without the scrutiny of any outside authority at all.

Viewed in the light of the *Charter* and, more specifically, in terms of the safeguards that exist in criminal law, this increase in powers is likely to be open to legal challenge. Given the CPSO track record in abuse of process with patients and doctors, more - not fewer - safeguards are desperately needed at this point.

The HPRAC Report addresses this issue in their recommendations 12, 13, 27, and 28. The authors of the HPRAC Report did not have the benefit of the information we have here provided, nor did they have Mr. Code's legal opinion to refer to. Hence, we would like to draw attention to the problems we see with their recommendations in the light of the information we have provided here.

HPRAC's recommendation no. 12 could amount to the Complaints Committee giving itself permission to act without any check from outside itself or checking on the Registrar. Similarly, recommendation 13 allows for the nebulous "other information" clause which may very well be suspect under the Charter. The lines are blurred between the educational function which Quality Assurance is to serve and the disciplinary role it is NOT to serve. Check and balances are lacking in our view. Furthermore, even though an appeal is supposedly possible, the same committee hears it, which is probably open to legal challenge under the Charter as well (Section 11 of the Charter deals with all the

various aspects of fairness in trial situations.) The same observations are relevant to HPRAC's recommendation no. 31, 27 and 28.

All of these recommendations are designed to improve efficiency, but in fact reduce accountability and checks and balances. Given the history of abuse of power and process at the CPSO, such a reduction of checks and balances cannot be healthy for the functioning of any college, as abuse is a potential anywhere at any time. Reduction of safeguards is under no circumstances equivalent to efficiency, nor is desirable, and probably not legal.

3. **The CPSO wishes to severely limit or eliminate the appeal option under HPARB** (p.8).

Applying to HPARB is an important route especially for patients who feel that the CPSO did not address their concerns. Since HPARB does not require a lawyer, it is more readily affordable for patients. It is startling also to find that, in reference to doctors using this route, one of the reasons given by the CPSO for requesting this elimination is their dismissal of "members who dislike being referred to discipline". If they don't like it, they should not have a route by which they can question the CPSO's decision to take them down that path.

The implication is, that the CPSO's judgement is somehow infallible or, at least, beyond questioning. A member's or a patient's perception that a potential injustice is in progress is not considered worthy of consideration. In our legal system, however, the perceptions of potential injustice by the accused, or the aggrieved, are taken very seriously. There is no reason why a quasi-judicial body like the CPSO should be exempt from this legal principle which serves patients as well as doctors.

Interestingly, the CPSO whistleblowers supplied us with an internal memo of February 1995 in which the College complained about the Board "asking intrusive questions about the details of the investigative process, and particularly about the process the Complaints Committee goes through when considering cases and rendering decisions." It will be recalled, that KPMG asked the same intrusive questions 5 years later. The 1995 memo concludes: "The College has taken the stance that these matters are not their concern."

We feel that the current request for elimination of appeal to the board would serve to increase secrecy and lessen accountability even more than is already the case. Fortunately, the HPRAC Report does not comment on this request.

4. **The CPSO wishes to have more power over "ungovernable members" (pp.8 &10) and requests mandatory enforcement powers "for all**

members … to participate in and cooperate with College processes" (pp.6 & 19).

The impression is that any form of dissent must be stopped in its tracks for the CPSO to be able to run more efficiently. The issue of "ungovernability" raises the question of progress in medicine and personal conscience. If a doctor is endangering patients, it ought to be a demonstrable fact, just as verifiable evidence is fundamental to the investigation of any case of criminal assault, injury, or negligence in our legal system. The notion of "ungovernability" is not open to objective measure. The CPSO comes close to defining what the authors of their submission mean by that notion on p. 11 where they refer to ungovernability as "deliberate behaviors".

One gets the sense that doctors are perceived by the CPSO administration as often naughty and unruly juvenile delinquents - rather like Dr. Frank Adams who was actually described to the Discipline Panel in similar terms by CPSO counsel Mr. Donald Posluns. Furthermore, in the Adams case the main reason why the prosecution sought revocation of license was because of Dr. Adams' stated refusal to comply with what CPSO Council member and pain expert Dr. Ellen Thompson described as "pre-Cambrian" notions on chronic pain management. Indeed, Dr. Adams made it perfectly clear in his Section 75 hearing that he would not treat patients as the CPSO's discipline panel wanted him to do. His refusal was based on his clinical experience and knowledge of international research which prohibited him from obeying the CPSO if the interest of the patients was what mattered most. It was this "deliberate behavior" that was supported by thousands of protest faxes and letters from his patients and led to such a public outcry in the media.

In view of the fact, that the CPSO tends to use the discipline process to establish standards of practice - contrary to the intent of the legislation - the notion of "ungovernability" highlights the fact that the CPSO sees itself as being both legislators and enforcers. However, in a civil society the police do not make the laws - the legislative assembly does.

Here the very principle of self-governance is in need of redefinition, and limits to such powers urgently need clarification. Considering also the (unchallenged) decision made by the federal court on the limits of administrative law on September 5, 2000, it is relevant for the provincial government to take such a decision into account when reviewing the powers of a parallel body such as the CPSO, which is also under administrative law, just as federal civil servants are.

In the same way, the request to be given more power to enforce cooperation, assumes that doctors don't know what is good for them. This request, in particular, is completely at odds with the assumption of a self-governing body of colleagues, which is supposedly the basis of a College's authority. HPRAC fortunately did not comment on this.

5. **The CPSO asks for access to the broad information base of the Ministry of Health data bank to be able to gain an understanding of individual doctors' "practice patterns"** (p.10).

As justification the author of the CPSO submission gives (p.10) that such information is needed to be able to do the job under the Act, namely "to develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession" etc. He states **"Colleges must be able to move beyond the examination of individual behaviors and begin to look at *practice patterns in the aggregate.*"** The author's reasoning concludes by asserting that **"research evidence suggests, that comparative data and benchmarking exercises *with appropriate feedback* are important influencers of practice patterns."** (Emphasis ours.)

On closer examination this is neither reasonable nor useful, even if the CPSO was blessed with a history of demonstrated good will, fairness, open-minded humility, and collegiality with its members - which, in our opinion, it is not. Even though HPRAC did not comment on this request, it is important to keep it in mind in context of broad government policy. The ideal of stream-lining information, practice patterns, patient need, and the funding of all of these in the name of efficiency is very powerful. In fact, however, diversity is as central to medicine as to any other aspect of nature. To take diversity seriously may very well be the most efficient and frugal approach:

Differing from aggregate practice patterns should not be grounds for disciplinary investigation: the needs of different physicians' patients (especially in hard to service areas like chronic pain and evolving medical specialties such as in environmental toxicology) must be expected to be different from more general aggregates as sought by the College.

Medicine is a practical science and a highly personal art. It does not exclusively function along the lines of "practice patterns in the aggregate". The doctor-patient relationship is personal and unique, always and every time. Because medicine is in part pain-driven, it is a highly personal process. As a science it is an observation-driven enterprise, starting all the way back in mythology. The god of medicine, Asculapius, was permanently injured and had a serious limp which could not be healed, even though he was semi-divine. The very source of medicine, in this metaphor, is suffering, injury, and pain. The fact that, over time, medicine displays patterns, as is the case with any historical process from technology to child-rearing habits, shows that human beings are social animals responding to external changes and internally changing perceptions.

The only valid focus of examination for a regulatory body, such as the CPSO, is the individual. A Section 75, for example, is designed to deal with an individual and that individual's responsibility to his/her patients. The complaints and discipline processes both center on individual events and acts in a specified moment in time - a point made very strongly in Mr. Code's analysis who criticized this lack of specificity as an abusive usage of the discipline process in the cases he examined.

We submit that it is not the job of the CPSO to examine entire groups of doctors, nor to "run" medicine autocratically. If the CPSO interprets the cited legislation ("establish and maintain standards of practice") in this narrow fashion, we submit they do so by ignoring the larger and universally assumed context of medicine as a human enterprise and, especially, as a legally protected endeavor. Since the Minister of Health is in charge of the CPSO, the people of the province run medicine, in the final analysis. As patients and human beings we are not supportive of the CPSO's small group of bureaucrats, who do not practice medicine, deciding through "benchmarking exercises" what is supposed to be, in this dis-embodied application of arbitrary opinion, the "appropriate feedback" to "influence practice patterns."

In this particular wish for legislative change we have the core ***problem, namely that the CPSO thinks they exclusively run medicine in Ontario****. We, feel that change in medicine, on the individual as well as the historical level, is a patient-driven process and must remain so. Medicine is a service for the many, not an fiefdom run by the few.*

Furthermore, the research the CPSO author cites to support the above request (between pages 24-40) is open to many interpretations. Much of this research is highly critical of the very concept of self-regulation; it is mystifying why this research is cited in this context at all, since it contradicts the author's point. Most of the literature cited is proof of the public's frustration with medical licensing authorities and supports our strong criticism, rather than the not so veiled wish for more control that the CPSO submission amounts to. The notion, that the CPSO should share the Ministry of Health's informational source for "appropriate feedback", is most alarming. We have experienced in Ontario, over the last decade of the CPSO's abuse of the RHPA, just what this sort of unilateral, arbitrary and autocratic "feedback" did to influence the practice of medicine:

a.. We saw how the Adams case was used as a "deterrent" to those practice patterns that the CPSO identified among pain doctors. Currently, we are forced to witness the potential miscarriage of justice in the ongoing case against pain expert Dr. Gale, also described above. We know from the CPSO whistleblowers, that Deputy Registrar Dr. Carlisle is planning to investigate all pain doctors in the province systematically through the (secret) Quality Assurance process as well as via Discipline (where Section 75's can be College-driven and have no regard for patient outcome). In short, in the hands of a fundamentally antique and frequently abusive organization, such as the CPSO has shown itself to be, such informational power is likely to be even more

disastrous to patient care, and it would help to put even more of a brake on medical progress than has already been witnessed to date.

b. We have seen how innovative allergy and asthma experts like Dr. Ravikovich and Dr. Kooner were treated and the total disregard the CPSO showed for the suffering of their patients. The CPSO showed itself to be willing to stop treatment methods that are "different" simply because they are different. The simple fact that these doctors have different practice patterns was enough to prosecute them.

c. The OMA Sections on Pain and Complementary Medicine were in part founded in order to have some strength through numbers and employ the democratic process as tools against unwarranted persecution. The Section head of one of them still does not give out the complete membership list to the very members of that OMA Section, for fear it might get into the CPSO hands accidentally and allow large-scale action, i.e. look at "practice patterns".

d. The correspondence in the case of Dr. Krop made it amply clear that the intention of the CPSO was to "deal with these clinical ecologists once and for all" basically "in the aggregate".

One danger in examining practice *patterns as patterns without the knowledge of those responsible for those patterns* lies in the very real possibility of actively homogenizing medical practice. That does not serve patients, nor is it efficient, as change is frequently for the better, especially in a practical science based on empirical experience. The problem of power is central*: who decides which way the pattern is to be stabilized?* As our environment - physical and social - changes so do our illnesses and the sources of trauma. Who is wise enough to know what ought to be receiving "appropriate feedback" to influence the direction of change? (Benjamin Franklin's famous observation applies here:"When everybody thinks the same, nobody is thinking.")

We would submit that the wisdom, which informs change, comes from patients whose understanding is born of suffering and from doctors who observe with care and compassion. This kind of experiential knowledge creates Medicine.

Finally, the danger of perverting science as an open-ended enterprise is equally serious and applicable, as we saw in the examples above where science was selectively used by the prosecution. In an e-mail of June 28, 2001, to all CPSO Council members, former Council member and pain expert, Dr. Ellen Thompson, applauded the forced resignation of Registrar Dr. J. Bonn (announced on that day) and wrote: **"We must never again be embarrassed by CPSO actions founded on the concept that valuable medical/scientific data are engendered only in TO and 100 miles radius around."**

So far, the Ministry of Health has not made their database available to the CPSO, and it is hoped that they never will. The cases presented above provide evidence for the selective targeting of specific medical specialties by the CPSO's administration, as was also shown in examples of Deputy Registrar Dr. J. Carlisle's correspondence. One hates to contemplate what he would do if he had access to a broad database on doctors' practice patterns. In effect, making such information available would amount to the Ministry of Health becoming subordinate to the CPSO in terms of determining policy. But the CPSO is not elected by the people of Ontario, as the government and the Minister of Health are.

6. **The CPSO requests "authority to obtain information about the member, such as medical history, educational records, and so forth, without the member's consent"** (p44).

This is a deeply troubling request - especially the phrase **"and so forth".** One wonders why the College would want to transgress privacy in such a blatant fashion with regard to its own members. If a member is to be brought into Fitness to Practice, one would assume that the reasons have to do with that person's verifiable performance as a doctor. Past records of education and health (and so forth) may not have anything to do with the matter at hand. After all, educational records are easily available by usually just asking for them from the member. No indication is given how such information would be used and what purpose it would serve. Not a single example is given: how many cases have actually come up where such a fundamental breach of privacy would have been helpful to protect the public? It is highly unlikely that such a request for power would withstand a *Charter* challenge. HPRAC is silent on this issue.

7. **The CPSO requests changes that would enable it to "combine information into one comprehensive investigation"** (p.2, 4).

The author of the CPSO submission states that presently "a variety of processes deal with different types of information… information from members of the public is channeled through the Complaints Committee. Other information [*see their chart in Figure One, p.3, which does not identify the fact that "other information" refers to College-driven Section 75 cases unrelated to complaints]* is channeled through the Executive Committee. Information labeled a clinical concern is often directed to the Quality Assurance Committee, whereas issues of incapacity [*substance abuse, mental incapacity etc.*] are channeled through the Executive Committee, a Board inquiry, and ultimately the Fitness to Practice Committee. Cases for the Discipline Committee can come from the Complaints or the Executive Committee."

The CPSO wants to streamline all of this into one process so that (p.6) **"all information coming to the College about a member, regardless of source, should be treated in a comprehensive and integrated fashion. This would mean that a patient complaint would be dealt with in a similar manner as information from a Coroner."** Furthermore, this process should also permit for "fast fact gathering" and the "ability for

the College to gather further information", and then send the case to either Quality Assurance or Discipline. No safeguards are suggested for such rapid action and no limits considered with regard to information gathering. Tagged on is the alarming request for legislative authority to ensure that members cooperate with these processes, already highlighted above and discussed in point 4.

Our impression of this request is that the CPSO is anxious to lump parking tickets together with murder cases. Any sort of streamlining implies a concentration of power and decision-making, rather than diffusion and balancing of power.

The CPSO whistleblowers were at great pains to explain that the vast majority of complaints are easily resolved, and that it is the really serious ones that are so frequently mishandled. The currently ongoing case against Dr. Errol Wai-Ping and all the other shocking doctors' cases reported in the *Star* provide examples. This allows especially the Deputy Registrar, who traditionally is in charge of discipline, to put CPSO resources in a highly targeted and concentrated manner exactly where he, arbitrarily, wants them to go.

If this request were granted, it would also nicely allow the Deputy Registrar to identify "deliberate behavior" etc. Finally, since the request discussed in point 2 above aims to eliminate the safeguard of having the Executive Committee approve action, the CPSO would then have a truly fast and efficient system through streamlining information and eliminating safeguards. The move to the equivalent of a police state would then be complete. The whole complaints and discipline process would boil down to the arbitrary "just because" that children offer questioning adults.

With power so unchecked and unbalanced, all the rhetoric about "serving the public" in the rest of the CPSO submission, rings hollow. With its credibility in tatters, requesting such additional powers simply reinforces the public perception of the CPSO as an "old boys club".

The HPRAC Report in essence agrees with this entire concept as evidenced in their recommendations no. 13 (already discussed above) and 14 which deals with merging the functions of the Discipline and Fitness to Practice. This is in need of careful examination because in Fitness issues all patients are presumably endangered (e.g. an alcoholic doctor), while Discipline issues are quite different and not as immediately urgent in most cases. In HPRAC's recommendation no. 49 flows from these considerations, and we feel that only those complaints should be on the register which actually led to a decision, a reprimand, or some sort of action such as a reprimand. This recommendation requires a legal analysis, as doctors are entitled to the same level of protection as any other citizen.

8. **In cases of third party complaints, the CPSO feels that these should be permitted with patients' consent or their legal representative *where feasible***.

This recommendation is based on one of the questions put by the HPRAC review committee to all the Colleges. It is not clear from the CPSO's response how important this issue is to them. It is obvious, that third party complaints in the case of a death (parents complaining about a child's death, a spouse about a deceased or injured partner) are legitimate exercises and necessary.

Our concerns have to do with negative experience of another kind. In some of the discipline cases described above, third party complaints were potential initiators of abuse. One "complaint" the CPSO prosecution attempted to use in the case of Dr. Krop was from the daughters of a woman who had spent a portion of her savings to make changes to her house in order to control her symptoms - which turned out to be very successful and improved her health greatly. Undertaking these changes was based on what she had learned about environmental control while being treated by Dr. Krop. The daughters were most annoyed that their mother's savings were being depleted. The mother's strenuous objection to having her case used in support of the prosecution was, fortunately, successful.

This point also raises the whole issue of patient consent in discipline cases. The record of those doctors reported above shows in every case the utter outrage expressed by cured or greatly helped patients in having their charts used against their will to prosecute the doctor on whom they rely. Our recommendations, therefore, will include in the next section, legislative change to enshrine patients' rights to refuse use of their charts. Possibly, a *Charter* issue is involved here: it seems that such a use of a patient's chart amounts to forcing that patient into giving information about somebody else.

HPRAC suggests (on p. 62 of their report) that third party complaints should be considered, but that entails that these parties are entitled to their own legal counsel. Other than family members of a deceased or incapacitated patient, third parties are not likely to be in direct contact with the physician concerned, and the field is wide open to spurious and irrelevant involvements all of which would complicate the matter greatly.

9. The CPSO wants to have the power to close a member's practice immediately, if concern exists that this doctor is dangerous to patient's (p.13).

Citing the 1990 Health Protection and Promotion Act, which provides powers to public health officers to close a business if a health hazard is identified, the author of the CPSO submission suggests the same powers should be available to the CPSO. We disagree for two reasons: in cases where such powers might have been used for the benefit of the public, such as in the now ongoing case of Dr. Errol Wai-Ping, the available powers to act quickly were not used for years. Under these circumstances, it is difficult to rid

oneself of an overwhelming sense of the absurd when discussing this point at all - it is patently clear that the CPSO has a dismal record in using the available powers, so why consider giving them more?

The second reason has to do with the very different procedures involved, actual and potential. The application of the Health Protection and Promotion Act has no secrecy involved and requires an impartial authority's consent. In addition, everything that is done, must be done expeditiously. Given the record of abuse in CPSO procedures, a doctor could be closed down for a long time before the facts of the situation are actually known and verified. In the meantime, his patients are without a doctor and he is without an income.

As for the HPRAC Report, its recommendations nos. 32 – 35 address this issue. We note that their recommendation no. 32 suggests that it is sufficient for the Executive Committee or the Complaints Committee to issue an interim suspension merely on the low civil standard of "balance of probabilities". This might be open to challenge under Section 7 of the Charter. The case law we cited earlier, such as *Bernstein 1977*, established that "balance of probabilities" is simply not acceptable in serious situations that could amount to professional death. The criminal standard of "reasonable and probable grounds" has, time and again, been established as appropriate in such situations. Interim suspensions are a vitally important tool for protecting the public from harm, but given that such suspensions are more likely in sexual abuse allegations, appropriate standards are needed to protect the doctor from frivolous accusations and to protect the public from loosing a doctor unnecessarily.

10. "The existence of a complaint or an ongoing investigation is not public", the CPSO submission states. "In an era of increased public expectations about access to information, the Colleges need legislative direction to provide more information to the public about their activities." (P14ff). They propose various changes.

If the CPSO did not have such a troubling history over the past decade, one would not be too concerned with this point. However, we feel that such a proposed change should first be examined by *Charter* experts and legal specialists in the rights and responsibilities involved in disclosing information to the public. The bottom line should be that doctors should have the same rights and protections which those accused of other crimes enjoy.

The HPRAC Report deals with this issue in their recommendations no 48 and 49. We would submit that legal advice should be sought to ascertain whether a different standard of privacy is applicable to a doctor than to any other citizen brought into the legal system. Under what circumstances do Canadian courts permit public access to information in ongoing legal/criminal proceedings against a person?

11. **In situations before the HPARB, the CPSO wishes to be exempt from the required provision of disclosure "because the College is the respondent in such hearings and accordingly would not ordinarily have an obligation to disclose. The College cannot know what information the applicant intends to rely on. Given that it is the applicant's process, it is applicant who should be obliged to disclose the relevant materials to the College."** (p.42 and 43)

Whatever rules apply to cases of negligence and criminal law should here be seriously considered once again before anything is done. The above appears reasonable until viewed in light of the CPSO's history of abuse. Disclosure has been one of the abuse issues in the cases described earlier.

In fact, what the doctor wants in the cases referred to here, is access to that information on the basis of which the CPSO acted against him/her in the first place. He or she was presumably not given that information, otherwise there would be no appeal. What the CPSO appears to be asking for (under the disguise of fair play) is protection from having to provide disclosure that was never the right of the College to withhold.

The Crown has the obligation, in the courts, to lay all the cards on the table. A quasi-judicial body like the CPSO, with the power to carry out professional death sentences and deprive patients of a doctor they might cherish, should not be allowed to have powers the Crown does not have.

HPRAC comments in detail on p. 73 of its report on this matter. We do not agree with their recommendation for reasons set out above.

12. The CPSO wishes to have the power to "amend the Notice of Hearing [in discipline cases] when the allegation has changed, or to conform to the evidence at a hearing." They wish to have the RHPA drop the requirement prohibiting such changes, or provide the power to amend this notice "before the hearing starts" or permit the panel to amend it "after the hearing starts, if it is just an fair to do so."

It is our understanding that in criminal cases in the courts, changes cannot be made to the material substance in a notice of hearing, except minor factual items. It is astonishing that the CPSO submission, which presumably was read by both Registrar Dr. J. Bonn and Deputy Registrar Dr. J. Carlisle, both of whom are also trained in law, would make such a request. In practice, this freedom which the CPSO does not have, is already being exercised in discipline cases. The cases of Dr. Krop, Dr. Ravikovich, Dr. Dean, and Dr. Kooner illustrated this fact.

In the currently ongoing case against Dr. Gale, his defense lawyer, Mr. Jerome Morse, made the point in a similar context, that the way his client is being prosecuted is as if he was "a moving target", making the proceedings "trial by ambush". The prosecution keeps changing the charges so that preparation of a defense is impossible. Another way to characterize this request is as if it was a request for a hunting license, regardless of the season.

It would be most interesting to have the author of the CPSO submission explain in practical terms just what such changes to the notice would look like, how the evidence could change, when a hearing is supposed to stick to the points originally raised, and just exactly who decides and on what basis "it is just and fair" to change the notice of hearing.

> **13. The CPSO suggests (p. 10 f) that a "Systems Review" would be helpful in situations where "the College must confine its inquiry to the actions of the member, when in fact a host of factors may have contributed to an adverse clinical outcome". The CPSO envisions "a system similar to that of the Coroner's review in Ontario – a public process through which recommendations are made to improve system design." However, the CPSO also wishes that this "system-level review could occur at the same time as the College's review of the individual-level issues."**

We are disturbed by the potential for self-incrimination, which is a *Charter* issue of serious importance. The systems review referred to here does not allow, in the case of a coroner's review, for the principal persons involved to be subject to a court procedure while simultaneously giving evidence at the review. This is, however, exactly what the CPSO submission to HPRAC suggests as desirable for doctors. The doctor would be expected to provide evidence with regard to what went wrong in the whole system he/she was involved in, while at the same time being in a disciplinary investigation where he/she stands to lose their license. Any evidence provided for the systems review is public and can then be used against him/her by the CPSO.

This potential for self-incrimination is highly relevant, being a fundamental Charter issue under section 13, because this already occurred in the long delays involved in the Section 75 cases described above as well as in the specific situations of self-incrimination discussed in the cases of Dr. Ravikovich and Dr. Krop: they were interviewed about their practices while deliberately being led to believe this was not taking place for purposes of a Section 75 investigation.

Any such Systems Review should only be undertaken by the Minister and not be administered and evaluated by any of the Colleges.

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IX. OUR RECOMMENDATIONS FOR ACHIEVING "GLASNOST"

As stated at the outset, an opinion is being prepared on what *Charter* issues may have been, and currently might still be, involved in the way the CPSO has handled complaints and discipline; the requests made in their submission to HPRAC, which we have critiqued here, will also be scrutinized in light of the *Charter*. We have here, in our opinion, major violations of the human rights of patients and doctors. These are wrongs that we feel must be attempted to be righted and, at the very minimum, be prevented in future.

We make three general recommendations, a proposed test for public accountability, and several highly specific suggestions for changes in legislation.

General Recommendations

1. **We suggest that the Minister of Health under the Public Inquiries Act, Part I, Section 2 initiate an inquiry, as this matter is *"connected with or affecting the good government of Ontario"* and ought to *be "declared a matter of public concern."*** The doctors who lost their licenses, or who have been unfairly convicted, and whose cases went to discipline over the signature of the recently fired Registrar Dr. John Bonn, need to have their cases re-examined and the miscarriage of justice, if proven, corrected. The patients' complaints connected with those doctors whose cases were made public by the *Star* inquiry demand the same attention, as they constitute grave matters of public concern.

2. **We suggest that the Ministry of Health establish a task force that re-examines the merit and processes of self-governance in order to develop a harmonization of such self-governance with the changing times.** New Zealand's *Cull Inquiry* may be helpful in this regard; a copy of this report is available upon request. Its most important recommendation is adopted here and found below in the specific recommendations. We believe that a structure that allows one small closely interconnected group of people to act as investigators, prosecutors, judge and executioner is very dangerous indeed because it does not ensure adequate checks and balances. Self-governance, as interpreted by the CPSO, may very well be in violation of Canadian Charter rights.

3. **We suggest that anything currently in the health care legislation and in the administrative rules of the Colleges (not just the CPSO) that permits unwarranted or arbitrary secrecy in the administration of discipline and complaints are removed**. It is imperative that transparency, accountability, fairness, confidentiality, and full disclosure are a legal and administrative reality. It is important to emphasize that secrecy is not and cannot be synonymous with

confidentiality and privacy. Secrecy, as we are experiencing it in the Quality Assurance process at the CPSO and the handling of complaints, makes verification impossible for even the involved parties.

4. **We suggest that consideration of patient outcome become essential, as it is already in the USA's medical guidelines sine 1997.** While the Kwinter Bill ensures that the *Medicine Act* supports the principle of responsible innovation in the doctor-patient relationship, the importance of patient outcome is not thereby also supported explicitly. MPP Marie Bountrogianni (Hamilton Mountain, Lib.) went on record during the Committee hearing on the Kwinter Bill on December 11, 2000, that this principle ought to be enshrined in health care legislation.

5. **We suggest that standards for the maintenance of medical excellence be designed along mandatory CMA and international medical lines.** Specialists in various areas, for example, are required to attend at least one major medical conference and take part in various educational exercises to maintain their membership status. A similar requirement could be considered as a CPSO policy. Discipline is not the appropriate forum in which to develop medical standards.

A Proposed Test for Public Accountability

The authors of the KPMG report express their concern about the fact that **"no test [exists at the CPSO] for assessing whether something is in the public interest"** (p.41) We herewith propose such a test. It likely requires refinement and improvement. We assume that Medicine is a patient-centered science. These questions should be asked before embarking on disciplinary action against a doctor and when assessing a patient complaint:

1. *Do the patient and the doctor both understand the same issues involved?*
2. *What was the outcome of the treatment in the opinion of the patient?*
3. *What was the outcome of the treatment in the opinion of the doctor?*
4. *Did the treatment in the specific patient's opinion improve or reduce the patient's quality of life?*
5. *Did the treatment in the doctor's opinion, in the specific patient's case, improve or reduce the patient's quality of life?*
6. *Was the outcome, if negative, inherent to the illness?*
7. *Was the patient informed of the risk of possible negative outcomes or side effects?*
8. *In the circumstances of a specific patient's situation, what is the minimum quantity and quality of evidence required to inform doctors and patients and to permit them to weigh the risks and benefits when deciding upon a course of treatment?*
9. *Is the treatment in keeping with and supported by research or by practice experience of a responsible group of medical professionals, nationally or internationally?*
10. *Was the therapy performed in keeping with the guidelines of a knowledgeable and experienced group of peers practicing in that specific area, nationally or internationally?*

Once this general test has been applied, the next stage would be a careful examination of the evidence. Most of the recommendations made by KPMG would, if implemented, ensure that bias and arbitrary application of judgement is reduced to a minimum.

If the reader employs these seven points in his or her mind as a tool to test the cases discussed in this submission, it will be clear how serious the abuse has been in the cases of doctors and patients presented here.

Specific Recommendations to HPRAC

We agree with most of the recommendations made by the authors of the KPMG report, except the last one regarding mandatory reporting of fellow members; we gave our reasons for this disagreement earlier and feel that the KPMG authors would likely agree with us, had they been in possession of the same set of facts that we are. We wish to add some specific recommendations.

1. **In a doctor's disciplinary investigation, the consent of the patients (or their surviving relatives) whose charts are being used for this purpose is essential.** Anything else may very well be a violation of personal rights. Almost every case we discussed proceeded against the stated objections of the patients whose charts were used for the purpose. This change might best be incorporated in the RHPA under Section 75, Schedule 2, and ought to require independent approval by a court.

2. **In order for the CPSO to continue to function at present and be safeguarded against the return of dysfunctionality in the future, it is necessary that the terms of the key staff be changed**. The President of the CPSO serves for merely one year, which means that the Registrar and the Deputy Registrar run the College, and the President is rendered essentially ineffective. Currently, the Deputy Registrar (now interim Registrar), Dr. John Carlisle, has been there for almost 3 decades and has become the institutional memory of the CPSO. Every President, of necessity, defers to his interpretation. Therefore, **we propose that the President of the CPSO serves for a longer term, possibly for 3 years and that the Registrar and the Deputy Registrar serve for fixed contracts, possibly for 4 years, with an upper limit of 2 terms of 4 years.** That way some time-overlap ensures administrative continuity but does not transfer control over policy to the Registrar and the Deputy Registrar ever again. The positions of Registrar and Deputy Registrar should be open for application by the entire membership in a process that involves broad consultation with all the appropriate stakeholders also from outside of the CPSO. This change may be incorporated in the *Medicine Act*, following Section 7.

3. Following on the KPMG recommendation that more public members be involved on Council, we would add **that every effort should be made that representatives of**

the patient advocacy groups, or individual and publicly known advocates, be appointed to Council as well. Our suggestions are threefold on this point:

a. It is now internationally a matter of routine to have representatives of NGOs (such as *Greenpeace)* not only sit on many international treaty panels, but sometimes even initiate such treaties, such as the recent one on Persistent Organic Pollutants. Similarly, this submission and the information it contains would never have been possible if such patient advocacy groups and concerned individuals had not done all the work required to unearth these facts. Such appointments would ensure transparency. This requirement might best be included in the *Medicine Act*, Section 6.
b. We believe that in order to prevent bias, or the appearance of bias, the physicians on discipline panels should be selected as for jury duty from the profession at large, as New Zealand has also proposed.
c. Furthermore the actual selection of the discipline panel members must be done by an outside organization.

4. **In the Regulations governing the *Medicine Act*, Part VII, Quality Assurance, Section 28, the requirements for a Peer Assessment do not include a definition of "peer".** The standard edition of the Oxford English Dictionary defines a peer as *"one who takes rank with another in point of natural gifts or other qualifications: an equal in any respect."* Currently, we know of at least 11 cases of doctors being called into supposedly random peer assessment who only share one thing in common: they publicly criticized the CPSO in newspapers or other media specifically on the CPSO's handling of the complaints and discipline processes. The documentation on these cases could not be readied in time for this submission. The statistical probability of these assessments to have been generated at random (as the College requires it to be and asserts it is done) is extremely remote. In these and many other cases known to us, there is always an often-acrimonious debate between the physicians and the College about who will do the review. Time and again an assessor is assigned who is in no way whatsoever a peer of the one to be reviewed. Therefore:

   a. A definition of peer is as essential to the smooth and fair functioning of the Quality Assurance programs.
   b. Furthermore, mediation and alternative dispute resolution (ADR) should be revived, and not be completely at the discretion of the CPSO's preference for secret routes.
   c. Records should be kept of all QA proceedings, at the very least on audiotapes.

In this context, as we turn to the *Regulated Health Professions Act*, we suggest changes to Schedule 2. Starting with Section 3, the duties of the College are provided. The sub-sections specify the details. We assume that the authors of this legislation

took it for granted that the practice of medicine is based on worldwide research and clinical experience. The fact is that the CPSO, as former Council member Dr. E. Thompson observed is capable of interpreting these provision to exclude anything outside a 100 mile radius of Toronto, as well as anything "you haven't heard of" (see Mr. Poslun's comment in Dr. Kooner's case above). That means, this can happen again and must be prevented.

5. We propose that sub-sections 2 through 4 of Section 3 be expanded as follows: "To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession **having full regard for internationally recognized standards of medical practice.**" (Highlighted portion is our suggestion to sub-section 3 of Section 3, Schedule 2).

It should be noted that Section 3(2) also states that "in carrying out its objects, the College has a duty to serve and protect the public interest." We understand this to imply that the College must take into consideration the needs and views of a broad range of stakeholders and developments in medicine within Canada as well as abroad. Given the College's actions in a number of discipline cases we have discussed, it may be necessary to spell out in Section 3 the importance of having full regard for internationally recognized developments in medical practice. It cannot be taken for granted anymore.

6. We propose that Section 25 of Schedule 2 be expanded as follows: a **provision is required that would make it mandatory for a copy of the actual staff report on a patient complaint to be provided to both the patient and the physician against whom the complaint was made.** This is an essential requirement and should be included in the legislation. Currently, the law only requires providing them with a copy of the decision.

7. **We propose that full disclosure of what led to a physician's disciplinary or peer assessment be a mandatory requirement.** Currently, such disclosure becomes a requirement only under Section 32, sub-section 2 if the case comes before the Board. It is highly likely, that such a change is needed to harmonize the RHPA with the *Charter*.

8. We propose **a safeguard to be added to Section 37, of Schedule 2**: currently, it is sufficient for the Discipline Committee of the CPSO to be of "the opinion that the conduct of the member exposes or is likely to expose his or her patients to harm" (Section 37, sub-section 1, b) to permit the Committee to "suspend or impose terms, conditions or limitations on a member's certificate of registration". We have seen the abuse of this power especially poignantly in the case of Dr. Adams. It may be argued that in cases of serious risk, such as might be the case in Dr. Ping's practice, such powers are needed. We submit that in the case of the innovative doctors as well as in the case of the incompetent ones, an additional safeguard would be helpful, especially to patients who feel abused and want the case to become watertight. This is, in our view, the case because it would help to protect the good doctor and ensure the

conviction of the bad one - down the line. Therefore, **we suggest that the Committee share this power of suspension by being required to go before a judge in a court of law and present its objective findings and reasons for such action, with the appropriate involvement of the member and his legal counsel. If an impartial, outside authority agrees that the evidence warrants such action, it should proceed, but not otherwise. The same consideration should apply to Section 71, which deals with incapacity issues and here denies the member an appeal before being suspended. It would be most important for the government to look carefully at the need for safeguards against frivolous accusations.** Time did not permit the inclusion of a doctor's case who was apparently coerced by the CPSO into admitting a non-existent drug problem and a statement that treatment was commencing in order to get back her license to practice. This doctor had no drug problem and never needed or went into a treatment program, but was simply specializing in pain management and ran afoul of the CPSO's prejudices in that area.

9. **We propose an addition to Section 42, sub-section 1 of Schedule 2, regarding the requirements for experts in disciplinary proceedings.** Currently, the legislation merely specifies what the defense and prosecution experts have to do to be admissible in a hearing, such as time-lines, identity etc. What the legislation does not provide is the need for the expert to be an expert in the relevant area of practice. The cases presented in our discussion showed that the CPSO has exercised its powers to promote arbitrary bias towards whatever specialty some members of the administration do not approve of. Thus, the reports made by the CPSO-appointed investigators in every case we presented were not done by members who practiced in that field, had knowledge of it, and some of them were even on record as being biased against that specific specialty. **Section 42 should include the requirement of a peer having expertise in the same field as the member being investigated, so that these absurd investigation reports cease to haunt the medical/legal literature in future.**

10. **We propose that Section 75 of Schedule 2 be removed from the sole authority of the CPSO and be placed into the hands of the courts.** On February 28, 2001, the parliamentary assistant to the Health Minister, MPP Bob Wood, asked during a session of the Standing Committee on General Government, the then Registrar, Dr. J. Bonn, about the manner in which a Section 75 investigation is initiated. Dr. Bonn explained that "I am empowered, with reasonable and probable grounds, to conduct a Section 75 investigation. That gives our inspectors the powers of search and seizure of records. That goes out over the registrar's signature." To this Mr. Wood replied, asking, "One thing we could say is 'OK, you continue to have that power, but we are going to give it, say, to the courts.' So if you want to have access without consent of the patient to a patient's records, you've got to get, in effect, a third party to authorize you to do that." Dr. Bonn objected that this would create extreme operational difficulties, and Mr. Wood invited him to study how efficiently and quickly the police can do this

We agree with the suggestion made by MPP Wood (see our recommendation 1 above). We suggest, in addition, that the entire Section 75 power should no longer be dependent solely upon the "opinion" of the Registrar, but require, additional safeguards external to College. Mr. Code's and Mr. Wilton's discussions on the abuse of Section 75 (items 1,2 and 3 in Appendix) amply support our view on this issue.

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X. SUMMARY AND CONCLUSIONS

The famous saying by architect van der Mees, "God is in the details" may usefully be supplemented with a corollary stating "and the Devil is in the generalities." It has been our aim to provide context and detail - in short the reality of our experience as doctors and patients with the CPSO administration over the past decade. The examples we provided are only a few. We have many more and all are available for scrutiny, if the government wishes to examine this disaster in the administration of medicine in Ontario.

There are two points worth quoting to summarize our presentation before moving on to our specific recommendations. Mr. Code made the first point; the second comes from the CPSO's submission to HPRAC.

1. Mr. Code, in pointing out how far off the mark the CPSO's prosecution was in those doctors' cases, which he studied, discussed the role of the prosecutor. Citing decisions up to the present, he quoted in detail from a decision made in 1955 in R. *v. Boucher*:

"It cannot be over-emphasized that the purpose of a criminal prosecution is not to obtain a conviction, it is to lay before a jury what the Crown considers to be credible evidence relevant to what is alleged to be a crime …. The role of prosecutor excludes any notion of winning or losing … His duty is not so much to obtain a conviction as to assist the judge and the jury in ensuring that the fullest possible justice is done. His conduct before the court must always be characterized by moderation and impartiality."

The cases we have described were prosecuted in a manner that certainly does not fit this ideal. Indeed, several lawyers for the defense and many amongst those patient groups co-authoring this submission noticed the same: usually when the prosecuting lawyer speaks in College Section 75 cases, it has been our observation that the discipline panel takes notes. When the defense lawyers speak (Mrs. Manning, Mr. Wilton, Mr. Hackland, Ms Chown for example), the discipline panel looks at them and rarely takes any notes at all.

No wonder, their written Decisions seem often to bear little resemblance to the actual proceedings and do not reflect the transcripts of the case.

With regard to patient complaints, the *Star* documented the lack of concern the CPSO displayed in so many cases where action was urgently needed. This abuse of the public and lack of concern for patient outcome are equally intolerable.

2. In the CPSO's submission to HPRAC there is a very strange comment on p. 18:

"It is difficult for Colleges to enforce provisions that may be constitutionally invalid." This observation is reiterated in their response to the HPRAC Report. It sums up the CPSO's attitude in many instances of our experience. One gets the eerie feeling that the CPSO experiences itself as being outside the range of rules of fairness acknowledged by the public generally. The assumption of the RHPA is one of good faith. Our examples from the last decade have shown, we believe, that this good faith appears to be often lacking in the CPSO's manner of handling patient complaints and physician's discipline. In the above comment we feel the CPSO displays an attitude that appears to show irritation with not being able to follow an agenda that is not in harmony with the highest law in the land.

The comment is made in context of certain sexual conduct issues, which some doctors have successfully challenged under the *Charter***.** In Prince Edward Island, on August 22, the Supreme Court ruled that "zero tolerance" rules are unconstitutional under Section 7 of the *Charter*.

The *Charter* is the highest law in the land, hence the comment <u>should read "It is impossible to succeed….."</u> because anything contemplated that is found not to be in accord with the *Charter* can be shown to be illegal. In the case of Dr. Krop, his lawyer Mr. M. Manning, made a compelling case for the unconstitutionality of the actions taken against his client and his points are worth contemplating; they are now available in the transcripts. The CPSO's policies and idiosyncratic interpretations of the law serve neither doctors nor patients. In our view, which is in its essentials corroborated by the findings of the KPMG report, the College administration neither represents the membership nor does it understand its mandate correctly. The financial implications of this situation can only be guessed at.

In conclusion we wish to comment on the CPSO' assertion, in their commentary on the HPRAC Report, that **"… we feel strongly that the legislation should provide Colleges with the appropriate framework to deal with issues … but should not prescribe, other than in broad policy terms, how Colleges should deal with these issues."**

It is our view that Colleges should most definitely not be left to do their work without clearly defined limits to their powers. The events of the last ten years, and the still ongoing inappropriate CPSO witch-hunts and dismissal of legitimate complaints, have proven that there is great need for such limits to be set. All College activities should be

scrutinized in the light of necessary checks and balances, and their activities, policies, and guidelines must be brought in line with our Constitution. Members of the health professions and those who are in need of their services are all entitled to the protection of their human rights.

The Committee for the Investigation of the College September 2001

GUIDE TO AUTHORS

OMA Section on Chronic Pain
Dr. Peter Rothbart, Chair
Rothbart Pain Clinic, York Mills Centre
16 York Mills Road
North York-Toronto, ON, M2P 2E5 – 416-512-6407

Ontario Physicians' Alliance
700 Bay Street Suite 1802
Toronto, ON, M5G 1Z6 - 416-595-1817

Citizens for Choice in Health Care
128 Queen Street South, Box 42264
Mississauga, ON, L5M 4Z0 - 416-905-826-9384

Voices on Healthcare Concerns and Accountability (VOHCA)
Box 27018 Gardiners P.O.
Kingston, ON, K7M 8W4 - 613-389-5599

Research Advocacy and Information Network for
Environmental Toxins (RAINET) Box 943
Uxbridge, ON, L9P 1N3 - 1-888-231-1971

Ontario Chelated Patients Association
Box 25
Schomberg, ON, L0G 1T0 - 905-939-8630

Environmental Health Group
2355 Barclay Cresc.
Burlington, ON, L7R 2B7 - 905-632-8634

Patients and Friends of Dr. F. Adams
Box 201
Tamworth, ON, K0K 3G0 - 613-379-2544

Patients and Friends of Dr. S. Kooner
5504 Empress
Windsor, ON, N8T 1B4 - 519-944-5504