Citation: ***Reddoch v. The Yukon Medical Council*** 2001 YKCA 13

Date: 20011211
Docket: YU00418
Registry: Whitehorse

COURT OF APPEAL FOR THE YUKON TERRITORY

BETWEEN:

ALLON REDDOCH

APPELLANT
(APPELLANT)

AND:

THE YUKON MEDICAL COUNCIL

RESPONDENT
(RESPONDENT)

Before: The Honourable Madam Justice Southin
The Honourable Madam Justice Ryan
The Honourable Mr. Justice Braidwood

Stephen R. Schachter and Kevin D. Loo	Counsel for the Appellant
David Martin	Counsel for the Respondent
Place and Date of Hearing:	Vancouver, British Columbia 15th November, 2001
Place and Date of Judgment:	Vancouver, British Columbia 11th December, 2001

Written Reasons by:
The Honourable Madam Justice Southin

Concurred in by:
The Honourable Madam Justice Ryan
The Honourable Mr. Justice Braidwood

Reasons for Judgment of the Honourable Madam Justice Southin:

[1] This is an appeal from an order of McIntyre J., pronounced the 18th August, 1999, dismissing "the appeal of Allon Reddoch from the findings of the Inquiry Committee and from the findings of the respondent".

[2] Essentially those findings were that the appellant, a family physician practising in the Yukon Territory, was guilty of "unprofessional conduct" in the care of a patient, Mary Ann Grennan, who died on the 28th April, 1996, at Whitehorse General Hospital as a result of having contracted botulism, probably from eating, on the 7th September, 1995, marinated or smoked fish. Ms. Grennan, who first attended at Whitehorse General Hospital at 09:00 hours (as the hospital used a 24 hour clock, I shall do likewise) on 8th September, 1995, went into respiratory failure late on the 11th September. It was not until then that the appellant first suspected botulism.

[3] The appeal as it was argued before us gives rise to questions, among others, of the scope of the appeal from the Council to McIntyre J., of the scope of the appeal from McIntyre J. to this Court, and of the proper meaning of the term "unprofessional conduct" in the Yukon ***Medical Profession Act***, R.S.Y. 1986, c. 114 (the Act).

[4] These are the reasons for the decision of the Yukon Medical Council:

> Dr. Reddoch clearly failed to apply the requisite skill and knowledge to the care of Mary Ann Grennan. He failed in all respects to take the normal actions that one would expect of a physician to diagnose and treat a patient with a serious illness. The committee considered mitigating circumstances. These mitigating circumstances consisted of the expression of genuine remorse by Dr. Reddoch. Dr. Reddoch was not indifferent to his patient, visiting her in hospital twice during the short time she was under his care. It is noted that he continued to care for Ms. Grennan throughout the terminal aspect of her illness with diligence. Dr. Reddoch relied too much on the focus and misadvice of other physicians and nursing staff. The Yukon Council did not consider Dr. Reddoch was culpable for not making the diagnosis of botulism. The illness that caused the death of Mary Ann Grennan is rare and had not been heretofore reported in the Yukon Territory. The application of proper medical care and procedures reduces the mortality rate of this disease but does not prevent death in all cases. The purpose of an inquiry is to ensure that adequate medical practice standards are maintained.
>
> The council is also mindful of the tragic circumstances of the outcome and is fully empathetic with the grief of the parents in this matter.
>
> [Emphasis mine.]

[5] The Inquiry Committee and the Council both had before them an agreed statement of facts and, in the case of the Inquiry Committee, the oral evidence of Dr. Paul Assad, a physician from the Lower Mainland of British Columbia who had, at one time, been an emergency room physician, and of the

appellant. I assume the Council had a transcript of the oral evidence as did McIntyre J. and this Court.

[6] It is not clear to me why Mr. Martin thought it necessary to call Dr. Assad, whose evidence went only to the question of good medical practice on the part of family physicians, a matter upon which the members of the Council, all family physicians practising in British Columbia, presumably were knowledgeable.

[7] The agreed statement of facts contained this passage concerning botulism:

> 39. A neuroparalytic disease caused by the toxin produced in clostridium botulinum. There are only a small number of cases per year in Canada and there is a mortality rate of about 14% rising to 25% in the case of a first patient in an outbreak. There have been no known previous cases in the Yukon. Most food-borne outbreaks in Canada are due to home prepared foods, especially fermented foods and improperly stored seafood. The symptoms of food-borne botulism include ptosis, visual disturbances, vomiting and sore throat followed by descending symmetrical flaccid paralysis in an alert afebrile person. There are no routine laboratory tests available to diagnose botulism. Injection of serum into mice can be used in tertiary centres, otherwise diagnosis is on history and clinical grounds. Treatment with specific antitoxin only neutralizes toxins that are unfixed to tissue. Supportive therapy, especially with assisted ventilation, is the mainstay of treatment.

[8] Dr. Assad, who had practised since 1973 or 1974, testified that he had never encountered a case of botulism. In

answer to the question whether he faulted Dr. Reddoch for missing the diagnosis of botulism in this case, he replied "no".

[9] The dictionary tells us that ptosis is "drooping of the upper eyelid from paralysis of the elevator muscle". I add to that passage, not as evidence, because it was not put before either the Committee or the Council and could not have been, but by way of explanation for the Council not faulting Dr. Reddoch for his failure to diagnose Ms. Grennan's condition, two extracts from authoritative medical publications:

From a bulletin on botulism published by the American Centers for Disease Control and Prevention in Atlanta, Georgia (see http://www.cdc.gov/ncidod/dbmd/diseaseinfo/botulism_g.htm):

> How common is botulism?
>
> In the United States an average of 110 cases of botulism are reported each year. Of these, approximately 25% are foodborne, 72% are infant botulism, and the rest are wound botulism. Outbreaks of foodborne botulism involving two or more persons occur most years and usually caused by eating contaminated home-canned foods. The number of cases of foodborne and infant botulism has changed little in recent years, but wound botulism has increased because of the use of black-tar heroin, especially in California.
>
> What are the symptoms of botulism?
>
> The classic symptoms of botulism include double vision, blurred vision, drooping eyelids, slurred speech, difficulty swallowing, dry mouth, and muscle weakness. Infants with botulism appear lethargic, feed poorly, are constipated, and have a weak cry

> and poor muscle tone. These are all symptoms of the muscle paralysis caused by the bacterial toxin. If untreated, these symptoms may progress to cause paralysis of the arms, legs, trunk and respiratory muscles. In foodborne botulism, symptoms generally begin 18 to 36 hours after eating a contaminated food, but they can occur as early as 6 hours or as late as 10 days.

From the *Journal of the American Medical Association*, 28th February, 2001, Vol. 285, No. 8, at p. 1065:

> Differential Diagnosis
>
> Botulism is frequently misdiagnosed....
>
> A large, unintentional outbreak of foodborne botulism caused by a restaurant condiment in Canada provides a cautionary lesson about the potential difficulties in recognizing a covert, intentional contamination of food. During a 6-week period in which the condiment was served, 28 persons in 2 countries became ill, but all were misdiagnosed (Table 3). The 28 were identified retrospectively only after correct diagnoses in a mother and her 2 daughters who had returned to their home more than 2000 miles away from the restaurant. Four (14%) of the cases had been misdiagnosed as having psychiatric disease, including "factitious" symptoms.

THE RELEVANT STATUTORY PROVISIONS

[10] By ss. 22 and 23 of the Act:

> Investigations
>
> 22. (1) The council, or any person as may be appointed for the purposes of this section by the council, may
>
> (a) investigate whether or not a member of the medical profession practising medicine in the Yukon is bringing to his practice such skill and knowledge as is considered

adequate according to generally accepted standards of the medical profession in the Yukon, and

(b) require such member to undergo such examinations as the council considers, for the purposes of the investigation, appropriate.

(2) Where an investigation or examination is carried out under subsection (1), the investigator shall submit, forthwith after the investigation or examination is completed, a written report to the council.

(3) The council shall serve on the member of the medical profession concerned in such an investigation a copy of the report and a notice of the time and place where the report will be considered by the council.

(4) Where a report is submitted to the council under this section, it may, after giving the member of the medical profession concerned a reasonable opportunity to answer any matter contained in the report, determine that the member should not be permitted to practise medicine or that his practice of medicine should be restricted and may act in accordance with subsection 24(3).

Inquiry

23. (1) The council may, on its own motion, or shall, where requested in writing to do so by

(a) any three members of the medical profession, or

(b) any member of the public, upon production of proof satisfactory to the council,

cause an inquiry to be made by an inquiry committee into any charge or complaint made, in any form or manner whatsoever, against any member of the medical profession practising medicine in the Yukon, or into a question concerning the conduct or mental condition or capability or fitness to practise medicine of any such member.

(2) Where an inquiry is to be made pursuant to subsection (1), the council may cause the member of the medical profession so charged or complained

against to be suspended from the practice of medicine in the Yukon until such time as the results of the inquiry are made known to the council by the inquiry committee pursuant to subsection 24(1).

(3) The council, in causing an inquiry to be made under this section, shall appoint an inquiry committee of not fewer than three members of the medical profession.

(4) If in the opinion of the council the charge, complaint or question to be inquired into appears to concern the mental or emotional condition of a member of the medical profession, the inquiry committee shall, in addition to the requirements of subsection (3) include at least one psychiatrist as a member.

(5) Notwithstanding anything contained in this section or section 24, the council may cause the conduct of a member of the medical profession practising in the Yukon to be summarily investigated by an investigator appointed pursuant to section 29, with a view to determining whether or not a complaint is frivolous or appears to be sufficiently serious to justify the appointment of an inquiry committee under this section.

(6) Where a charge or complaint is found by the investigator not to be frivolous, but not sufficiently serious to justify the appointment of an inquiry committee, the council may, upon hearing the member of the medical profession so charged or complained against, reprimand such member.

[11] By s. 24:

Report of inquiry committee and action by council

24. (1) An inquiry committee shall find the facts of the matter to be inquired into and, in addition, shall find whether the charge or complaint has been proven, and shall report its findings to the council in writing as soon as practicable.

(2) At any time after it has commenced taking the evidence respecting a charge or complaint, the inquiry committee may of its own motion suspend from practice the member of the medical profession whose conduct is under inquiry until the next meeting of the council and shall promptly give written notice of the suspension to such member and the registrar.

(3) If the council, upon a report made under subsection (1), considers that a member of the medical profession practising medicine in the Yukon has been guilty of infamous or unprofessional conduct or that such member is suffering from a mental ailment, emotional disturbance, or addiction to alcohol or drugs that might, if such member continues to practice medicine constitute a danger to the public, the council may

(a) cause the name of such member to be struck from the Yukon medical register, the temporary register, the limited register or the corporation register,

(b) suspend such member from the practice of medicine for such period as may be prescribed by the council,

(c) cause the name of such member to be struck from the Yukon medical register, the limited register or the corporation register, as the case may be, and direct the registration of such member in the temporary register be subject to whatever terms and conditions the council may prescribe,

(d) impose upon such member a fine, not to exceed the sum of $10,000, to be paid into the Yukon Consolidated Revenue Fund within such time as the council may prescribe,

(e) reprimand such member, or

(f) suspend the imposition of punishment and place such member on probation upon whatever terms and conditions the council may prescribe.

(4) The fine provided for in paragraph (3)(d) may be imposed in lieu of or in addition to any imposition of punishment under paragraph (3)(b, (c), (e) or (f).

> (5) If a charge or complaint, or allegations of a breach of a term of probation, is made against a member of the medical profession who is on probation under subsection (3), the council may inquire into the matter in a summary manner and, upon proof thereof to the satisfaction of the council, terminate the probation and impose another punishment or penalty under subsection (3).
>
> (6) A fine imposed upon a member of the medical profession under subsection (3) is a debt due by such member to the Government of the Yukon, and if it is not paid within the time for payment fixed by the council, that member is deemed suspended from the practice of medicine until the fine is paid.
>
> (7) Where a charge or complaint, or allegation of a breach of a term of probation, made against a member of the medical profession is, in the opinion of the council, unfounded or without sufficient evidence to substantiate the charge, complaint or allegation, the council may summarily dismiss the charge, complaint or allegation without any further action on the part of the council.

[12] The provisions as to appeals I shall quote hereafter.

THE CHARGES AGAINST THE APPELLANT

[13] The appellant was charged thus:

> The Yukon Medical Council has, pursuant to section 23(1) of the Medical Profession Act, S.Y.T. 1979 (2nd) c. 114, and amendments thereto appointed an Inquiry Committee, the members of which are as follows:
>
> - Dr. Robert Marshall - Chair
> - Dr. Glen McIver - Member
> - Dr. J.G. Wilson - Member
>
> You are hereby given notice that the said Inquiry Committee will inquire into your conduct or capability or fitness to practise medicine in the

> Yukon with regard to the following charge, namely, that you, from about September 10, 1995 to about September 11, 1995, failed to take appropriate steps in the management, treatment and care of your patient, Mary Ann Grennan, at Whitehorse General Hospital, in that you did not:
>
> 1. record an adequate history of her present illness;
> 2. carry out adequate physical examinations;
> 3. make an adequate record of any physical examinations conducted;
> 4. record your expected differential diagnosis and working diagnosis; and
> 5. record a plan for the management of her illness.
>
> In relation to the foregoing, you have been guilty of infamous or unprofessional conduct.

[14] It was not the thrust of the charges, as I understand the course of proceedings, that if the appellant had done what the Committee found he ought to have done, the outcome for the patient would have been different.

[15] The thrust is in this passage of Mr. Martin's submission to the Inquiry Committee:

> I also want to make it clear at the outset, and I think this is obvious, that Dr. Reddoch, in the charges, is not blamed for missing a diagnosis of botulism. Dr. Assad candidly, again, an indication of his candidness, admitted that. There is nothing in the charges that relate, in this matter, to a failure to diagnose botulism.
>
> The concern, of course, and it's through one of the questions that I put to Dr. Reddoch, is, did he go down the proper road that might have led him to that diagnosis, even accepting that if he'd gone down that proper road, and missed it, he wouldn't

> have been faulted? But this is a case about a doctor who didn't go down the proper road, in my submission to you.

HISTORY OF EVENTS

[16] On the 8th September, 1995, Ms. Grennan was taken by her father to the emergency room of the Whitehorse General Hospital. She was seen by Dr. Kanachowski who, having obtained the history of eating fish and noted the patient's blood pressure, temperature and pulse, diagnosed "gastroenteritis with mild dehydration". She and her father were told to go home as they had food poisoning and nothing more could be done at the hospital for them.

[17] At home, she got progressively more ill and around midnight on the 8th September her mother telephoned the appellant (the 9th and 10th September were his days off), told him that Ms. Grennan had eaten fish, was sick, and that the others who had eaten the fish were sick but not as sick as Ms. Grennan. He then telephoned the hospital so they could expect Ms. Grennan's arrival. At 00:24 on the 9th September, Ms. Grennan was back in the emergency room where she was still experiencing vomiting, abdominal cramps and dizziness. Dr. Galloway then on duty diagnosed gastroenteritis with dehydration. She was discharged in the care of her mother at

02:05 hours with the advice to take clear fluids, use Gravol, and to return if intractable vomiting or pain developed.

[18] Upon returning home, her condition deteriorated and she was back at the emergency room on Saturday, the 9th September, at 21:06 hours, where she was seen by Dr. S. Alton. Dr. Alton admitted Ms. Grennan to the Whitehorse General Hospital, "with a diagnosis of resolving gastroenteritis (food-borne), persistent dysphagia NYD due to either candida or to dehydration with 5 to 10% dehydration". Dysphagia is difficulty in swallowing.

[19] At 15:00 hours on Sunday, the 10th September, Dr. Reddoch visited Ms. Grennan for the first time. A serious point in issue before the Inquiry Committee was whether it was at that point that the appellant assumed the care of the patient from Dr. Alton or whether he did not assume it until the following day and, if the former, what he ought then to have done.

[20] When Dr. Assad began his evidence, he had put to him by Mr. Martin a series of assumptions founded on the hospital records:

> [I have interpolated the names of the physicians and the times, where appropriate.]
>
> Q And I'm just going to read to you the assumptions that you were asked to take into account, and you can just confirm that these

were the assumptions for your opinion. One, Ms. Grennan was a healthy 16-year old with an unremarkable past medical history....

A Yes.

Q Two, Dr. Reddoch had delivered and cared for Mary-Ann from birth to the present admission.

A Yes.

Q Three, Ms. Grennan had eaten smoked salmon on the 7th of September. Her father also had eaten the same salmon.

A That's correct.

Q Four, the following day, both were found to be ill. Ms. Grennan visited the Whitehorse General Hospital emergency room in the morning of the 8th [Dr. Kanachowski, 09:02 hours], with dizziness, vomiting, abdominal pain, but no diarrhea. Her pulse was elevated at 132 beats per minute.

Five, she was discharged from her first ER visit, only to return 13 hours later, with persistent vomiting and abdominal pain.

Six, during her second emergency visit [9th September, 00:24 hours - Dr. Galloway], a correct diagnosis of food poisoning was noted in the chart. She was discharged [9th September, 02:05 hours] following her second visit, only to return 19 hours later [9th September, 21:06 hours - Dr. Alton] with persistent vomiting, increased abdominal pain and, at this time, a complaint of difficulty swallowing. She was treated for dehydration and admitted to the ward under the family physician, Dr. Reddoch.

Seven, Ms. Grennan was visited 18 hours later [10th September, 15:00 hours] by Dr. Reddoch. He noted that she was weak and tired. He attributed the condition to anaemia, haemoglobin of 102, and the fact that her grandmother had just passed away.

Eight, after admission to the ward, the nurses' notes indicate, from the very beginning, that Ms. Grennan was unable to swallow foods. She was forcing the fluid down only to see it gurgle back up. Multiple references were found describing the marked weakness of the patient, such as "too weak to hold a glass", "rag doll",

> and "unable to get back to bed from commode without the assistance of two males".
>
> Nine, several references in the nurses' notes suggest that this behaviour was dramatic and possibly hysterical. The nurses kept insisting and encouraging oral fluids even in the face of marked dysphagia.
>
> [Ten] On the 11th of September, the nursing staff called Dr. Reddoch because they were concerned about the patient's marked motor weakness and dysphagia. Dr. Reddoch attended about 07:00 hours and suggests a diagnosis of globus hystericus, with anxiety. He felt that her symptoms were psychological in origin. She was given the tranquillizer ativan, one milligram.
>
> Eleven, on the 11th of September, Dr. Reddoch makes her record -- a second visit at 17:30 hours. This time he feels that she is getting dehydrated and orders an IV to two-third to one-third at 100 cc an hour. He could not find any laboratory documentation of her state of hydration, such as electrolyte or renal function test for that day. We know that her electrolytes were normal on the 10th of September.
>
> Twelve, after Dr. Reddoch's visit, another ativan is offered to the patient; she takes it reluctantly. Her voice is now only a soft whisper. At 21:15 hours, she is drooling, unable to swallow her saliva.
>
> At 21:30 hours, Ms. Grennan's mother phones to see if she could spend the night with the patient. She is reassured that she is well taken care of and that she is in a safe place.
>
> And last, number 14, at 23:10 hours, she is found in respiratory arrest and unresponsive. A code 99 is called, she is resuscitated and transferred by air ambulance to St. Paul's Hospital in the early hours of September 12, 1995.

[21] On the footing of these assumptions, Dr. Assad was asked for an opinion and said this:

> A Well, Dr. Reddoch basically came in after the patient had been admitted by another physician and, therefore, being the attending physician, he is taking over this case. And in my opinion, this is probably one of the more difficult parts of medicine is, when you are taking over a case from somebody, you have not been perhaps present, you're coming in cold and, therefore, it's a, I think, very important procedure here, to basically redo some of the steps that have been perhaps done already; meaning taking another history, doing another physical examination. So that you not only write a supplemental note, but also, in your own mind, you are happy that you know exactly where -- how the patient -- what the status of the patient is, as well as where you're going to go with this patient. Really, that's the whole exercise of a note, a transfer note, or when you're taking over the care of a patient.
>
> So I think that history should include what's gone on, why was the patient visiting the emergency, why was the patient admitted; and since admission, how has the patient been doing. Has she been getting better; is she getting worse? If she is getting worse, what are the problems, what are the complaints. And that, again, should be followed by an examination.
>
> Q A physical examination?
>
> A That's right.
>
> [Emphasis mine.]

[22] Later he said:

> A Well, I think the so-called mini-neurological would have been indicated here. First of all, what kind of response was the physician getting, speaking to the patient? Did he observe her perhaps standing or walking? Or did he get information from other staff members, on their observation when she was standing or walking?
>
> Basically, standing is a very good indication of motor function. You know, it's a very simple test; just asking the patient to

> stand if they're able. So that certainly would have been indicated.
>
> Cranial nerves, things like gag reflexes. Was she able to open her eyes, move her eyes in all directions? Did she have any obvious, kind of, facial problems, deformity, paralysis, etc.? And then perhaps a quick sensory examination to light touch and reflexes.
>
> That, I think, would have been a more than adequate neurological examination.

[23] As I understand Dr. Assad's evidence, it is that these examinations should have been performed on Sunday at 15:00 hours.

[24] What was not included in the assumptions (I do not suggest as a result of any deviousness on Mr. Martin's part) but did come out and was put to Dr. Assad, were two other facts which appear from the hospital records and which I will call Six B and Nine B so that they may be fitted into the assumptions:

> Six B, Dr. Alton saw the patient at 09:30 hours on the 10th September.
>
> Nine B, midnight, 10th-11th September, and 03:30 hours, 11th September, Dr. Alton saw the patient and wrote orders. Up to the morning of the 11th, Dr. Alton was the on-call physician.

[25] Dr. Assad made no criticism of the work done by Dr. Alton, whom he concluded had performed proper examinations including mini-neurological examinations.

[26] The appellant's evidence on this point was that Dr. Alton had done the work and he saw no need to redo it. He testified thus:

> Q Now, just going back to Sunday afternoon [10th September], when you saw her; did you undertake a complete physical examination, including neurological assessment and rectal examination?
> A No.
> Q Why not?
> A Well, it -- it really wasn't my place, because at that point Dr. Alton was still the attending physician. And I still wanted to have the end of my weekend.
>
> But even if I had assumed care on the Sunday afternoon, I wouldn't see any need for doing a rectal examination [Dr. Assad had made a point of saying such an examination should have been done] in someone who'd had a gastro-enteritis or food poisoning, who was getting better and who I was planning on sending home the next day. The idea of doing a rectal examination on someone who's getting better is, I don't think, necessary. I very much accept Dr. Assad's point, that a rectal examination, in someone who is having an acute abdomen, a peritonitis, is quite normal. In fact, it's invaluable. But not at this situation.
>
> Also, Dr. Alton had just done a neurologic examination, and I wouldn't see any need to repeat it.

[27] The report of the Inquiry Committee is some 35 pages long and, therefore, I cannot quote it, but it begins with an account of the evidence of some 30 pages.

[28] "Part 5 - Findings of Fact" begins on page 31 of the report. The Committee first addressed what it called a question of credibility, referring to this passage from ***Faryna v. Chorny***, [1952] 2 D.L.R. 354 at 357:

> The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.

[29] With respect, this passage of ***Faryna v. Chorny*** was not apposite, simply because "credibility" in the usual sense of the word, which is a determination of who is accurately recounting past events, did not arise. For instance, no issue arose as to whether the appellant had himself done a mini-neurological examination as described by Dr. Assad. The appellant did not assert that he had.

[30] What was in issue was a matter of opinion: whether the appellant's treatment of his patient, using the word treatment as encompassing all that he did and did not do, was below acceptable standards of practice. For instance, he testified,

as I have already noted, that he had not considered it necessary to redo what he understood Dr. Alton had done. Dr. Assad was of a contrary opinion.

[31] To put it another way, for a trier of fact to speak of "credibility" when the real issue is not what are the primary facts but whose opinion on those primary facts should be accepted, is unhelpful.

[32] But be that as it may, having found the appellant not to be "credible" and Dr. Assad to be so, the Committee went on to address the question of when the appellant had taken over the care of the patient. It said:

> The committee then went on to establish the date on which Dr. Reddoch had in fact taken over the care of Ms. Grennan. We felt this was an important matter because, if it was at the time of his September 10th visit, there would have been an extra 16 hours during which time he could have developed his differential diagnosis and plan of treatment. If the date of take-over was not until September 11th, then we could not include any of the 10th in considering the charges against him.
>
> In reaching our decision, we considered Dr. Reddoch's contention that it was not hospital practice to take over a patient's care without writing the order for this in the doctors orders - which he did not do until September 11th.
>
> We then considered the contrary evidence of his written statement in the patient's discharge summary of December 21, 1995 that he assumed care on September 10th. We also considered his actions on September 10th of reviewing Ms. Grennan's chart,

> visiting her, then writing orders, a brief case history and a discharge plan on her chart.
>
> It is our opinion that Dr. Reddoch did in fact become the responsible doctor for Ms. Grennan on September 10th and that his visit to her on that day was not a social visit, but a medical doctor-patient visit.
>
> We do accept, however, that Dr. Reddoch was not "on call" for the weekend. Dr. Alton was the physician "on call" and visited the patient at midnight and gave orders at 03:30 hours on September 11th while she was on call at the hospital. This is the acceptable practice for physicians at the Whitehorse General Hospital and the nurses are aware of it.

[33] When the Committee said that he was "writing orders" it erred. The appellant did not write orders on 10th September.

[34] Too much was made of this issue. Dr. Alton was the on-call physician for the weekend. The appellant had no reason not to leave Ms. Grennan in her charge until Monday morning and Dr. Alton had no reason not to continue to keep an eye on the patient. The sad reality is that neither of them suspected that Ms. Grennan was gravely ill.

[35] The Committee then addressed each of the charges and found each proven. Despite the awkward way in which the charges were framed and the awkward way in which the Committee addressed them, what the Committee found in substance was that the appellant ought not to have relied on Dr. Alton's work, and ought himself to have done a thorough physical

examination, and that having done so he ought to have recorded the results and set out his expected differential diagnoses and working diagnosis. That, of course, is how the Council saw the matter as is shown by the emphasized portion in its reasons at paragraph 4, *supra*.

[36] The Council having dealt with the matter, the appellant then appealed pursuant to s. 33 of the ***Medical Profession Act***:

> Appeals
>
> 33. (1) Any person making a complaint in respect of which an inquiry has been held, or any person who has been affected by any decision of the council under sections 19 to 27, may appeal from the decision or direction of the council to a judge of the Supreme Court at any time within 30 days from the date of the decision or direction of the council.
>
> (2) The judge may, upon the hearing of an appeal pursuant to subsection (1), reverse, confirm or amend the decision or direction of the council or order a further inquiry by the inquiry committee and make such other order, either as to costs or otherwise, as the judge may determine, including a direction that any registration struck off be restored or that any suspension or probation be terminated.
>
> (3) An appeal lies from the decision of the judge to the Court of Appeal within 30 days thereafter, and the Court of Appeal has all the powers that may by this Act be exercised by the judge appealed from.
>
> (4) An appeal taken from a decision or direction of the council shall be deemed to include an appeal from the findings and report of the inquiry committee.

> (5) Pending the outcome of an appeal pursuant to subsection (1), any suspension of a member of the medical profession from the practice of medicine, or any striking off of the name or other particulars of a member of the medical profession from any registry made pursuant to this Act shall remain in full force and effect unless otherwise ordered by the court.
>
> (6) The council may, on such terms as it sees fit, stay the operation of any punishment or penalty imposed by it upon any person bringing an appeal under this section pending the outcome of the appeal, and the council may require the giving of reasonable security for its costs of the appeal and payment of any fine already imposed as a condition of granting the stay.

THE JUDGMENT BELOW

[37] The learned judge below set out the grounds of appeal before him thus:

> 19 On the finding of unprofessional conduct Dr. Reddoch alleges:
> (i) that the Inquiry Committee and the Yukon Medical Council did not have jurisdiction to convict him;
> (ii) the Inquiry Committee's reasons were inadequate;
> (iii) Dr. Assad's evidence was unreliable;
> (iv) the Committee failed to properly consider Dr. Reddoch's evidence and the local standard of care;
> (v) Dr. Reddoch criticized findings of the Committee on assumption of care, adequacy of notes and adequacy of physical examinations.

[38] Either of his own motion or upon an objection *in limine* of the respondent, the learned judge addressed the question of whether the appellant had by his counsel so conducted himself

before the Council that he could no longer be heard to argue that on the facts as found he had not been guilty of "unprofessional conduct".

[39] Having set out some of what the appellant's counsel (not Mr. Schachter) had said, the learned judge said:

> 41 For my part, I consider Dr. Reddoch to be bound by the position he took before the Council. Dr. Reddoch took this position after reflection and obviously, in consultation with his lawyer: "I should say that it's not an easy thing for Dr. Reddoch to instruct me to take this position with respect to the charge" (Transcript 38/4-8). Dr. Reddoch intended that the Council rely on his position as articulated by his lawyer. He could have made all the arguments to Council he made to this court. I assume he did not in order to demonstrate his professionalism in accepting the criticisms found in the report. Further, this acceptance of criticism would be of benefit to him in the penalty phase. The Council had no misapprehension about the position taken by Dr. Reddoch. As noted, it did not find it necessary to adjourn to arrive at the conclusion Dr. Reddoch's conduct was unprofessional (Transcript 146/22).
>
> 42 The Council relied on Dr. Reddoch's "expression of genuine remorse" in arriving at its decision. (The decision of the Yukon Council Characterization and Penalty Regarding Dr. Allan Reddoch, 19 August, 1998, page 1). I consider Dr. Reddoch's position before the Council to be analogous to that of someone who has pleaded guilty to an offence and asks that the plea to be taken into account in sentencing. I acknowledge that guilty pleas and consent judgments can be set aside, but that was not the position taken before me. Rather, it was said that the admissions were simply a recognition of the inevitable. That is, that the Council would accept the report of the Inquiry Committee and that Dr. Reddoch would be able to argue against those

> findings at this level. For the reasons expressed, I do not accept that characterization.
>
> 43 However, I intend to go on to consider each argument made by Dr. Reddoch. I do so because I may be wrong that Dr. Reddoch is bound by his position before the Council. Second, it is trite that with respect to jurisdiction, parties cannot consent to jurisdiction if it is not there.

[40] It is convenient to dispose of this point before summarizing the remainder of the reasons below.

[41] Having read the whole of the submission made by counsel for the appellant, and whatever else may be said, I do not consider those submissions are the equivalent of an accused changing a plea from not guilty to guilty. Taken as a whole, they amount to counsel saying, "On the authorities cited to you, I expect you will find him guilty of unprofessional conduct."

[42] In my opinion, such a submission does not prevent a party to proceedings coming to this Court and arguing that on the facts as found no offence was committed. In other words, he is not thereby precluding from raising in a higher court which is not bound by the authorities quoted at first instance, the issue of law as to the application of the proper standard. The interpretation or application of a legal standard is as much a question of law in proceedings of this nature as it is

in criminal proceedings. As to such a question being a question of law in criminal proceedings, see ***R. v. Araujo***, [2000] 2 S.C.R. 992.

[43] The learned judge addressed what he called "the standard of review" and found it to be "reasonableness". He then looked at all the findings and found all of them to be "reasonable".

SCOPE OF THE APPEAL

[44] As I have noted, the learned judge addressed what he called the "Standard of Review". He began thus:

> 26 Courts typically apply three standards of review to decisions of regulatory tribunals: correctness, unreasonableness, and patent unreasonableness. These standards are part of a spectrum of standards which range from "... correctness, at the more exacting end of the spectrum, and patently unreasonable, at the more deferential end".

[45] The learned judge then went on to refer to ***Canada (Director of Investigation and Research) v. Southam Inc.***, [1997] 1 S.C.R. 748; ***Pushpanathan v. Canada (Minister of Citizenship and Immigration)***, [1998] 1 S.C.R. 982; ***Pearlman v. Law Society (Manitoba)***, [1991] 2 S.C.R. 869; and ***Jory v. The College of Physicians and Surgeons of British Columbia***, [1985]

B.C.J. No. 320 (Q.L.), (13 December 1985) Vancouver Registry A850601 (B.C.S.C.).

[46] With respect, the learned judge was mixing up two related but different questions - the standard of review on an application for judicial review when the issue is strictly one of jurisdiction and the scope of review of findings on an appeal.

[47] In ***Jory v. The College of Physicians and Surgeons of British Columbia***, *supra*, McLachlin J., as she then was, on the heading of the Scope of the Appeal under the British Columbia ***Medical Practitioners Act***, R.S.B.C. 1979, c. 254, said this:

> B. SCOPE OF THE APPEAL
>
> Section 62(3) of the Medical Practitioners Act, R.S.B.C. 1979, c. 254 provides that an appeal from a decision of the Council shall "be deemed to include an appeal from the findings and report of the inquiry committee".
>
> Section 64 provides that the appeal shall be heard and determined "on the merits".
>
> The Court's task under these provisions is similar to that of a Court of Appeal sitting on appeal from the judgment of a lower Court. *Since the appeal is "on the merits", the Court is not confined to consideration of errors of law or breaches of natural justice in the course of the hearing or the decision. It is to consider all of the evidence and proceedings in the case and reverse the decision below if the findings of fact are clearly wrong or if some injustice occurred:* Latimer v. College of Physicians & Surgeons of B.C. (1931), 55 C.C.C. 132, [1931] 3 D.L.R. 304

> (B.C.C.A.). The failure of the tribunal below to consider material evidence may be as important as the evidence which it in fact considered: Hirt v. College of Physicians and Surgeons of B.C. (1985), 63 B.C.L.R. 185 (S.C.) at 206.
>
> At the same time, the Court sitting on appeal will interfere with the findings of the tribunal below on matters of fact and credibility only in exceptional circumstances, since that tribunal is in the superior position of having heard the witnesses and observed their demeanour over the course of the hearing. In particular, in appeals from tribunals composed of professional persons considering professional conduct, the Court will be hesitant to substitute its opinion for that of the members of the tribunal below on matters involving professional competence, practise, or ethics.
>
> The standards of proof required in cases such as this is high. It is not the criminal standard of proof beyond a reasonable doubt. But it is something more than a bare balance of probabilities. The authorities establish that the case against a professional person on a disciplinary hearing must be proved by a fair and reasonable preponderance of credible evidence: Regina v. Discipline Committee of the College of Physicians and Surgeons of the Province of Saskatchewan, Ex parte sen (1969), 6 D.L.R. (3d) 520 (C.A.). The evidence must be sufficiently cogent to make it safe to uphold the findings with all the consequences for the professional person's career and status in the community: Hirt v. College of Physicians and Surgeons of B.C., supra at p.206.
>
> [Emphasis mine.]

[48] In ***A.B. v. College of Physicians and Surgeons (B.C.)*** (1994), 43 B.C.A.C., 69 W.A.C. 173, Gibbs J.A. commented at paragraph 15 that the ***Jory*** case is "accepted as authoritative in this province".

[49] I agree and while there are differences in wording between the sections under consideration by McLachlin J., as she then was, and the sections in the Yukon ***Medical Profession Act***, I do not consider the differences are of any significance.

[50] To what extent, if at all, the learned judge's confusion of these discrete issues affected his judgment, I am unable to say.

[51] As this Court is given, by s. 33(3), all the powers of the learned judge below, I propose now to apply to the report of the Inquiry Committee and the decision of the Council the test propounded by McLachlin J.

[52] In this Court, the appellant alleges:

> I. The chambers judge and the Committee erred in relying upon the evidence of Assad in determining the appropriate local standard of care.
>
> II. The chambers judge and the Council erred in holding that the appellant should be disciplined for an isolated inadvertent act.
>
> III. The chambers judge erred in holding that the standard of review was reasonableness, not correctness.

[53] As to reliance upon the evidence of Dr. Assad, the learned judge found it was reasonable for the Committee to accept his evidence. So it was insofar as Dr. Assad testified as to good medical practice. But what is disturbing is that

Dr. Assad knew nothing of the way in which medicine was practised in Whitehorse. A question not directly addressed in the evidence is whether, in September 1995, it was the practice of the family physicians in Whitehorse, upon returning to work on Monday morning after a weekend off and assuming the care of a patient who had been admitted to the hospital on the weekend in the care of the physician on duty, to redo the work done by that physician. It is quite possible to have a prevailing standard of practice which is simply not adequate, but what the prevailing standard of practice in a community is does go to the question of whether a physician should be condemned for "unprofessional conduct".

[54] The difficulty I have with this assertion of the appellant of error is that he did not testify as to what the practice was of the other physicians in Whitehorse. He testified only as to his own practice.

[55] There being no evidence of local practice differing from what Dr. Assad said was proper medical practice, we cannot give effect to this ground of appeal.

[56] As the argument before us developed, the critical issue on this appeal became apparent. It is whether the words "unprofessional conduct" in this statute encompass the appellant's acts of omission which, on the findings of the

Committee, can be summed up as a failure to exercise reasonable care and skill in the management of one patient whom neither he nor three other physicians believed to be gravely ill. In my opinion, the answer to that question is "no". The route which should have been gone down is not the route of s. 24 but the route of s. 22, an investigation into the standard of practice of the appellant.

[57] A great many authorities were cited to us. I do not propose to analyse them as the facts differ from case to case, and the statutes under consideration, while *in pari materia*, are not identical.

[58] It is open to the Legislature of the Yukon to define "unprofessional conduct" as including a single failure to exercise reasonable care and skill in the management of one patient. If it chooses to do so, it is not improbable that every physician in the Yukon will be guilty at some time or another of an offence. As I remarked in ***de la Giroday v. Brough*** (1997), 33 B.C.L.R. (3d) 171 at 175:

> I doubt that there is a professional man or woman, no matter how generally competent and experienced, who has never had occasion to say to himself or herself, "How could I have been so blind?" Such might well have been the reflection of the defendant in ***Lankenau v. Dutton***, [1999] 5 W.W.R. 71, 79 D.L.R. (4th) 705, 55 B.C.L.R. (2d) 218 (B.C.C.A.), who was, on the evidence, a most competent surgeon.

[59] In coming to this conclusion, I am not in any way differing from the Inquiry Committee's conclusion as to what proper practice was in the circumstances or their conclusions as to what had in fact happened.

[60] What I do say is that when the issue is one of a failure of reasonable care, the conduct of the physician in order to constitute "unprofessional conduct" must have about it some quality of blatancy - some cavalier disregard for the patient and the patient's well being.

[61] There was no blatant disregard in this case.

[62] I would allow the appeal.

"THE HONOURABLE MADAM JUSTICE SOUTHIN"

I AGREE:

"THE HONOURABLE MADAM JUSTICE RYAN"

I AGREE:

"THE HONOURABLE MR. JUSTICE BRAIDWOOD"