COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,
RSA 2000, c. H-7

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. RICHARD EARLE BARR

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

I. INTRODUCTION

The Hearing Tribunal held a hearing into the conduct of Dr. Richard Barr on July 19, 2021. The members of the Hearing Tribunal were:

Dr. John Pasternak of Medicine Hat as Chair, Dr. Goldees Liaghati-Nasseri of Rocky View, Ms. Nancy Brook of Ryley (public member) and Ms. Archana Chaudhary of Edmonton (public member). Ms. Katrina Haymond acted as independent legal counsel for the Hearing Tribunal.

In attendance at the hearing was Mr. Craig Boyer, legal counsel for the Complaints Director of the College of Physicians & Surgeons of Alberta. Also present was Dr. Richard Barr (the "Investigated Member") and Mr. Matthew Riskin, legal counsel for Dr. Barr.

II. PRELIMINARY MATTERS

Neither party objected to the composition of the Hearing Tribunal or its jurisdiction to proceed with the hearing. There were no matters of a preliminary nature.

III. CHARGES

The Notice of Hearing listed the following allegations:

1. **You failed to prepare in a timely manner the Outpatient Procedure Report (dictated by you on January 7, 2016) for the cystoscopy performed on your patient, [redacted]., on November 20, 2015;**

2. **You did fail to ensure that your patient, [redacted], was informed in a timely manner regarding the pre-operative planning for tapering of his Coumadin in advance of the Lithotripsy scheduled for January 8, 2016.**

At the outset of the hearing, Mr. Boyer indicated that the parties were proceeding by way of an admission. Further, the Complaints Director wished to withdraw allegation #1 and was only proceeding with allegation #2.

IV. SUBMISSIONS

Mr. Boyer advised the Hearing Tribunal that the parties had negotiated an agreement with regards to the allegations. He explained that the two parties would be proceeding by way of an admission and a joint submission.

The Hearing Tribunal was presented with Exhibit 1, the agreed Exhibit Book tabs 1-24 and Exhibit 2, the Admission and Joint Submission Agreement.

[redacted]

Mr. Boyer made brief submissions regarding the background giving rise to the allegations. The most pertinent factors leading to this agreement were:

- The matter had first been dismissed by the Complaints Director with advice given, and after being challenged by the Complainant, was sent back for a Hearing by the Complaints Review Committee.

- [redacted] (the "Complainant") had suffered a stroke approximately two days after a Lithotripsy procedure performed by the Investigated Member.

- The Complainant had been prescribed anticoagulant medication that required tapering prior to the procedure performed on January 8, 2016.

- The Parties compiled expert opinions which were consistent in establishing that there is inherent risk in doing so and therefore no proof that that the Investigated Member's actions caused the stroke.

- The focus of the matter then became the failure of the Investigated Member to communicate to the Complainant in a timely fashion regarding the planning for the tapering of the anticoagulation.

Mr. Riskin briefly indicated that Dr. Barr does admit the allegation and admits that his actions constitute unprofessional conduct.

V. EVIDENCE AND FINDINGS

The Hearing Tribunal considered the evidence submitted in the Exhibit Book by agreement, and Dr. Barr's admission. Having considered the evidence, the Hearing Tribunal accepts Dr. Barr's admission, and finds that allegation #2 is proven and constitutes "unprofessional conduct" pursuant to s. 1(1)(pp) of the *HPA*.

The Hearing Tribunal reviewed all of the evidence provided by the parties, and advised the parties that it accepted the Investigated Member's admission and found that allegation #2 was proven.

The essential evidence presented to the Hearing Tribunal to support the Admission and the Hearing Tribunal's finding was:

- Dr. Haw For Chin stated that the plan was for the Complainant to be seen by the anticoagulation clinic approximately one week prior to the procedure booked for January 8, 2016, in order to explain the best approach to discontinuing the oral anticoagulation and bridge with injectable low molecular weight heparin until after the procedure.

- Information from the Unit Manager of the Lithotripsy Program established that Dr. Barr had been unable to schedule the Complainant with the pre-admission anticoagulation clinic and had stated he would call the patient

directly. She had stated that if they had known of the less than ideal set up, they would have worked to schedule the procedure at a later date.

- As of the day of the Lithotripsy procedure the Complainant had discontinued his anticoagulant apparently on his own but had not had the injectable bridging anticoagulant initiated. The Investigated Member elected to proceed with the procedure in order to prevent further delays.

- The letter from Dr. Haw For Chin established that he had been asked to see the Complainant on the day post Lithotripsy procedure to advise on the proper management of anticoagulation at that point.

- Dr. Haw For Chin advised the Complainant to initiate low molecular weight heparin that day and to restart the oral anticoagulant on January 10, 2016.

- Unfortunately, the Complainant suffered a stroke on January 9, 2016.

- The Complainant was at significant risk for a stroke for 6 months prior to the procedure given that during that time the Complainant was in sub-optimal range of protection and that even with optimal management of the anticoagulant bridging, there was a significant risk of stroke due to him having a prosthetic heart valve.

- Another expert witness, Dr. Howard Evans, a Urologist, stated that the Investigated Member caused no harm in going forward with the procedure on January 8 given that the Complainant's oral anticoagulant test showed no increased risk for bleeding during the procedure. However, he also indicated that the Investigated Member failed to arrange for optimal anticoagulant bridging management to reduce the risk for stroke prior to the Lithotripsy.

VI. EVIDENCE REGARDING PENALTY

Following the Hearing Tribunal's confirmation that allegation #2 was proven, Mr. Boyer advised that he wished to have the Complainant provide the Hearing Tribunal with an impact statement regarding the impact he had suffered as result of the actions of the Investigated Member.

The Complainant testified that he had suffered significant financial and social effects due to having had a stroke in January 2016. He has since been unable to work at his previous job as it took one year to get his license to drive after the stroke. He also indicated that socially it has affected his relationship with his partner, and his ability to help with his son. He stated that he has had to retrain for other forms of employment and is still engaged in that process.

VII. JOINT SUBMISSION ON PENALTY

Following the Complainant's testimony, Mr. Boyer advised the Tribunal that the parties had arrived at a joint submission on penalty.

Mr. Boyer provided the Tribunal with a Brief of Law addressing the deference that a discipline tribunal must exercise when presented with a joint submission on penalty. The authorities establish that the bar for rejecting or varying a joint submission is very high; a joint submission should only be varied or rejected where it would bring the administration of justice into disrepute.

Incorporating the factors in *Jaswal*, Mr. Boyer stated that the joint submission dealt appropriately with the need for deterrence and remediation. It was agreed by the parties that the Investigated Member had breached the Standard of Practice which dealt with continuity of care in that he failed to have sufficient systems in place to deal with timely communication and the continuity of care of his patient.

It was proposed that:

- a reprimand would be an appropriate deterrence.
- As for remediation, it was proposed that a consultant acceptable to the College review the communication systems currently in place in the practice of the Investigated Member, to identify where improvements can be made and to assure implementation. This would include a 14 day benchmark for preparation of letters back to referring physicians and an effective triage system of internal communications within his office and hospital work. The College itself would endeavour to improve this skill set amongst members at large.
- The Investigated Member would complete on-line courses acceptable to the Registrar that pertain to quality improvement prior to the end of October, 2021.
- The Investigated Member be responsible for two thirds of the costs of this hearing and investigation.

VIII. ORDERS AND REASONS FOR ORDERS

The Hearing Tribunal reviewed the brief presented and the submissions and agreed that the sanction addressed the appropriate deterrence and remediation factors necessary to give the public confidence in the medical profession.

The Hearing Tribunal therefore makes the following orders pursuant to s. 82 of the *Health Professions Act*:

1. Dr. Barr shall receive a reprimand;
2. Dr. Barr shall undergo a review of his Clinic's electronic systems, by an external party agreed upon by Dr. Barr and the Complaints Director (the "Consultant"), to identify whether the systems can incorporate reminders to be brought to the attention of Dr. Barr and his staff, for the following benchmarks:

a. The dictation of consult letters back to referring physicians within 14 days of the patient's attendance;

b. The dictation of reports regarding the patient's attendance or procedure performed on the patient within 14 days of the patient's attendance; and

c. Denoting internal communications from Dr. Barr's staff to Dr. Barr as either Routine, Important or Urgent, for Dr. Barr to act upon accordingly.

3. To the extent that the Consultant confirms that the existing systems cannot incorporate the benchmark reminders, the Consultant will identify required changes necessary to do so, and Dr. Barr shall implement at his own cost those changes within 30 days of their identification, or some other timeframe as agreed upon by the Complaints Director in the event that factors beyond Dr. Barr's control warrant an extension.

4. Dr. Barr shall at his own expense complete the Institute for Healthcare Improvement Courses Q1 101 to Q1 105 on implementing health care improvement by October 31, 2021, or such later date acceptable to the Complaints Director. (http://www.ihi.org/education/IHIOpenSchool/Courses/Pages/OpenSchoolCertificates.aspx)

5. Dr. Barr shall prepare a report to the Complaints Director by December 15, 2021, or such later date acceptable to the Complaints Director, outlining the performance of the changes implemented in his office as outlined in paragraphs 2 and 3. This report shall include an ongoing measurement plan to ensure the changes result in a sustained improvement, and if not, what further changes are being implemented to consistently achieve the benchmarks.

6. Dr. Barr shall be responsible for 2/3 of the costs of the investigation and hearing, payable on terms acceptable to the Complaints Director.

Signed on behalf of the Hearing Tribunal by the Chair:

Dated this 1st day of October 2021