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. CAREY JOHNSON

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

November 7, 2022

I. INTRODUCTION

1. The Hearing Tribunal held a hearing into the conduct of Dr. Carey Johnson on June 22-24, 2022. The members of the Hearing Tribunal were:

   Dr. Neelam Mahil of Edmonton as Chair;
   Dr. Don Yee of Edmonton;
   Ms. June MacGregor of Edmonton (public member);
   Mr. James Lees of Edmonton (public member).

2. Ms. Ayla Akgungor acted as independent legal counsel for the Hearing Tribunal.

3. Appearances:

   Mr. Craig Boyer, legal counsel for the Complaints Director;
   Dr. Carey Johnson, Investigated Member, who gave evidence on his behalf on June 23, 2022;
   Ms. Valerie Prather, legal counsel for Dr. Johnson;
   Ms. Jaspreet Singh, colleague of Ms. Prather.

4. Also in attendance were:

   [redacted], Complainant, mother of pediatric patient A and witness for the Complaints Director, who gave evidence on June 22, 2022;
   Dr. Sarah Curtis, Expert Witness for the Complaints Director, who gave evidence on June 22, 2022;
   Dr. Michael Rieder, Expert Witness for the Respondent, who gave evidence on June 23, 2022;
   Dr. Jonathan Bush, Expert Witness for the Respondent who gave evidence on June 24, 2022;
   Dr. Marina Salvadori, Expert Witness for the Respondent who gave evidence on June 24, 2022.

II. PRELIMINARY MATTERS

5. There were no objections to the composition of the Hearing Tribunal or the jurisdiction of the Hearing Tribunal to proceed with the hearing.

6. There were no other matters of a preliminary nature raised by the parties.

III. CHARGES

7. The Notice of Hearing listed the following allegations:

   On or about March 1, 2015, you did display a lack of skill or judgment in the provision of professional services to your pediatric Patient A, particulars of which include one or more of the following:

a. Failing to obtain an adequate history of frequency and adequacy of oral intake and urinary output before presentation at hospital,

b. Failing to obtain an adequate history of frequency or amount of any vomiting,

c. Failing to observe the patient for an adequate period of time to assess oral intake and urinary output,

d. Failing to perform and record in the patient's chart an adequate physical examination of the patient given the presenting history and symptoms,

e. Failing to investigate alternate diagnosis of urinary tract infection, pneumonia, or bacteremia and sepsis, and

f. Prematurely discharging your patient.

8. Dr. Johnson, through his legal counsel, denied all the allegations made against him.

IV. EVIDENCE

9. The following Exhibits were entered into evidence during the hearing:

Exhibit 1 - Agreed Exhibit Book containing Tabs 1-13:
Tab 1 – Notice of Hearing dated May 21, 2021
Tab 2 – Notice of Hearing dated December 1, 2021
Tab 3 – Complaint letter dated February 22, 2017
Tab 4 – Letter of response from Dr. Johnson dated June 5, 2017
Tab 5 – Alberta Children's Hospital record for Patient A, March 2015
Tab 6 – Transcription of Emergency – Urgent Care Form, dated March 1, 2015
Tab 7 – Public health Nursing Record for Patient A
Tab 8 – EMS ambulance record for March 5, 2015
Tab 9 – Complete Medical Examiner's file for Patient A
Tab 10 – Expert Opinion from Dr. Sarah Curtis dated February 13, 2019
Tab 11 – Expert Opinion from Dr. Michael Rieder dated May 19, 2022
Tab 12 – Expert Opinion from Dr. Marina Salvadori dated May 30, 2022
Tab 13 – Expert Opinion from Dr. Johnathon Bush dated June 6, 2022
Exhibit 2 - CPS Bronchiolitis Guidelines
Exhibit 3 - AAP Bronchiolitis Guidelines
Exhibit 4 - Statement of Assumed Facts as prepared by counsel for Dr. Johnson

Exhibit 5 - X-Rays
Exhibit 6 - Pathology Slide Images

10. The following individuals testified during the hearing:

[redacted]

11. Mr. Boyer first called [redacted], mother of pediatric Patient A, as a witness. She is a family physician who completed her MD at the University of Calgary in 2010 and completed her Rural Family Medicine Residency Training in 2012. Since then, she has worked in Viking, Camrose, New Zealand, and has been practicing family medicine in the Calgary area since 2015.

12. Mr. Boyer reviewed with [redacted] the Complaint Reporting Form she completed in 2017 relating to the care her son received from Dr. Johnson in March 1, 2015. Additional documents included with the initial complaint were also reviewed, including medical and autopsy records for Patient A.

13. [redacted] testified that prior to mid-February 2015, her son was a healthy and happy 3-month-old child. On or around February 19, 2015 she stated he developed signs of a viral respiratory tract infection including sinus congestion and cough. On Saturday February 28, 2015 her son was supposed to be immunized but he was hot to the touch, had a fever (between 39-39.5 degrees Celsius using a Braun ear thermometer) and was not quite his energetic self. [redacted] stated that she was giving him Tempra (Tylenol) and breast feeding. She took him to the Public Health Nurse, a discussion was had between [redacted] and the Public Health Nurse, and the decision was made not to give him his vaccines that day as he was too unwell.

14. [redacted] testified that her son was still ok at that time, had a really good wet diaper on Saturday morning but as the day progressed, he was not eating as much or peeing as much and wasn't as energetic. She stated that night he had a fever over 39 degrees Celsius and his last feeding was around 7pm. [redacted] described that normally her son would feed every 3 or 4 hours and when she woke him up and tried to feed him at 4am, he would not feed. She checked his temperature at this time and it was 39.1 or 39.2. [redacted] gave him some Tempra at that time. She stated that morning at 7am there were some crystals in his diaper but no urine and he still would not feed and she was concerned that he had not fed or peed for 12 hours.

15. [redacted] testified that she left the house prior to 7:30am on March 1, 2015 to take her son to the Children's Hospital. They arrived around 8am and were seen by the ER triage nurse around 8:30am. She stated that the triage nurse took a look at her son in his car seat, took his vitals including pulse oximeter and ran a temporal artery thermometer really quickly over his forehead. The nurse indicated that her son has no fever now, listened to the front of his chest, and noted he had a cough and stuffy nose. Her son's weight from the public health visit the day prior (7.2kg) was also recorded. She

recalls waiting in the waiting room for 20-30 minutes before another nurse took her to an examination room. This nurse clarified some of the details of the history, asked her to take her son out of his car seat and listened to the front and back of his lungs. She thinks this nurse assessed the hydration status of her son, but does not remember all the details.

16. [redacted] testified that shortly thereafter Dr. Johnson came into the room, introduced himself, and that she knew him from working with him before as a clerk and resident. She told him what was going on, that she was worried about her son, and the history of 3 days of fever, not eating, not peeing and a background cold.

17. She recalled that Dr. Johnson examined her son on the ER bed with his unbuttoned onesie and that her son just lay there flat when Dr. Johnson used his stethoscope to listen to his chest on the front and checked his ears. Her son didn't get upset, scream or make a fuss during the examination. He told her that it was not an ear infection and that her son probably had RSV (Respiratory Syncytial Virus infection) and that she needed to keep him upright and hydrated. [redacted] said she challenged the diagnosis noting that she had RSV one and half years before, that her son should have some passive immunity and that she did not think this was a simple case of an upper viral respiratory tract infection and that her son was also not peeing. She stated that Dr. Johnson told her that he had been to a talk recently about relative hypervolemia in the neonatal infant and explained that even if her son had no intake for three days, he will still be ok and maintain hydration status. He told her not to worry and if he still wasn't peeing in three days, then to bring him back. According to [redacted], it was about a 10-minute visit and then Dr. Johnson told them they could go home. She stated they were back home before 10am and had expected they would be there for most of the morning. There were no tests done including no blood pressure or weight. A pulse oximeter was used and his temperature and oxygen sats were checked only once at triage. There were no tests ordered.

18. [redacted] recalled feeling frustrated, exasperated, and confused as Dr. Johnson had told her to keep her son upright and to breastfeed but she found this problematic as he would not feed. She took his temperature when they were back home and it was 39.4 degrees Celsius. She gave him Tempra every 6 hours or so, his fever would come down and he would be a bit more alert, but still would not feed. By 5pm that day, his condition was the same and he still did not feed. She called her local pharmacist and prescribed her son Amoxicillin. She stated about an hour and a half after his first dose, around 8pm, he took a small feeding and then continued to feed every 6-8 hours afterwards. n the following days, Monday through Wednesday, she testified that her son was eating better, seemed to perk up and was producing wet diapers again. He seemed to be doing better until Thursday morning March 5, 2015 at 11am when he was found unresponsive in his bouncy chair by his father, while [redacted] was in Vulcan doing a rural family medicine locum. Her son subsequently passed away.

19. On cross-examination by Ms. Prather, [redacted] confirmed that in 2015 she had two children older than her son and agreed that she was an experienced parent and that her husband was also a competent and caring parent. She testified that her son was born on November 25, 2014 at 39 weeks gestational age as a term infant. She used disposable diapers and her son was exclusively breastfed, both by the breast and by bottle.

20. She testified that her son's first signs of illness were around February 19 or 20, 2015, sometime between Valentine's Day and Family Day. She testified that on Feb 28, 2015 her son was feeding and producing wet diapers throughout the day until 7pm but that as the day progressed, he became less active and lethargic, which she attributed to his fever. She stated that he had a fever over three days which responded to Tempra for around 3-4 hours at a time.

21. When Ms. Prather questioned [redacted] about some discrepancies in her testimony during the hearing compared with testimony she gave under oath on June 23, 2021 with respect to civil legal action against Dr. Johnson, [redacted] replied that since that time she has had a better chance to review her notes and the timeline of events that had occurred and also that it was a long time ago. Some of those discrepancies included the timing and extent of her son's fever and also when her son last fed on the evening of Feb 28, 2015 (i.e. 7 or 9pm) with [redacted] stating it was in the evening sometime and she thought it was around 7pm and that was around the normal time he fed before bed. Similarly, when asked about the decision to not give her son his 2-month vaccines, [redacted] recalls it being in mutual decision after discussion with public health nurse which Ms. Prather pointed out was contrary to the public health nurse's contemporaneous note which stated "Mom is a family GP and feels she wishes to hold off on vaccines for today." When asked about the notes she was referring to, [redacted] stated she made notes about the events that happened that day, separate from the notes in the emergency record and the notes she made for her lawyer, but could not recall specifically when she made those notes.

22. Ms. Prather then reviewed with [redacted] that she tried to feed her son at 4am and he would not feed and at that time he had a fever of 39.5 degrees Celsius and gave him some Tempra and when she tried to feed him again at 7am he did not want to eat and that he was sleepy and looked exhausted.

23. She reviewed with [redacted] the information documented in the pediatric emergency assessment record for her son: typed notes of the triage nurse including the following vital signs of Temperature 37.8 degrees Celsius, Heart Rate 150 bpm, Respiratory Rate 45, oxygen saturation 99 %; handwritten notes of the bedside nurse; and then the history and physical examination as documented by Dr. Johnson. [redacted] acknowledged that the vital signs documented were within the normal range. [redacted] agreed that Dr. Johnson told her about relative hypervolemia of the neonate, where a 3-month-old child could not have fluid for 3 days and maintain adequate

hydration but disagreed completely that Dr. Johnson had a prolonged discussion with her about return to the clinic if she was concerned. She also agreed that she had prescribed the Amoxicillin (1.5 milliliters orally, 3 times per day for one week) to her son on March 1, 2015 and that he was improving in terms of his feeding, peeing and energy levels in the days leading up to his death.

24. The Hearing Tribunal asked [redacted] to review again what she recalled of Dr. Johnson's examination of her son. She stated her son was lying flat on his back on the bed and Dr. Johnson unbuttoned his onesie. He took an otoscope, turned his head to both sides and looked at her son's ears. He looked at his head and she believes he palpated the fontanelle. He used his stethoscope to listen to four spots on his chest and palpated his abdomen. There were no vitals such as temperature or pulse oximeter done at the time. [redacted] stated she prescribed the antibiotics to her son because she was worried that he had sepsis, that Amoxicillin had good coverage, and that it was relatively harmless. She believed the antibiotics kept her son alive for four more days.

25. When asked about the notes she referred to during her testimony, [redacted] stated since her questioning in the civil action last year in 2021, she has compiled a document for herself based on texts, squiggly notes, and a letter to her lawyer dated May 12, 2015 to try and get the timeline correct.

Dr. Sarah Curtis

26. Mr. Boyer next called Dr. Curtis as an Expert Witness for the Complaints Director. Dr. Curtis completed her medical school in St. John's Newfoundland followed by a three-year pediatric residency. She then completed a pediatric ER fellowship in Edmonton and has worked as a staff physician in the pediatric ED (Emergency Department) at the Stollery Children's Hospital since 2006. On questioning about her qualifications by Ms. Prather, Dr. Curtis informed us that she works about 76 eight-hour shifts per year and would see about 10-16 patients per shift. Approximately 30% of her work is clinical, 30% research, and the rest involves teaching and administration. Her research is in pediatric emergency medicine.

27. There was no objection by counsel for Dr. Johnson to the qualification of Dr. Curtis as an expert in pediatric emergency medicine and Dr. Curtis was qualified as such by the Hearing Tribunal.

28. Dr. Curtis confirmed that the expert report she wrote was authored in 2017. She commented that the child did not appear to be weighed although there was a weight documented. She noted there was no blood pressure done on this patient and that all patients in the ED require a full set of vitals to be documented including the blood pressure, which she stated is highly relevant to an infectious process. Dr. Curtis commented that some things were unclear in the chart - for example, she referred to a nurse's note which appeared to reference the last good wet diaper was the previous morning, which was 24

hours prior to registration and then later it was written in the chart that the last void was 12 hours ago. She stated there were things missing in the history documented by Dr. Johnson including the volume and frequency of intake and of urine output. She noted there was no cardiovascular examination documented and that congestive heart failure could present in this manner.

29. Dr. Curtis stated it was her opinion that Dr. Johnson did not meet an acceptable standard of care for a pediatrician practicing in an emergency department in the province of Alberta. She noted the key basis for her opinion was that this child was at risk for acute kidney injury and required further assessment and intervention. Dr. Curtis opined that Dr. Johnson's observation in the ED was far too brief. She stated that important determinations were missing from the clinical assessment and that she would have kept the child in the emergency until he had a good feeding and one or two wet diapers. If this did not occur, she would have then offered interventions including syringe or bottle feeding, nasogastric (NG) or potentially an intravenous catheter (IV) to give fluids and improve his hydration and energy. If she moved to IV, she would have also done some bloodwork.

30. Dr. Curtis testified that she had not ever heard of hypervolemia or that a child this age could survive three days without hydration. She stated that her opinion was only based on the documentation of the visit of March 1, 2015 and then what happened in the resuscitation room on March 5, 2015. All she knew was that the child had been resuscitated on March 5, 2015. She also stated that the only thing she was asked to comment on by the CPSA was the care provided on that day, not the cause of death or whether any actions or inactions contributed to that death. In addition, she stated she would not have accepted the charting done by Dr. Johnson if it was done by her own resident or medical student.

31. On cross examination by Ms. Prather, Dr. Curtis confirmed that she was aware that the child had died several days later on March 5, 2015 and was not aware of the clinical course after discharge and that he was improving. Dr. Curtis agreed with the Canadian guidelines on bronchiolitis that RSV is generally a self-limiting illness that resolves over time with supportive care and that she had no knowledge of the child having any risk factors such as cardiovascular disease, premature delivery or immunodeficiency that would make him prone to complications of RSV.

32. She also agreed with Ms. Prather that the physician assessing the patient is in the best position to determine the treatment for the patient, that there can be shorthand in charting taken to help efficiencies, and that reasonable physicians can disagree on what is appropriate care. Dr. Curtis also agreed on cross-examination that in her report, she wrote that the patient was not feeding and had no void for 24 hours, which was different from the evidence provided by the patient's mother that her son continued to have wet diapers throughout the day and his last feed was between 7 and 9pm on February 28, 2015. However, she did not think that the criteria for discharge was met and felt that

most reasonable physicians who she has trained and worked with at the Stollery Children's Hospital would have observed the child longer, although she agreed there are no firm guidelines for this.

Dr. Carey Johnson

33. Ms. Prather called Dr. Johnson as her first witness. Dr. Johnson is pediatrician who completed his undergraduate training in zoology and genetics at UBC followed by completing his MD at the University of Calgary in 1984. He then completed his pediatric residency in 1988 and it was split between the U of C and UCLA. He was selected for the Weingart International fellowship in pediatrics and medical genetics, worked as a staff physician for 4 years in the UCLA network of hospitals, and completed the Howard Hughes Investigatorship in Los Angeles between 1989 and 1991. In 1991, Dr. Johnson moved to Calgary and started working in the Departments of Pediatrics and in Medical Genetics. He estimated that 2/3 of his time (150 hours per month) is spent in the pediatric emergency department while the other 1/3 (100 hours per month) is spent in medical genetics. He works full time in the ED, which works out to about 150-200 shifts per year and sees an average of 20 patients per shift. He stated that the Alberta Children's Hospital is a very high-volume facility, one of the busiest in the country and in North America. Part of his role involves teaching, both clinical and didactic, of medical students, clinical clerks, residents and fellows.

34. Ms. Prather asked Dr. Johnson to review his experience with RSV, bronchiolitis and pneumonia. He outlined his usual process and knowledge of these common conditions, which he stated he has treated many times. He admitted that he has no recollection of the events of March 1, 2015 and is relying on his chart note and standard or usual practice to provide evidence in these proceedings.

35. Dr. Johnson reviewed the time he spent with patient (0910h to 0940h) and stated it is an important metric that they are told to keep track of. At 0910h he entered the patient room; at that time, the chart would have been available at the nursing station and he would have had the information from the triage nurse and also the information from the bedside nurse available; it is his normal practice to review this before seeing the patient. He stated the patient had a CTAS score of 3 with 1 being the most severe and 5 the least, and at the age of 3 months a child automatically qualifies for CTAS 3. Although he did not recall the discussion with the nurses, his usual practice is to stop and ask them what they think and have a casual discussion. In general, Dr. Johnson stated the physical examination of a 3-month-old is a mixture of art and technique. He noted that an intermittent fever is different than a persistent fever, which is constantly present whether you take Tylenol or not. He noted that the patient had sisters with viral illness at home which is a supportive piece of information and a possible source of transmission. Dr. Johnson also noted slightly decreased intake and decreased urine output overnight; he stated this is common and typical features of a baby this age with a viral illness.

36. On exam, he identified a classic bronchiolitic cough, mucoid discharge in the eyes and an active level of alertness. He stated that lethargy which the mother described would not be consistent with a GCS (Glasgow Coma Scale) of 15/15. In addition, he noted features that showed the child was well hydrated included the normal vital signs and moist mucous membranes. He noted that blood pressure, not documented on the chart, is the least sensitive or vital of the vital signs and he has never in his career seen the blood pressure being low when the rest of the vital signs are normal. His respiratory exam showed decreased air entry to the bases and wheezes in both lungs which are typical findings with a viral systemic process. Dr. Johnson stated he did not note any increased work of breathing; the fact that the bedside nurse noted it is consistent in his mind with the presentation of bronchiolitis, which can be very variable from moment to moment.

37. Although Dr. Johnson did not document a cardiovascular examination on this patient's chart, it would be his normal practice to do it and if there was anything of concern, he stated he would have noted it for sure. In addition, he reviewed his usual abdominal, extremity and integumental exam. Dr. Johnson stated all the findings were consistent with RSV bronchiolitis with no focal findings.

38. The plan was to keep the baby propped up due to increased mucous secretions and spit up from a viral illness, breastfeed and give Tylenol for fever. He expected within 24 to 48 hours for the baby to start breast feeding again. He stated no additional fluid was needed as a baby this age drinks about 1.5 L of breast milk per day and only requires 400-500 cc per day to make up for insensible fluid losses, even with a fever. That is why their urine is so dilute and has no colour. While Dr. Johnson stated that hypervolemia is a colloquial term, it refers to this high reserve of fluid that babies have. He stated that children at this age can sleep 12 hours with no evidence of dehydration the next morning and children who have been found abandoned after 12 hours appear normal; after 24 hours, they are very hungry but still have normal vital signs; after 48 hours, they have mild to moderate signs of dehydration and abnormal vital signs; and after 72 hours, they have severe dehydration and eventually the blood pressure crashes.

39. Prolonged discussion regarding return to clinic suggested to Dr. Johnson that this was a longer than the typical discussion that he would have with any family about return to the ED if the child was not improving or if they had additional concerns. He gave examples of continued refusal to breastfeed, cyanosis, or increased work of breathing. He stated in pediatrics and especially with babies this age they would encourage follow up and never tell the family not to return. Dr. Johnson stated he would not tell the mother not to bring her son back for 3 days.

40. Although the mother doubted that her son had RSV because she herself had previously had RSV, Dr. Johnson noted that RSV does not produce durable IgG

antibodies that would transfer from the mother's breast milk to the baby and in fact, a baby with RSV could get it again. He also notes that all babies 3 months old are incompletely vaccinated so the patient not having had his most recent vaccine would not factor into his decision making.

41. On cross examination, Mr. Boyer asked Dr. Johnson to review the usual chronology of events when a patient presented to the ED. He stated that the patient and family would arrive and walk straight up to the triage desk, unless there was a line up, and the triage nurse would do an initial assessment and take a history. From there they would go to the registration areas where a person sets up the chart and then they would proceed to the waiting room. When a room was available, the patient and family would be ushered in by an aide and then the bedside nurse would provide a second assessment and document it in writing and then hang the chart by the door or on a board for the doctor. Dr. Johnson stated the next step is for him to talk to the nurse, review the chart and go see the patient. At the end of his assessment, he would document the time and put the chart again beside the door.

42. Mr. Boyer asked Dr. Johnson if he was familiar with the AHS document HEAL (Health Education and Learning) - Vomiting and Diarrhea; he stated he does not remember seeing this document and did not agree with how it classified dehydration (i.e., Dr. Johnson did not agree that if a child had not voided for 6 hours, he would be moderately dehydrated). He confirmed that he must have misheard when he wrote the patient had sisters plural not singular with viral illness at home and that he does not know why he did not record the cardiovascular examination when it is his usual practice to do it and document it. Similarly, Dr. Johnson stated he would check the fontanelle and not record it if it was normal and would check the capillary refill and although it was not recorded, most of the time he would have recorded it.

43. When asked by Mr. Boyer if he had taken any lessons from this experience, Dr. Johnson stated that he has and it has reinforced the importance of clinical examination, documenting your findings from a legal perspective, and sharing information with parents so you are clear and confident in their understanding of what you have said to them. He also confirmed when asked by Ms. Prather that these lessons do not make him think that he has done anything improper but that medicine is about lifelong learning and that this has been a seven-year process where he has been under a microscope.

44. When questioned by the Hearing Tribunal, Dr. Johnson stated that the short time the child and family spent in the ED could reflect the early hours of a Sunday morning where the traffic was not particularly heavy and that he does not know why there is a discrepancy between the amount of time he documented he spent with the patient (30 minutes) and the amount of time the mother said the visit took (10 minutes). He does not believe the assessment could have been completed in 10 minutes. In addition, when asked why the bedside nurse's note was documented at 0920h, which is after Dr. Johnson would have gone in the room, he stated that many times the

nurses will complete their written assessment after the doctor has gone into the room. When asked about the quality of his charting and if he would accept the same from one of his learner's, Dr. Johnson stated that the expectation is for learners to document more than a staff person would to document their thinking process. He noted that emergency physicians rarely require that much room to document their assessment. He also stated it is very common that a family may not agree with his diagnosis or decision to discharge as they only admit about 15 patients per day with the remaining 250 patients being sent home. He said there is little opportunity to keep a child for further observation especially those with completely normal vital signs. Another issue is the risks in keeping a 3-month-old child unnecessarily in the ED which includes picking up other infectious diseases. When asked about a vomiting history, Dr. Johnson stated they always take a vomiting history and it is a standard question in a little baby. In this case however, the child was not feeding and not vomiting but rather having spit ups related to mucous congestion from a viral illness.

Dr. Michael Rieder

45. Ms. Prather next called Dr. Rieder as an Expert Witness for the Respondent. Dr. Rieder is a pediatrician who works in pediatric emergency medicine and in clinical pharmacology at the Children's Hospital of Western Ontario. He also works as an Investigating Coroner for the Ontario West Region. He has worked at and was a founding member of the Children's Hospital of Western Ontario since 1986 and prior to that worked at both the Hospital for Sick Children in Toronto and in Michigan. He is the second author on the Canadian Paediatric Society position statement on bronchiolitis from 2014 and he confirmed this remains the current position statement to this day. In addition, he is a distinguished University Professor and has provided several expert opinions to the Canadian Courts and, the Attorney General of Alberta, and to Health Canada.

46. There were no objections from counsel to the Complaints Director to the application to have Dr. Rieder qualified as a pediatrician to provide opinion evidence on the standard of care of a pediatric emergency physician in 2015 and on the cause of death in this case. The Hearing Tribunal accepted Dr. Rieder as an expert witness in these areas of qualification.

47. Dr. Rieder was asked to confirm the documents he reviewed in preparing his expert opinion. He summarized the findings of his report as stating that Dr. Johnson met the standard of care expected of a pediatric emergency medicine physician in the care he provided to pediatric Patient A on March 1, 2015.

48. Dr. Rieder stated that bronchiolitis is a common illness, affecting about one third of infants. It is typically caused by RSV and is a lower respiratory tract infection with symptoms that include runny nose, fever, noisy respirations, wheeze, increased respiratory rate and some distress. It is typically a self-limiting illness and no specific therapy has been proven effective. Some

children with risk factors can get quite sick but it generally involves symptomatic management.

49. Dr. Rieder stated that Patient A was a healthy term baby and his presentation to the Alberta Children's Hospital was typical of a child with bronchiolitis. Dr. Rieder stated there were no signs of dehydration based on the history and physical exam and there is no evidence to suggest this child was at risk for more serious things such as acute renal injury or sepsis. He also did not agree with Dr. Curtis that the blood pressure needed to be recorded for this patient. Dr. Rieder stated that the heart rate was normal so he knows that the blood pressure would be normal, as in babies the blood pressure is based directly on how fast the heart beats. In addition, Dr. Rieder stated that skin turgor is the most reliable assessment of hydration in a 3-month-old and this is what Dr. Johnson would have been referring to under integumental exam.

50. He does not think there were any investigations required in this child; further, the guidelines do not recommend them and they can be very invasive. There was also no indication that this child required admission to hospital and Dr. Rieder stated that most physicians would have discharged him home in probably the same amount of dwell time that Dr. Johnson did and that longer observation would not have changed the unfortunate outcome for this child. The clinical course after he returned home is consistent with the expected course of bronchiolitis.

51. He also found that Dr. Johnson as an experienced ER physician cuts to the chase in his record and documented only the key findings, which is entirely reasonable. Dr. Rieder also commented that he does not believe the mother's prescribing of the antibiotic Amoxicillin at a dose of 30 mg/kg (recommended dose is 80-90 mg/kg) was responsible for any improvement seen in the child after discharge. He noted it takes antibiotics time to reach a therapeutic level and it would typically take up to 72 hours to see any improvement; the mother commenting that her son was better after just one subtherapeutic dose was just not credible in his opinion.

52. When asked by Ms. Prather to review Dr. Johnson's care in relation to the Notice of Hearing Charges, Dr. Rieder stated: a) Dr. Johnson documented a history of oral intake and urinary output b) there was no history of vomiting in this child so obtaining a history of it was unnecessary c) the dwell time in the emergency department was appropriate and the child was ok to be discharged d) the physical examination was adequate for the presenting complaint e) there was no clinical indication to investigate any of those alternate diagnoses f) the patient was in good hands at home and there were risks of keeping the child unnecessarily in the ED or in hospital in terms of nosocomial infections.

53. On cross examination by Mr. Boyer, Dr. Rieder reviewed the CPS guidelines on Bronchiolitis and that the hydration and observation referenced can occur inside the hospital or at home. He confirmed that the findings that Dr. Johnson wrote in his chart were enough for him and confirmed that in his mind, the CVS status

of this child was normal. He admitted there is not a lot of research on the extent of the risks that a patient faces in proportion to length of stay in ED or in hospital and that although he has not practiced in Alberta, the guidelines and approach to bronchiolitis are really Canada wide.

Dr. Marina Salvadori

54. The next Expert Witness called by Ms. Prather was Dr. Salvadori who is both a pediatric emergency room physician and pediatric infectious disease specialist. She completed her MD at Queens University in 1991, pediatric residency at University of Manitoba in 1995, and a fellowship in Pediatric Infectious Diseases at the Sick Kids Hospital in Toronto in 1998. She has worked as a general pediatrician at the Sick Kids Hospital, in the pediatric ED at the Children's Hospital of Western Ontario and since January 2020, has been working for the Public Health Agency of Canada as a clinical lead in the COVID response, and since June 2021 as a consultant in pediatric infectious diseases at the Montreal Children's Hospital. She also does research, has academic appointments, and has prepared previous expert opinions for the courts.

55. There were no objections raised by counsel for the Complaints Director to the application to qualify Dr. Salvadori as a pediatrician specializing in pediatric emergency room medicine and pediatric infectious disease medicine to provide opinion evidence on the standard of care and causation. The Hearing Tribunal granted the application.

56. Dr. Salvadori stated that Dr. Johnson definitely met the appropriate standard of care in this case and that neither his action nor inaction would have changed the most unfortunate and tragic outcome. She disagreed with Dr. Curtis that the child should have been kept longer in the hospital for observation, noting the risks of keeping an infant in the ED and that the parents were reliable and responsible and could care for him at home. She stated that Dr. Johnson's diagnosis and clinical judgement was correct and that is why the child started to feed and improve in the days to follow. She does not believe that the child had pneumonia as the course would have gotten a lot worse over the five-day period rather than continue to improve. Dr. Salvadori notes that a child with pneumonia would not have gotten a lot better on a tiny dose of antibiotics and then have suddenly expired.

57. On cross examination by Mr. Boyer, Dr. Salvadori indicated that she did not agree with the AHS HEAL document classification of dehydration. She felt that after 6-12 hours of a dry diaper in an infant, you would want to assess the hydration status of the infant but that the guidelines referenced in this document seemed a bit extreme. She asked who authored them and if they were geared more to parents rather than to physicians. She stated in this case, no one is saying that the child had no dehydration but that there were no signs that this child required any sort of intervention other than what was advised. In terms of the quality of Dr. Johnson's charting, she classified it as directly in the average of all the notes she has seen in her career.

58. When asked by the Hearing Tribunal what her threshold would be to do something more for this child, she stated while there is no specific trigger, certain red flags would be the following: respiratory rate over 70/min, oxygen saturation 92% or lower, heart rate over 180bpm, parental ability or inability to cope, baby's size and growth and how long the history is. She stated that ultimately a physician needs to use their clinical judgment and there was nothing concerning to her about Dr. Johnson's care and judgment in this case.

Evidence related to cause of death

59. In addition to the evidence summarized above, both Dr. Rieder and Dr. Salvadori gave testimony on the cause of death of Patient A. Counsel for Dr. Johnson also called Dr. Johnathan Bush, a pediatric pathologist, as a further Expert Witness, who was qualified to provide opinion evidence on Patient A's cause of death.

60. After Dr. Rieder gave his testimony and prior to Dr. Salvadori and Dr. Bush being called as witnesses, counsel for the Complaints Director raised a concern with the Hearing Tribunal about the need to hear from Dr. Salvadori and Dr. Bush on the issue of cause of death as cause of death was not an allegation against Dr. Johnson in the Notice of Hearing. Counsel for the Complaints Director noted that Dr. Rieder had already opined on cause of death and indicated that Dr. Johnson should not be permitted to call multiple witnesses to cover the same issues. Counsel for the Complaints Director suggested that Dr. Johnson wanted the Hearing Tribunal to make findings on cause of death for use in the civil litigation between [redacted] and Dr. Johnson.

61. In response, counsel for Dr. Johnson indicated that while the Notice of Hearing does not contain allegations on cause of death, that [redacted] makes it clear in her complaint that her view is that Dr. Johnson's failure to meet the standard of care resulted in her baby's death. To that extent, cause of death is very relevant. Further, Dr. Johnson is entitled to his "day in court" and the expert opinions are already part of the Agreed Exhibits so the Hearing Tribunal should hear what the experts have to say.

62. During the hearing, the Hearing Tribunal determined that it would hear from both Dr. Salvadori and Dr. Bush as their opinions were already contained in the Agreed Exhibits and it was quite late in the proceedings for counsel for the Complaints Director to raise an objection to the testimony of two expert witnesses, especially when it was known well in advance who would be testifying on behalf of Dr. Johnson. However, the Hearing Tribunal also noted at that time that while it was permitting the remaining witnesses to testify on cause of death issues, it was mindful of the scope of the allegations and would determine the weight and relevance of the expert evidence in its overall findings.

63. Ultimately, the Hearing Tribunal has concluded that the issue of cause of death is beyond the scope of the allegations that the Hearing Tribunal must determine. The allegations focus solely on the care that Dr. Johnson provided to Patient A on March 1, 2015. There is no allegation about the care causing or contributing to what happened to Patient A after he left the hospital on March 1, 2015. Accordingly, the Hearing Tribunal has not considered the testimony or exhibits related to cause of death to inform its decision in this matter nor has it summarized that evidence in these reasons for decision.

64. Further, the Hearing Tribunal wishes to be clear that its decision not to consider the evidence on cause of death is not a comment in any way on the expertise, qualifications or credibility of the expert witnesses who gave evidence on the cause of death. The evidence has not been considered simply because the Hearing Tribunal does not see it as relevant to the allegations set out in the Notice of Hearing. While the issue of cause of death may have been raised in [redacted] complaint, it is ultimately the allegations in the Notice of Hearing that define the scope of the Hearing Tribunal's task.

V. SUBMISSIONS

Submissions Made by Counsel for the Complaints Director

65. Mr. Boyer, in his closing argument, asked the Hearing Tribunal to come back to the focus of this hearing, which is the allegations in the Notice of Hearing relating to the quality of care that happened on March 1, 2015. He stated that the Hearing Tribunal should refuse to be drawn into the cause of death, which is the focus of the concurrent civil litigation between Dr. Johnson and [redacted] He commented that it is unfair to [redacted] as the Complainant when on cross-examination she was taken to photographs in the Calgary Medical Examiner's office file of the inside of the home which appeared to be messy and in disarray, as it served no purpose other than to besmirch her as a parent and as a person. In addition, Dr. Salvadori's criticism of [redacted]'s decision to prescribe antibiotics to her son suggests that Dr. Salvadori is taking sides and this lowers the value of her evidence.

66. Mr. Boyer also suggested that calling more than one expert could be considered piling on or duplicative and stated that Dr. Rieder was more than qualified to come and give the evidence in response to Dr. Curtis' opinion. He also noted that the reports of the experts for the Respondent did not get delivered to the Complaints Director until June 2022, while Dr. Curtis' original opinion is from 2017.

67. Mr. Boyer outlined that the role of the Hearing Tribunal, as set out in *Walsh v. Council for Licensed Practical Nurses*, includes the following: to make findings of fact; determine what did or did not happen; identify the standard of conduct that is expected of the professional in those factual circumstances; and, apply that standard to the facts as established by the Hearing Tribunal.

68. In terms of credibility, Mr. Boyer stated we already know that Dr. Johnson has no memory of what happened that day so the medical records created by the triage nurse, by the bedside nurse, and by Dr. Johnson are central to this case. The only evidence that we have from any person who can recall what happened is [redacted], who as a concerned parent and family physician took her 3-month-old with general malaise, cough, stuffiness, low-grade fever over the previous week or so and then refusing to eat and not creating wet diapers, to the Alberta Children's Hospital.

69. In the absence of any specific recollection, Dr. Johnson described his standard of practice, but on cross-examination, it was identified that some aspects of the standard practice were not followed. For example, not recording the cardiovascular system examination, nothing about the capillary refill rate, and no record of inspection of the fontanelle. Dr. Curtis stated that Dr. Johnson's care fell below the standard of practice expected and cites a number of references including the Canadian and American Guidelines. Dr. Rieder is certainly one of the authors of the guidelines, but Mr. Boyer submitted that the guidelines should in fact speak for themselves.

70. In addition, Mr. Boyer submitted there is some discrepancy between the times that Dr. Johnson noted on the chart, the time the bedside nurse noted her assessment, and the amount of time [redacted] felt the whole visit took. Mr. Boyer stated that based on this, Dr. Johnson likely spent less time with [redacted] and her son than the 30 minutes he claimed. In addition, Mr. Boyer submitted that the Canadian guideline (Exhibit 2) states that the most important component of monitoring is regular and repeat clinical assessment which includes feeding and hydration status. The American guideline (Exhibit 3) provides the same approach and strongly recommends that clinicians provide fluid support for infants diagnosed with bronchiolitis who cannot maintain hydration orally. Mr. Boyer stated that both guidelines advocate caution and monitoring, which is consistent with Dr. Curtis' opinion that, given the child had Tempra at 4am, it would be helpful to monitor the child and see if the fever returns and to what level once the Tempra wears off and if the child feeds over a period of time. Dr. Johnson also said that Sunday mornings are typically a little quieter and his shift went until 7pm; therefore, the child could have been monitored for a few hours - that was not an unreasonable expectation.

71. In addition, Mr. Boyer submitted that although Dr. Johnson described his usual discharge advice as encouraging parents to return to the hospital if they have any concerns that is not what was described by [redacted]. She described receiving guidance that an infant could remain well hydrated for up to three days so there was no concern about the hydration status of her son for some time.

72. The issue for the Hearing Tribunal to decide is whether Dr. Johnson met the expected standard of care, and it is not being alleged that his care caused or contributed to the death of this child. Dr. Boyer then provided two cases that

are both CPSA hearing tribunal cases. One is a Dr. Samuel case from 2016 where Dr. Samuel failed to come to the hospital to do an in-person assessment of a 17-year-old female who had previously voiced suicidal ideation; the Hearing Tribunal found that this failure to attend amounted to unprofessional conduct. In this case, the charge nurse had interviewed the patient and said there was no active suicidal ideation so she could not hold the patient against her will. Unfortunately, the suicidal ideation returned and the girl committed suicide the next day but there was no allegation that Dr. Samuel had failed to prevent her taking her life, because it is just not predictable. Another case that Mr. Boyer brought to our attention is the Dr. Hudson case from 2017 where Dr. Hudson failed to undertake a more involved assessment of a young man who had returned to the ER with continuing complaints of abdominal pain. The young man had a rare condition, a twisted bowel and ended up going home, taking Fentanyl, and dying of an overdose. Although the death was not related to the care provided by Dr. Hudson, the tribunal found that Dr. Hudson's failure to do a more thorough assessment amounted to unprofessional conduct. Mr. Boyer states that this is the type of case we are talking about with Dr. Johnson. His care did not cause the death of the infant, but failed to meet the standard of care and that amounts to unprofessional conduct under the *HPA*.

Submissions Made by Counsel for the Investigated Member

73. Ms. Prather, in her closing argument, stated that the Hearing Tribunal is tasked with determining whether Dr. Johnson displayed a lack of knowledge or judgement in the provision of medical care to pediatric Patient A and there are two steps to this: was there a failure to meet the standard of care, and if there was, was the failure enough to make a finding of unprofessional conduct. Ms. Prather stated the Complaints Director has the burden of proving these allegations with clear, convincing, and cogent evidence. She stated that if the Complaints Director needed additional time to address the expert opinions, the Complaints Director could have applied for an adjournment but that application was not made. Ms. Prather suggested it is because they could not have obtained any contrary evidence themselves.

74. Ms. Prather stated the reason why the cause of death is important is that it informs what the standard of care is. She stated that what the Complaints Director wants the Hearing Tribunal to know is that a baby died five days after being seen in the emergency room by Dr. Johnson but does not want the Hearing Tribunal to consider why or what happened even a few hours after that baby was discharged on March 1, 2015. Not even to consider that the baby started to feed which is what babies do when they are recovering from bronchiolitis, contrary to the complainant's view that the amoxicillin had the effect of causing the baby to feed.

75. Ms. Prather stated that the case involves a tragic outcome and that Dr. Johnson's care and his professional reputation is being impugned. While the cause of death of the baby may colour the assessment of Dr. Johnson's care

and whether it met the standard, what happened day after day from March 1st to 5th, when the baby did, as Dr. Johnson predicted, start to feed and get better and better is equally relevant.

76. The complaint sets out very clearly that, in the complainant's view, Dr. Johnson's care caused her son's death. The complaint, along with the autopsy report, which they have challenged, was provided to the College's expert, Dr. Curtis, without her being given any evidence of what happened, the clinical course, after discharge from the hospital on March 1. The allegations in the Notice of Hearing essentially say that Dr. Johnson should have done more. It specifically identifies that pneumonia should have been considered as an alternative diagnosis, which is simply not possible to assess without asking what happened in the clinical course following discharge and what the ultimate cause of death was. Ms. Prather submitted that the question of causation illuminates whether Dr. Johnson did indeed meet the standard of care.

77. In terms of assessing the fact witnesses, [redacted] and Dr. Johnson, Ms. Prather suggested that the Hearing Tribunal consider both the credibility (veracity or truth telling) and the reliability (ability to recall evidence due to the passage of time) of those witnesses. It is based on memory for [redacted] and based on contemporaneous records and standard practice with respect to Dr. Johnson. Ms. Prather submitted that the contemporaneous evidence is always the more reliable of the two. The event at issue occurred nearly seven years ago and the complainant's written complaint was not sent to the College until February 2017, two years after her son's death. Ms. Prather stated when she challenged [redacted] on some of the evidence she had given a year ago in questioning for civil litigation, she said it is hard to remember what happened a year ago yet she would say she remember distinctly what happened on March 1, 2015. She would respectfully submit that [redacted]'s recollection of events has been understandably coloured by the significant personal and family trauma she has experienced losing her son.

78. Ms. Prather submitted that the fact the Dr. Johnson has no recollection of the events on March 1st does not diminish his contemporaneous notes nor his evidence about standard practice. In fact, she submitted it would be remarkable if Dr. Johnson did have a memory of what occurred because this was a very routine examination and presentation of bronchiolitis and everything was otherwise normal with this baby.

79. Mr. Boyer raised the fact that there was no note of the cardiovascular exam in this case and Dr. Johnson acknowledged that he usually writes the CVS normal but did not do it in this case. However, his evidence was that he knows he listened to the heart because he recorded the heart rate and if there had been anything unusual to hear, he would have made a note of that. His evidence was that while he relies on the nurses to take the temperature and do the pulse oximetry, which were both normal, he always does the heart rate and respiratory rate himself because those are the two most vital of the vital signs.

80. Mr. Boyer and the Hearing Tribunal both referred to the nursing note and pointed out that it is written at 9:20 which does not make sense in terms of the normal course of events but Ms. Prather argued that the fact of the matter is we don't know why the nurse wrote 9:20 down. The nurse was not called as a witness. What we know is Dr. Johnson's evidence that it is standard practice to note the time you come in, 9:10, and the time that you leave the room and hang up the chart, 9:40. This begs the question of why would he have written anything differently that day? Dr. Johnson's evidence was that he knows he saw the triage notes, the typed notes, but cannot say for sure if he saw the handwritten notes of the bedside nurse.

81. Ms. Prather then turned to what constitutes unprofessional conduct: in this case, if Dr. Johnson's care fell below the standard expected of an average, prudent pediatrician practicing in emergency medicine. It is not the gold standard but rather it is the broad middle ground. She stated what you need to look at is whether Dr. Johnson turned his mind to the important issues here and that doctors are not expected to get it right every time. Ms. Prather provided a reference from a textbook written by Bryan Salte, one of the leading textbooks on the law of professional regulation, where he clearly describes that not all errors are unprofessional conduct. Subsequent decisions have concluded that a physician cannot be found guilty of unprofessional conduct if there exists a responsible and competent body of professional opinion that supports the physician's conduct, judgement or treatment, which is the case here.

82. Other decisions have indicated there must be some failure amounting to gross negligence or some quality of blatant disregard for the patient or patient's' well-being before you can conclude unprofessional conduct as outlined in the decision of *Reddoch v. The Yukon Medical Council.* The Yukon Court of Appeal reviewed the decision of the hearing tribunal, and in that case, they decided that the definition of unprofessional conduct could not include a failure to exercise reasonable care and skill in the management of one patient. To do so, they said would likely result in every physician being guilty of unprofessional conduct, because everybody makes small mistakes. In the view of the Court of Appeal, the standard to find unprofessional conduct requires a quality of blatancy or some cavalier disregard for the patient. This standard of requiring blatancy was also adopted recently by the Hearing Tribunal of the CPSA in the *Jiwa* case. Turning to the expert evidence in this case, Ms. Prather stated that the Hearing Tribunal should consider the relevance of the expert's training, experience and specialty to the medical issues and any reason for the expert witness to be less than impartial. The standard that Dr. Johnson was required to meet must be based on what a reasonable, prudent emergency room physician would do.

83. It was the submission of Ms. Prather that the opinion of Dr. Curtis should be given limited weight as it was coloured by the knowledge of the patient's death on March 5th along with the autopsy report. In addition, Dr. Curtis was of the understanding that the patient had not had any intake or output for 24 hours

and when she was asked to assume 12 hours as testified to by the Complainant, she said her evidence or opinion would have been different if she had known that. In addition, Ms. Prather submitted that Dr. Curtis gave less weight to the normal vital signs and that the child appeared well hydrated to two nurses and Dr. Johnson, and that he did not appear lethargic. On cross examination, she agreed that an infant with normal vital signs is less likely to have a serious condition such as any type of acute kidney injury and that all of the vital signs in this case were reassuring. She also agreed that whether to observe the infant in hospital or to discharge and allow for feeding at home depends heavily on clinical judgment. In addition, Ms. Prather submits that Dr. Curtis has less experience than Drs. Johnson, Rieder and Salvadori and, therefore, the way she may exercise her clinical judgement may not be comparable to theirs. Ms. Prather also submitted that Dr. Curtis' opinion demonstrated anchoring bias in that she had the knowledge that the patient died five days later. Dr. Curtis also misunderstood that the patient had not fed or voided for 24 hours.

84. Turning to the specific allegations in the Notice of Hearing, the first of which is a failure to obtain an adequate history of frequency and adequacy of oral intake and urinary output before hospital, Ms. Prather states that Dr. Johnson clearly noted slightly decreased intake and decreased urine output overnight which is consistent with what the mother described. On physical exam, Dr. Johnson noted that the child appeared well-hydrated which shows he clearly turned his attention to whether the child was dehydrated or not.

85. The second allegation is a failure to obtain an adequate history of frequency or amount of any vomiting. The medical records from the nursing assessments state that the patient had increased spit-ups and the mother confirmed this on cross-examination. Dr. Johnson indicated it would be standard practice in examination of an infant to ask if there was a history of any vomiting; in this case there was no vomiting so there would be no further investigation or discussion about that. Dr. Johnson further testified that increased spit-ups is a common finding in children with bronchiolitis due to the increase in mucous production, which was confirmed by Dr. Rieder as well. The question of vomiting seems irrelevant in the face of a well-hydrated baby with moist mucous membranes and normal vital signs.

86. The third allegation is failing to observe the patient for an adequate period of time to assess oral intake and urinary output. An adequate period of time is in the eye of the beholder, the one who is exercising the clinical judgment. Both Dr. Rieder and Dr. Curtis agreed that reduced intake and corresponding reduced output are associated with viral illness. Dr. Rieder explained that the guidelines do not set any required time for monitoring of an infant diagnosed with bronchiolitis who has normal vital signs and, in his opinion, Dr. Johnson spent the adequate time required. Dr. Rieder also explained that a baby can be monitored in the hospital or at home, in the care of a capable and attentive parent. Dr. Curtis also agreed that this is a matter of clinical judgment that

different physicians could exercise their clinical judgment differently, and that the guidelines do not specify any time period.

87. The fourth allegation is failing to perform and record in the patient's chart an adequate physical examination of the patient given the presenting history and symptoms. Dr. Johnson's physical examination, as noted in the chart, consisted of a visual examination including noting the child was active and appeared well hydrated. He repeated and noted the most vital of the vital signs, the heart rate and respiratory rate, both of which were normal. He did an assessment and noted moist mucous membranes and said he always checks the cap refill as part of standard practice, although did not specifically note it (it is noted in the nurse's note as normal, less than 2 seconds). Dr. Johnson also recorded a head and neck examination including the ears, and the mother gave evidence of Dr. Johnson doing that including touching the top of the head to assess the fontanelle. Dr. Johnson gave evidence of his standard chest examination including listening to the lungs with a stethoscope and observing breathing; he noted no increased work of breathing when he assessed the child. Although Dr. Johnson did not record a cardiovascular examination, he recorded the heart rate of the baby and would have listened to the heart in order to do so. Dr. Johnson also gave evidence that if there was anything concerning, he would have made note of it.

88. The abdominal, extremity and integumentary examination were also all recorded by Dr. Johnson. Dr. Rieder gave evidence that the physical examination completed and charted by Dr. Johnson met the standard of care. While Dr. Curtis was critical that a blood pressure was not taken, Drs. Johnson, Rieder and even Dr. Curtis agreed that with a normal heart rate and normal respiratory rate, it is not possible for the baby to have an abnormal or low blood pressure. In Ms. Prather's submission, Dr. Curtis in her criticism is looking for a gold standard of perfection that is not something required by the standard of care. Both Dr. Rieder and Dr. Salvadori confirmed that Dr. Johnson's chart notes were reflective of an experienced physician who is efficient, and gets to the important points. Dr. Johnson's chart entries reflected completely average adequate notes.

89. The fifth allegation in the Notice of Hearing is failing to investigate alternate diagnosis of urinary tract infection, pneumonia, bacteremia and sepsis. The Complaints Director had specifically put in issue that Dr. Johnson should have investigated these four different possibilities but Ms. Prather stated that Dr. Johnson should not have been considering all these things when on March 1, 2015 there was absolutely no evidence of them. All the experts agree that there was no evidence of UTI, pneumonia, bacteremia or sepsis at that time and none of those alternate diagnoses actually came to fruition. All the evidence supports that Dr. Johnson correctly concluded that the patient had RSV resulting in bronchiolitis.

90. Finally, the sixth allegation in the Notice of Hearing is prematurely discharging Patient A. Dr. Rieder and Dr. Salvadori both testified that the decision to

discharge is a matter of clinical judgement based on the child's illness presentation, vitals, home situation and the competence of the parents. Admission to hospital must be decided based on risk factors and balancing the risks of keeping the infants in the ER or offering invasive treatments that are not effective or necessary, which is why the bronchiolitis guidelines were put into place in 2014. Ms. Prather argued that to second guess Dr. Johnson's clinical judgment and keep the baby a couple more hours, when the baby fed at home anyways, is setting a standard that is just untenable.

91. In Ms. Prather's respectful submission, the Complaints Director has failed to prove the allegations in the Notice of Hearing and, the case law requires much more than the minor matters identified by Dr. Curtis for there to be a finding of a breach of the standard of care let alone unprofessional conduct.

92. In reply, Mr. Boyer noted that the case of *Reddoch v The Yukon Medical Council* is no longer good law and the Supreme Court of Canada in the case of *F.H. v McDougall* in 2008 stated that the standard of proof in civil cases, such as these unprofessional conduct proceedings, is always on a balance of probabilities. Further, in the Health Professions Act, the definition of unprofessional conduct is very broad and the failure to meet a standard of care is included in that definition; therefore Reddoch*,* which states there has to be something of a blatant disregard, is no longer good law and doesn't apply to Alberta.

VI. FINDINGS

93. **For the reasons that follow, the Hearing Tribunal has dismissed all the charges against Dr. Johnson.**

a) Failing to obtain an adequate history of frequency and adequacy of oral intake and urinary output before presentation to hospital

94. **The Hearing Tribunal found this allegation to be unproven.** Dr. Johnson did record in the patient's medical record that there was slightly decreased intake and decreased urinary output overnight, which is consistent with the history that the patient's mother provided. In addition, Dr. Johnson did comment on the hydration status of the infant by noting "Well hydrated" on the chart, which shows he turned his mind to the patient's hydration status which would be directly related to the oral intake and urinary output before presentation to hospital. Similarly, Dr. Johnson noted "moist mucous membranes" on the chart which is an indicator of hydration. In addition, he documented "prolonged discussion" about return to clinic and testified that he discussed with the mother relative hypervolemia of the neonate, which further supports that he gave adequate thought to the hydration status and the fluid needs of this patient. [redacted] confirmed in her evidence that there was a discussion about hypervolemia with Dr. Johnson.

95. In addition, both Expert Witnesses for the respondent, Dr Rieder and Dr. Salvadori agreed that Dr. Johnson recorded and in turn asked about the pertinent parts of the history which included oral intake and urinary output. They both stated that Dr. Johnson unequivocally met the standard of care for a pediatric emergency physician overall and in regards to this specific allegation. They noted that Dr. Johnson wrote down the key pertinent points of the history and as an experienced physician, did not need to write as detailed notes as a more junior physician or learner would need to do.

96. Dr. Curtis, Expert Witness for the Complaints Director on the other hand, felt that more should have been recorded and done for this patient. However, she was also of the understanding that the child was not feeding and had not voided for a period of 24 hours, which was inconsistent with the history provided by the mother, [redacted]. [redacted]'s evidence was that she told Dr. Johnson that her son had not voided in 12 hours.

97. Overall, the Hearing Tribunal preferred the expert opinion testimony of Drs. Rieder and Salvadori over that of Dr. Curtis. This was due to their greater clinical experience and more accurate understanding of the patient's presentation and history in relation to hydration status. While the Hearing Tribunal did find Dr. Curtis to be a credible witness, at the same time it found that her opinion was based on an inaccurate understanding that Patient A had not voided in 24 hours, which Dr. Curtis acknowledged under cross examination was "different information" than she had been working with. Further, when asked in cross-examination if Dr. Johnson turned his mind to whether Patient A was appropriately hydrated, Dr. Curtis agreed that Dr. Johnson had done so.

b) Failing to obtain an adequate history of frequency or amount of any vomiting

98. **The Hearing Tribunal found this allegation to be unproven.** Dr. Johnson testified that it is part of the standard of practice to ask the parent of any infant if there is any history of vomiting. In this case, there was no history of vomiting, therefore no need to document it in the clinical record or ask any additional questions about it. There was documentation by the nurses of increased spit-ups which is consistent with the increase in mucous secretions that occurs with a viral infection such as RSV bronchiolitis and not the same thing as vomiting.

99. Dr. Curtis acknowledged in her testimony that the triage nurse did not note any vomiting or diarrhea. On re-direct from Mr. Boyer, Dr. Curtis clarified that she was not sure on the history whether there was vomiting or increased spit-ups, but confirmed that there was a note in the chart that there was increased spit-ups. Further, [redacted] testified that what she had conveyed to the triage nurse during the March 1, 2015 visit was that her son had been experiencing increased spit-ups.

100. The experts for the Respondent felt this allegation was largely irrelevant to the case at hand, given the lack of history of vomiting in this child.

101. On review of the evidence, there was no reference to vomiting made by [redacted], the triage nurse or Dr. Johnson. While there was some discussion of increased spit-ups, the Hearing Tribunal accepts that vomiting and spit-ups are clinically different things, and based on the history presented, vomiting was not a concern and there was no need for Dr. Johnson to obtain an adequate history of frequency or amount of any vomiting.

c) Failing to observe the patient for an adequate period of time to assess oral intake and urinary output

102. **The Hearing Tribunal found this allegation to be unproven**. Given the presentation of the child and the normal vital signs, there was no indication that the child needed to be kept longer in the hospital for observation. All the experts agreed that what is an adequate period of time is a matter of clinical judgment and that the guidelines themselves do not specify a certain amount of time for monitoring. Dr. Rieder and Dr. Salvadori were in full support of Dr. Johnson's decision to discharge and his recommendations on discharge for the mother to prop the baby up, continue to breast feed and offer Tempra for fever. In addition, Dr. Rieder indicated that the bronchiolitis guidelines (Canadian Paediatric Society) he co-authored do not specify where a child should be monitored and advised that a child's intake and output can be monitored at home by a caring and competent parent without exposing the infant to the risks of contracting a nosocomial infection that may occur if they are kept unnecessarily in the emergency department. Dr. Johnson himself said that continuing to monitor a child with normal vital signs in the emergency department is not a standard practice and not without risks.

103. The experts agreed that one factor that could be considered in determining whether to discharge a patient is whether there are caring and competent parents able to care for the child at home. The evidence here is that Patient A's parents had three children and were experienced parents, and further that Patient A's mother is a physician.

104. Dr. Curtis, on the other hand, felt that the child should have been kept longer for in the emergency room for monitoring of intake and output and if the child continued not to feed, additional interventions should be undertaken. On cross-examination, Dr. Curtis agreed that discharge is a matter of clinical judgment, but she maintained that most physicians that she had worked with would have been concerned about sending this baby home.

105. It is clear from Dr. Curtis' evidence that her opinion on discharge was premised on her understanding that Patient A was not feeding well or voiding well. Again, however, Dr. Curtis acknowledged that her opinion was based on the understanding that it had been 24 and not 12 hours since the child had fed or voided. This misunderstanding of the facts has led the Hearing Tribunal to

put less weight on Dr. Curtis' opinion that the child needed to be observed for a longer period prior to discharge.

106. When the fact that it had been 12 hours and not 24 hours since the last feeding or void is considered along with the fact that the child had normal vital signs including temperature, heart rate, oxygen saturation and respiratory rate, the Hearing Tribunal accepts that there were not clinical indications which would have justified keeping Patient A for a further period of observation in the hospital. As noted by the expert witnesses, further observation is also safely carried out at home by caring and competent parents.

d) Failing to perform and record in the patient's chart an adequate physical examination of the patient given the presenting history and symptoms

107. **The Hearing Tribunal found this allegation to be unproven.** Dr. Johnson did in fact record a history and physical examination that was agreed by Dr. Rieder and Dr. Salvadori as entirely adequate and acceptable, reflective of an experienced clinician who focuses on pertinent clinical details and findings. The Hearing Tribunal found the evidence that Dr. Johnson gave of his standard and routine practice, especially his clinical approach to a child presenting as Patient A did, was very detailed and reflective of a thorough, experienced and nuanced physician. The Hearing Tribunal found he was a credible witness and though Dr. Johnson testified he had no specific recollection of his clinical encounter with Patient A and his mother, had no reason to doubt that he did anything other than his usual practice with this child. The patient's mother herself corroborated much of what Dr. Johnson noted in the chart and described as his usual practice.

108. The Hearing Tribunal acknowledges the argument of the Complaints Director that the evidence supports that some parts of Dr. Johnson's standard practice were not followed in this case. However, although the cardiovascular exam was not recorded by Dr. Johnson, the Hearing Tribunal believes that the exam was performed as Dr. Johnson listened to the baby's chest and took the heart rate. In addition, while a blood pressure was not taken, Dr. Johnson and his experts made it clear that with normal vital signs of heart rate and respiratory rate, there would be no way that the blood pressure would be abnormal or low – so, in fact, it was not necessary to record it. The Hearing Tribunal found Dr. Johnson credible in the evidence he gave that as part of his examination he would have checked the capillary refill and fontanelle, even though he did not specifically record those two findings in the chart. Indeed, [redacted] testified that she recalled Dr. Johnson palpating the fontanelle.

109. Dr. Curtis, on the other hand stated that all patients presenting to the emergency department in Alberta require a blood pressure to be done; there was however no documentation provided to support this as a policy statement. She also agreed with the other experts that if the child's other vital signs were normal, it is improbable that the blood pressure would be abnormal or low.

110. The Hearing Tribunal also agrees with counsel for the Respondent that the standard of care is in fact not a standard of perfection but rather a standard of what an average and competent physician with similar training and background would have done. Forgetting to write something down such as the cardiovascular exam does not in and of itself amount to unprofessional conduct as all physicians will make mistakes or forget to write something down on occasion. The evidence supports that Dr. Johnson did an entirely adequate assessment and charting of an otherwise healthy robust infant presenting with symptoms compatible with routine RSV bronchiolitis.

e) Failing to investigate alternate diagnosis of urinary tract infection, pneumonia, or bacteremia or sepsis

111. **The Hearing Tribunal found this allegation to be unproven.** Given the history and presentation of this infant, there was no significant evidence suggestive of these other diagnoses at the time of his presentation to the emergency department on March 1, 2015. The experts for the Respondent stated that those diagnoses were far-fetched for this specific clinical encounter and that Dr. Johnson was in fact correct with his diagnosis and treatment recommendations at the time the patient presented to the emergency department. Specifically, Dr. Rieder noted that urinary tract infection in the absence of fever is unlikely. Similarly, bacteremia and sepsis are unlikely in the absence of fever, and pneumonia with a normal respiratory rate is likewise unlikely.

112. Dr. Curtis, the expert for the Complaints Director, did not specifically discuss or raise concerns about the alternate diagnoses of urinary tract infection, pneumonia, or bacteremia or sepsis in her testimony or in her expert report. Rather, Dr. Curtis stated she was concerned about the infant being at risk for acute kidney injury; however, this concern may have arisen because Dr. Curtis was under the impression that it had been 24 hours since the child last fed or voided. Further, under cross-examination, Dr. Curtis agreed that a baby with a normal heart rate, normal respiratory rate, moist mucous membranes, normal cap refill, normal fontanelle, normal Glasgow Coma Scale and appearing well hydrated makes the possibility of acute kidney injury less likely.

113. The Hearing Tribunal accepted the usual clinical approach Dr. Johnson described including consideration of a broad differential diagnosis with any new patient, ruling out serious illnesses, and then narrowing down the diagnosis based on the specific history and physical examination findings. The Hearing Tribunal accepts that he took this approach with Patient A. There is insufficient evidence that Dr. Johnson failed to consider the appropriate diagnoses or rule out serious illnesses in his assessment of Patient A.

f) Prematurely discharging your patient

114. **The Hearing Tribunal found this allegation to be unproven.** This allegation raises similar considerations to allegation c) about a failure to observe. The relatively quick turn-around time in the emergency department that day does not necessarily mean that any steps were missed or that the patient was prematurely discharged.

115. All the experts agreed that monitoring of a child with RSV bronchiolitis can in fact occur at home with capable parents, and that the guidelines do not specify where the monitoring of intake and output should occur. In addition, it was noted that there are risks of keeping a 3-month-old infant in the hospital unnecessarily and the guidelines themselves do not recommend invasive testing but rather supportive measures that are consistent with Dr. Johnson's discharge advice.

116. Dr. Johnson's note of prolonged discussion regarding return to clinic suggests he did discuss with the mother the option of returning if things did not improve or if there were additional concerns. Dr. Johnson's evidence that he would never tell a parent not to return to the emergency for 3 days was deemed credible given his experience and the fact he stated follow up is one of the fundamental credos of pediatrics, especially in a child of this age.

117. The Hearing Tribunal, at the same time, empathizes with the stress and concern that [redacted] was experiencing when she received the diagnosis and information from Dr. Johnson. Although she is herself a physician, she was acting at the time as a mother of an ill child.

118. The Hearing Tribunal found that Dr. Curtis' evidence and opinion that the child should have been kept longer was influenced by her understanding of the length of time the child had not fed prior to presenting to the emergency room and possibly biased by her knowledge that the child had died five days later. Dr. Curtis herself agreed that clinical judgement is key in assessing these situations; that the person in the best position to make that decision is the one assessing the child, and that competent physicians can disagree on the best course of action. This evidence does not support that Dr. Johnson engaged in unprofessional conduct by discharging the patient when he did.

VII. CONCLUSION

119. As set out in the reasons above, the Hearing Tribunal does not find that any of the charges again Dr. Johnson are founded. Accordingly, the Hearing Tribunal does not find that Dr. Johnson engaged in unprofessional conduct.

120. While the Hearing Tribunal did not find unprofessional conduct on Dr. Johnson's part, this case nevertheless involved a tragic outcome and the Hearing Tribunal extends its profound sympathies to [redacted] and her family for their heartbreaking loss.

Signed on behalf of the Hearing Tribunal by the Chair:

Dr. Neelam Mahil

Dated this 7th day of November, 2022.