COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,
R.S.A. 2000, c. C-7

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. ROBERT HALSE

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. Robert Halse on April 15th, 2020.

The members of the Hearing Tribunal were: Dr. Paul Greenwood of Edmonton as Chair, Dr. Oluseyi Oladele of Edmonton and Ms. Pat Matusko of Beaumont (public member). Ms. Ayla Akgungor acted as independent legal counsel for the Hearing Tribunal.

In attendance at the hearing was Mr. Joseph Redman, legal counsel for the College of Physicians & Surgeons of Alberta (the "College"). Also present was Dr. Robert Halse and Mr. Tim Ryan, legal counsel for Dr. Halse.

The Court Reporter was Ms. Shelley Becker.

There were no objections to the composition of the Hearing Tribunal or the jurisdiction of the Hearing Tribunal to proceed with a hearing. There were no objections to the hearing proceeding as a Zoom meeting due to the COVID-19 restrictions.

II. ALLEGATIONS

The allegations to be considered by the Hearing Tribunal against Dr. Halse were set out in the Notice of Hearing as follows:

1. On April 11, 2018 and on April 13, 2018, you did demonstrate a lack of skill or judgment in the provision of professional services to your patient, R.G., particulars of which are set out in the expert opinion from Dr. L.B.; and

2. On April 13, 2018, you did demonstrate a lack of skill or judgment in failing to be present to supervise the medical student, Mr. S. K., whom you had asked to meet with your patient, R.G., at the Ponoka hospital.

Dr. Halse admitted the allegations and agreed that the conduct set out in the allegations amounted to unprofessional conduct. The Hearing proceeded by way of an Agreed Exhibit Book and a Joint Submission on Sanction by Dr. Halse and the College. No witnesses were called.

III. PRELIMINARY MATTERS

There were no preliminary matters raised by the parties.

IV. EVIDENCE – EXHIBITS

The parties entered a Joint Exhibit Book as Exhibit 1. Exhibit 1 contained the following tabs:

1. Notice of Hearing dated March 5, 2020
2. Complaint Reporting Form by R.G. dated April 21, 2018
3. Email from D.G. (adult daughter of R.G.) dated January 23, 2019
4. Dr. Halse's response dated May 28, 2018

5. Dr. Halse's additional information dated October 1, 2018
6. Dr. Halse's additional information dated October 16, 2018
7. Dr. Halse's additional information dated January 23, 2019
8. CT Requests completed by Dr. Halse dated April 13, 2018
9. Ponoka Hospital Records for R.G. on April 13, 2018
10. Red Deer Hospital Records for R.G. on April 14, 2018
11. Memo by Dr. Giddings re: interview of Nurse J.H. on April 11, 2018
12. Memo by Dr. Giddings re: interview of medical student S.K. on April 13, 2018
13. Memo by Dr. Ritchie regarding phone call with D.G. on August 19, 2019
14. Opinion from Dr. L.B. dated September 27, 2019
15. Canadian Stroke Best Practice Recommendations for Acute Stroke Management: *Prehospital, Emergency Department, and Acute Inpatient Stroke Care, 6th Edition, Update 2018*
16. Canadian Council of Motor Transportation Medical Standards for Driving (CCMTA, 2013)
17. Transient Ischemic Attack (TIA): Prognosis and Key Management Considerations and required form

A Joint Submission Agreement was entered as Exhibit 2.

V. SUBMISSIONS ON UNPROFESSIONAL CONDUCT

(a) Submissions of the Complaints Director

Mr. Redman for the College stated that there was an admission of unprofessional conduct and referred to the Joint Submission Agreement.

Mr. Redman reviewed the Health Professions Act ("HPA") sections relevant to the hearing for Dr. Halse. He submitted that the HPA specifically contemplates that a member can make an admission at any point before a Hearing Tribunal has made a decision.

Sections 70(1) and 70(2) of the HPA deal specifically with admissions and state as follows:

> 70(1) At any time after a complaint has been made but before the hearing tribunal has made a decision as to whether unprofessional conduct has occurred, an investigated person may submit a written admission of unprofessional conduct to the hearings director.
>
> (2) An admission under subsection (1) may not be acted on unless it is acceptable in whole or in part to the hearing tribunal.

Mr. Redman also reviewed the definition of unprofessional conduct in the HPA. Specifically, subsection 1(pp)(i) defines it as: (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services. Mr. Redman argued that this was the section of the definition of unprofessional conduct that applied to Dr Halse in his care of R.G. from April 11 to 13, 2018.

Mr. Redman stated that physicians owed a standard of care to their patients and in this particular case, it was a series of lapses in judgment that which resulted in an adverse outcome for a patient. Mr. Redman referred the Hearing Tribunal to the expert opinion of Dr. L.B. and to Dr. Halse's admission in this regard and noted that there was sufficient evidence to support a finding of unprofessional conduct in this case.

(b) Submissions of Dr. Halse

Mr. Ryan for Dr. Halse stated that Dr. Halse admitted to the two charges in the Notice of Hearing and urged the Hearing Tribunal to accept the admission on the basis that legal counsel had gone through the matter in fine detail and reached a conclusion that should be acceptable to the Hearing Tribunal.

VI. FINDINGS ON UNPROFESSIONAL CONDUCT

The hearing was the result of an investigation into a complaint to the College about the care delivered by Dr. Halse to R.G. in April of 2018. R.G. complained to the College in a document dated the 21st of April 2018. His claim was that the care provided by Dr. Halse between Wednesday April the 11th 2018, and Saturday April 14th, 2018, fell below the standard expected of a family physician. As a consequence of this failure, R.G. suffered a stroke which might have been prevented or the outcomes mitigated had the appropriate investigations been delivered more expeditiously.

The Hearing Tribunal finds that the documents set out in Exhibit 1 reveal the following facts:

Wednesday April the 11th, 2018.

R.G. was at this time an active 88-year-old man who was still engaged in farming with his two sons and was capable of all activities of daily living. He was in his bank in Ponoka when he noticed that he was feeling lightheaded and dizzy and was unable to sign his name. He made an appointment to be seen by his family physician, Dr. Halse, at the clinic in Ponoka and was seen later that day. Dr. Halse took a history and conducted an examination of R.G. He found a normal blood pressure and physical examination showed no signs of weakness or slurred speech. It appeared that Dr. Halse diagnosed a transient ischemic attack and arranged for a CT scan of R.G.'s head, to be done in Red Deer, an electrocardiogram and some blood work to be done in Ponoka. He directed R.G. to go to the hospital in Ponoka for these tests.

R.G. went to the Ponoka General Hospital with the paperwork for these investigations and was told that they did not do CT scans at that facility. He left without having any blood work or electrocardiogram done and went home.

Thursday April 12th, 2018.

R.G. had a prior appointment at the Red Deer General Hospital to see his cancer specialist Dr. C.T. R.G. and his son drove to the Red Deer Regional Hospital for this appointment and he was seen by Dr. C.T. It appears that Dr. C.T. did note some right sided weakness and did facilitate the

booking of the CT scan in Red Deer. As the requisition was not marked urgent, it was not done that day, so R.G. and his son returned to Ponoka without having had the CT scan.

Friday April 13th, 2018.

R.G. called his daughter in Edmonton and she noted his speech was slurred. She told R.G. to go to the hospital to be seen urgently. R.G. had called Dr. Halse's office and Dr. Halse sent Mr. S.K., a medical student working with Dr. Halse, to the emergency room to examine R.G. R.G. was seen in the Ponoka hospital emergency room by Mr. S.K. and apparently an emergency physician on duty in that Emergency Department. R.G. was found to have slurred speech and right sided weakness and Dr. Halse arranged for a neurologist, Dr. O.I. to review R.G. after the CT scan was completed. R.G.'s son was advised to drive R.G. to the Red Deer General Hospital for the scan as Dr. Halse believed it would be quicker than waiting for the emergency medical services to arrive and transport him.

R.G. and his son drove to the Red Deer General Hospital and had the CT scan done. They were unaware of the arrangements to see Dr. O.I., so after the scan they returned to Ponoka.

Saturday April 14th, 2018.

One of R.G.'s other daughters visited R.G. at his house. He was obviously ill with slurred speech, right sided weakness and inability to bear weight on his right leg. The daughter called Healthlink and was told to contact EMS which she did. An ambulance came, and R.G. was transferred from his house in Ponoka to the Red Deer General Hospital and admitted with a completed stroke to the care of Dr. T.G., an emergency department physician. R.G.'s condition was outside the time window for thrombolytic treatment.

The College investigation included an expert opinion by Dr. L.B., a family physician in a rural community with hospital privileges and a practice similar to Dr. Halse. This review concluded:

"Throughout my review of this case, a pattern of poor documentation is evident in Dr. Halse's records. His clinic visit note from April 11, 2018 contains few details. On his note from the Emergency Department encounter on April 13, 2018 only a diagnosis is added in addition to the medical student and nursing documentation. There is no documentation of the phone consult with Dr. O.I. and subsequent plan. Additionally, there were no written instructions provided to the patient at either encounter. As outlined above, Dr. Halse failed to meet an acceptable standard of care for a General Practitioner practicing in Alberta in 2018 in regard to his management of R.G.'s presenting symptoms on April 11, 2018. This includes inadequate history-taking, physical examination and documentation as well as a failure to follow guidelines for management."

The expert opinion found that guideline treatment was to have sent R.G. for an emergency CT scan at the initial visit on Wednesday April 11, 2018. Early and urgent investigation may allow the use of thrombolytic treatment of threatened stroke and prevent a completed stroke occurring or reduce the neurological deficit.

One additional concern regarding Dr. Halse's management is that R.G. was not advised that he must not drive, posing a risk to himself and the public. According to the Canadian Council of

Motor Transportation Medical Standards for Driving (CCMTA, 2013), "patients who have experienced 1 or multiple TIAs should be instructed not to drive until a comprehensive neurological assessment shows: no residual loss of functional ability, no obvious risk of sudden re-occurrence and any underlying cause has been addressed with appropriate treatment."

Based on the evidence set out above, the Hearing Tribunal is satisfied that the conduct described in Allegation 1 occurred and that the conduct amounts to unprofessional conduct in that it demonstrates a lack of knowledge, skill or judgment in the provision of professional services. The Hearing Tribunal accepts the expert opinion of Dr. L.B. that Dr. Halse's conduct as described above failed to meet an acceptable standard of care for a general practitioner practicing in Alberta in 2018.

With respect to the second allegation, the documents contained in Exhibit 1 revealed that there was a lack of supervision of the medical student, Mr. S. K. On Friday April 13, 2018, Dr. Halse sent Mr. S.K. to the Ponoka Hospital emergency department and asked him to examine R.G. as he was said to be showing signs of a stroke. There was no apparent follow up between Dr. Halse and Mr. S.K. R.G. was allowed to depart from the emergency department by car with his son. They were unaware that after the CT scan was completed, R.G. should have been seen by the neurologist Dr. O.I. This information was not communicated by Dr. Halse to Mr. S.K. Neither Mr. S.K. nor the emergency department physician was able to inform R.G. of these arrangements.

Based on the evidence above, the Hearing Tribunal is satisfied that Dr. Halse demonstrated a lack of skill or judgment in failing to be present to supervise Mr. S.K., who he had asked to meet with R.G. at the Ponoka Hospital.

Accordingly, the Hearing Tribunal accepts Dr. Halse's admission of unprofessional conduct and finds that Dr. Halse has engaged in unprofessional conduct with respect to both allegations 1 and 2.

VII. SUBMISSIONS ON PENALTY

The Hearing Tribunal was presented with a Joint Submission on Sanction. The Joint Submission on Penalty sought the following sanctions:

1. Dr. Halse should receive a reprimand;
2. Dr. Halse's practice permit should be subject to a condition that he be prohibited from being involved as the supervising physician for any medical learner unless and until he receives written approval from the Complaints Director (if Dr. Halse is interested in returning to supervising medical learners, the practice review under paragraph 3 shall include assessment of his supervision skills);
3. Dr. Halse should undergo, at his own cost, a practice review focusing on issues and concerns identified through the complaint investigation and the opinion of Dr. L.B.;

4. Dr. Halse should be required to implement any changes to practice and/or upgrading as recommended by the practice review (as determined by the Complaints Director and if there is a disagreement over the nature, scope or duration of any practice condition or change, the Hearing Tribunal would be the final decision maker on that issue);and
5. Dr. Halse should be responsible for 75% of the costs of the investigation and hearing.

(a) Submissions of the Complaints Director

In his submission on sanctions, Mr. Redman pointed out the linkage between the conditions in Order #2 referencing the supervision of learners, and that should Dr. Halse wish to take part in supervising learners, this will be incorporated into the practice assessment and review referenced in Order #3.

Mr. Redman reminded the panel of the *R v Anthony-Cook (2016 SCC 43*) case whereby the panel has a duty of deference to joint submissions, unless there is an overriding concern that accepting the submission will bring the administration of justice into disrepute or is contrary to the public interest.

He then referred to the *Jaswal d*ecision which contains the factors that a hearing tribunal should consider when assessing the appropriateness of sanctions. The Jaswal decision lists those factors as follows:

1. the nature and gravity of the proven allegations

2. the age and experience of the offending physician

3. the previous character of the physician and in particular the presence or absence of any prior complaints or convictions

4. the age and mental condition of the offended patient

5. the number of times the offence was proven to have occurred

6. the role of the physician in acknowledging what had occurred

7. whether the offending physician had already suffered other serious financial or other penalties as a result of the allegations having been made

8. the impact of the incident on the offended patient

9. the presence or absence of any mitigating circumstances

10. the need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of medicine

11. the need to maintain the public's confidence in the integrity of the medical profession

12. *the degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct*

13. *the range of sentence in other similar cases.*

Mr. Redman argued that any offense which comes before a Hearing Tribunal is serious. The offense committed by Dr. Halse is a standard of care issue and Dr. Halse is not a repeat offender. Within the spectrum of offences dealt with by the College this is towards the lower end of seriousness.

The second point Mr. Redman highlighted was the 6th factor in the *Jaswal* case: the role of the physician in acknowledging the offense. Mr. Redman noted that Dr. Halse had taken responsibility for his actions at an early stage and cooperated fully and was in agreement with proceeding by joint submission. This is also reflected in the cost charged to Dr. Halse of 75% of the costs of the investigation and hearing. Mr. Redman noted that his willingness to undergo a full practice review contributed to this.

The next factor Mr. Redman referenced was number 8, the impact on the patient. The impact on R.G. was serious. R.G. suffered a stroke with permanent disability which had significantly impacted his quality of life. However, R.G. did continue to have Dr. Halse as his family physician. Mr. Redman therefore felt that although the matter was a serious one the concerns raised by the inquiry and investigations have been or will be addressed by the sanctions.

The final factor addressed by Mr. Redman was the 10th *Jaswal* factor: the need to promote specific and general deterrence. Mr. Redman indicated that serious consideration was given to this aspect of the orders for sanction and that the practice review was an important part of ensuring that the issues raised by Dr. L.B. are addressed and not repeated.

(b) Submissions of Dr. Halse

Mr. Ryan agreed with the points made by Mr. Redman and had no further comments.

(c) Question from the Hearing Tribunal

After a brief recess, the panel reconvened and asked Mr. Redman for more specifics on how the supervision assessment would be done. Mr. Redman advised the panel that if Dr. Halse wishes to accept students, he will inform the practice review team. This team will then incorporate an assessment process into the review and recommendations. Mr. Redman said that the submission was not specific in this area, as at the time it was agreed, Dr. Halse was uncertain if he wished to resume supervision of learners. The practice review will be similar to the College IPR (Individual Practice Review) program. This is a comprehensive and thorough review which produces recommendations which must be addressed before the College gives approval to return to practice.

VIII. FINDINGS ON PENALTY AND ORDERS

The Hearing Tribunal accepts that when presented with a Joint Submission, the principle of deference applies and a Joint Submission should be accepted unless the Hearing Tribunal has concerns that the Joint Submission would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

In making that assessment, the Hearing Tribunal is cognizant that the overriding consideration is whether the orders for penalty protect the public interest. The proposed orders for penalty must also be assessed in the context of the relevant *Jaswal* factors.

As far as the nature and gravity of the proven allegations, the Hearing Tribunal agrees that a failure to meet the required standard of care, particularly when that failure results in an adverse incident for a patient, is very serious. However, when all of the circumstances are considered, the Hearing Tribunal agrees that the conduct at issue is on the lower end of the spectrum of unprofessional conduct. This suggests that the orders for penalty should also be on the corresponding lower end of the spectrum.

The Hearing Tribunal accepts that Dr. Halse's acknowledgement of his unprofessional conduct and his willingness to make a formal admission is a significant mitigating factor when it comes to the assessment of penalty. When a member acknowledges his or her unprofessional conduct, not only does the member take responsibility for the unprofessional conduct, but the acknowledgment also allows the parties to streamline the hearing proceedings and dispense with the need for more protracted proceedings and the calling of witnesses. This saves time and resources for all concerned.

The Hearing Tribunal has also considered the impact of Dr. Halse's conduct on R.G. The impact on R.G. was significant. Had symptoms been properly identified and interventions made earlier, the stroke could have been prevented or the outcome could have been significantly mitigated. This is indeed unfortunate and this factor points to the need for more significant penalties, especially with respect to education and remediation. The Hearing Tribunal is satisfied that the practice review will achieve this objective.

As noted by Mr. Redman, the need to promote specific and general deterrence, and thereby to protect the public and ensure safe and proper practice, is a significant consideration when assessing penalties. In the circumstances, the Hearing Tribunal is satisfied that the proposed penalties will reinforce to both Dr. Halse and to members of the profession in general that the required standards must be met both with respect to patient care and the supervision of medical learners.

In terms of costs, the Hearing Tribunal is cognizant that when the order for costs is less than 100%, the other members of the profession bear the remaining costs of the investigation and prosecution of Dr. Halse's unprofessional conduct through their membership fees. However, the Hearing Tribunal agrees that a full costs award is not appropriate given Dr. Halse's admission of unprofessional conduct. This admission would have allowed the College to shorten the investigation proceedings and streamline the unprofessional conduct hearing resulting in reduced overall costs. Here, the parties have agreed on 75% as the appropriate amount of costs to be borne

by Dr. Halse and the Hearing Tribunal sees no reason to interfere with the parties' assessment in this regard.

The Hearing Tribunal therefore makes the following orders for sanction with respect to Dr. Halse:

1. Dr. Halse shall receive a reprimand;

2. Dr. Halse's practice permit will be subject to a condition that he be prohibited from being involved as the supervising physician for any medical learner until he receives written approval from the Complaints Director;

3. Dr. Halse will undergo, at his own cost, a practice review focusing on issues and concerns identified through the complaint investigation and the opinion of Dr. L.B;

4. If Dr. Halse indicates that he is interested in returning to supervising medical learners, the practice review described in #3 above shall include an assessment of Dr. Halse's supervision skills;

5. Dr. Halse will be required to implement any changes to practice and/or upgrading recommended in the practice review and as determined by the Complaints Director;

6. If there is disagreement over the nature, scope or duration of any changes required to be made to Dr. Halse's practice or any upgrading required to be taken by Dr. Halse as contemplated in #5, the Hearing Tribunal shall make final determinations on this issue; and

7. Dr. Halse shall pay 75% of the costs of the investigation and hearing.

The Hearing Tribunal retains jurisdiction to address any issues arising out of the implementation or application of the orders listed above.

In announcing the decision on penalty to the parties, the Chair of the Hearing Tribunal reminded Dr. Halse that R.G. had suffered a serious adverse outcome as a consequence of the errors in professional standards, and the stroke might have been prevented by earlier action. The Hearing Tribunal also recognized that notwithstanding this adverse outcome, R.G. had remained a patient of Dr. Halse. The Chair hoped that the sanctions applied, and the review of his practice will allow Dr. Halse to improve his practice, and with appropriate training, continue to teach medical students.

Signed on behalf of the Hearing Tribunal
by the Chair

Dated: May 20, 2020

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Dr. Paul Greenwood