COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF

A HEARING UNDER THE *HEALTH PROFESSIONS ACT*, RSA 2000, c C-7

REGARDING THE CONDUCT OF DR. GULNAZ JIWA

DECISION OF THE HEARING TRIBUNAL OF

THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

I. INTRODUCTION

On December 13 and 23, 2019, the Hearing Tribunal (the "Tribunal") held a hearing into the conduct of Dr. Gulnaz ("Gul") Jiwa. The Hearing Tribunal members were:

Dr. Stacy J. Davies, Chair
Dr. Paul Greenwood
Mr. Doug Dawson, Public Member

Mr. John R. Carpenter acted as Independent Legal Counsel for the Hearing Tribunal.

In attendance at the hearing were:

- Mr. Craig Boyer, Legal Counsel for the Complaints Director of the College of Physicians & Surgeons of Alberta (the "College").
- Dr. Gul Jiwa attended on December 13 and 23, 2019 and gave evidence on her own behalf on December 13, 2019.
- Ms. Valerie Prather, Q.C., and Jeffrey Westman, Student-at-Law, Legal Counsel for Dr. Gul Jiwa.
- The Complainant, L.C., attended and gave evidence on December 13, 2019.
- Dr. Brian Hauck was called as an Expert Witness on behalf of the Respondent and gave evidence on December 13, 2019.

In December 23, 2019, the Tribunal heard argument on behalf of the Complaints Director and on behalf of the Respondent.

There were no objections to either the Tribunal's composition or jurisdiction.

II. ALLEGATIONS

There were two allegations before the Tribunal as set out in the AMENDED NOTICE OF HEARING in respect to Dr. Gul Jiwa:

1. You did fail to record in the Operative Report relating to your surgery on your patient, L.C. performed on December 15, 2016, that you had removed the left fallopian tube in addition to the removal of the cyst on the fallopian tube.

2. You did fail to ensure that your patient, L.C., had signed the consent for the procedure performed by you on December 15, 2016.

For the reasons outlined below, the Tribunal finds the above facts are established but they do not amount to Unprofessional Conduct pursuant to the *Health Professions Act*.

III. PRELIMINARY MATTERS

The parties did not present any preliminary matters.

IV. EVIDENCE

A. L.C.'s Testimony

The parties entered Exhibits 1 to 16 by agreement. During the hearing, the tribunal received four additional exhibits.

The Complainant, L.C., testified. L.C.'s family physician referred her to Dr. Jiwa for a consultation when a paraovarian cyst was found because of an MRI ordered for an unrelated health issue. The Complainant had been experiencing pain for some time and when given the option of conservative management or surgery, L.C. opted to have the cyst removed. L.C. testified that Dr. Jiwa reviewed with her some of the risks of surgery and the possibility that it might not resolve her pain, but did not review the specific surgical procedure with her.

When L.C. attended for surgery on December 15, 2016, a nurse brought paperwork for her to review and sign. L.C. identified a form entitled Consent to Surgery or Invasive Procedure Form (Policy PRRR-01) contained in her Royal Alexandra Hospital patient chart. She testified that when she read, "possible left salpingo-oophorectomy" in the description of the procedure, she asked the nurse what that meant and was surprised that it described removal of both the left ovary and left fallopian tube. As a result, she testified that she requested clarification from Dr. Jiwa and intentionally did not sign the box in the form provided for her consent. When the resident, the anaesthesiologist, and Dr. Jiwa attended, L.C. testified that she told Dr. Jiwa she only wanted the cyst removed. She testified that she had not been told that the fallopian tube is best removed with a cyst. The surgery proceeded and L.C. was discharged later the same day without complications.

L.C. attended Dr. Jiwa's office in February of 2017 for a post-operative visit that she described as short, about five minutes. She testified that in the appointment she thanked Dr. Jiwa for doing the surgery, advised that she felt much better now that the cyst was out, and advised that she had some questions for the anesthesiologist and requested an appointment with him. Dr. Jiwa checked her incisions and showed her photos of the paraovarian cyst that she removed as well as a photo of the right ovary that she advised also had a cyst that up until then L.C. was unaware of. Dr. Jiwa then moved to leave the room and L.C. understood that the appointment was over.

As L.C. thought she may require surgery for an unrelated matter, she requested the records related to her surgery of December 15, 2016. When she received those

records in January of 2017, they consisted of only five pages. L.C. felt that she had not received enough information so she requested her Netcare records. When these were received in mid-March of 2017, she noticed what she described as a discrepancy between the Pathology and the Operative Report. L.C. made a further request for the complete hospital records and 34 pages were received in May of 2017.

On March 17, 2017 L.C. filed her complaint to the College of Physicians and Surgeons (the "College").

In her Complaint, L.C. states in part that:
Before entering the O.R., I said to ^Dr. Jiwa [sic] "I want only the cyst removed if at all possible. She was accompanied by another staff member and Dr. Jiwa spoke very little. When I first awoke after the surgery, I asked the staff ^PAGU [sic] member standing beside me, "Did they remove only the cyst?" She said, "Yes" … On March 15, 2017 I received (by mail) from the Health Records office at UAH a copy of the Pathology report. It states that a fallopian tube, as well as paratubal cyst was tested. The O.R. report does not state that my fallopian tube was removed.

When testifying before the Tribunal, L.C. stated that after she had refused to sign the required consent, no one returned to her to request that she sign it. Also, she does not recall a consent form being provided to her when she visited Dr. Jiwa in her office.

In cross-examination, L.C. confirmed the health information that she provided to Dr. Jiwa when she attended as a result of her referral. However, L.C. insisted that she provided much of that information through the health questionnaire that she completed rather than in face-to-face discussion with Dr. Jiwa.

It was clear to the Tribunal that L.C. felt Dr. Jiwa should have given her more attention and time. Her health status was nonetheless clear and accurate, whether it was obtained through the questionnaire or discussion with Dr. Jiwa.

When questioned before the Tribunal, L.C. disputed whether, at the time of the surgery, she was menopausal or pre-menopausal. She confirmed that conservative management had been suggested as one of the treatment options but disputed whether the details of this option had been reviewed with her. There was no question that the paraovarian cyst had been identified, that she had been in pain for some time and, as a result, voiced her wish that it be removed. L.C. confirmed that her condition had become so uncomfortable that she contacted Dr. Jiwa's office to ask that the surgery be expedited and Dr. Jiwa accommodated her request.

L.C. confirmed that at her February 8, 2017 post-operative appointment with Dr. Jiwa, she reported feeling better and that Dr. Jiwa had shown her three photographs taken at the surgery, including one of the removed paraovarian cyst from her left ovary and another of the right ovary. L.C. denied that Dr. Jiwa discussed that the resected cyst was benign and that there was no concern about a

malignancy on the left side. She agreed that Dr. Jiwa pointed out that there was also a cyst on the right ovary, but again denied that she was told that it was benign and not of concern.

The evidence reflects that L.C.'s family physician wrote two letters to Dr. Jiwa. On March 1, 2017 Dr. Jiwa wrote L.C.'s family physician and confirmed that L.C. had done well post-operatively and had only minimal post-operative pain. Dr. Jiwa also advised that L.C. had questions about her anesthetic record that she had tried to address and that she had confirmed there were no complications with her anesthetic.

On March 21, 2017, the family physician wrote to Dr. Jiwa again. In her letter she made a statement that L.C. seemed quite traumatized by what sounded like a normal anaesthesia experience. In her testimony, L.C. took issue with this statement. The family physician explained further, in the same letter, that L.C. had obtained her pathology and surgical reports and had come to the appointment with the family physician to ask why the pathology report stated that a salpingectomy had been performed, whereas the Operative Report identified that only a paraovarian cyst resection was done. Dr. Jiwa responded the next day with an explanation handwritten on the letter advising that: "The paratubal cyst/paraovarian cyst (cyst between tube and ovary) is best removed by removing the fallopian tube too as it gets blood supply from there [.] I also left a message for [L.C.] Hope that helps."

L.C. confirmed that on March 22, 2017, Dr. Jiwa left her a voice message but she could not recall what was said. She did not return the call. She stated that she no longer trusted Dr. Jiwa and had already filed a complaint against her with the CPSA. At the time that she received the voicemail message from Dr. Jiwa, she felt that it was best not to communicate with her again. L.C. stated that she was not aware, until she received the Investigation Report, that her family physician had texted Dr. Jiwa on March 31, 2017 to advise of L.C.'s concerns and that Dr. Jiwa had responded that she would be happy to meet with L.C. to discuss her concerns.

In addition, L.C. confirmed that she asked her family physician to request that the radiologist review the MRI again, and that the radiologist provided an addendum to the MRI Report dated April 27, 2017.

Counsel for Dr. Jiwa took L.C. back to her Complaint of March 17, 2017 where she stated that she wanted three questions answered in writing. In the first question, L.C. requested visual proof with an explanation of the reason that her fallopian tube was removed. L.C. testified that Dr. Jiwa never explained to her that her fallopian tube was removed.

Counsel pointed out, and L.C. acknowledged, that she had not disclosed in her Complaint that she had deliberately refused to sign the consent form that she reviewed in the hospital just prior to her surgery. Counsel then reviewed communications between L.C. and a Patient Advocate. On August 17, 2017 L.C. emailed the Patient Advocate stating that, "More recently, upon closer examination

of the hospital consent form. I saw that my signature is missing from the consent for surgery …" In response to a question from Counsel for Dr. Jiwa, L.C. confirmed that she did not tell the Patient Advocate that she had deliberately withheld her consent.

L.C. further confirmed she made a separate complaint about Dr. Jiwa to the Royal Alexandra Hospital. Alberta Health Services ("AHS") responded to that complaint in a letter dated August 9, 2017, and advised that Dr. Jiwa had removed the tube for technical reasons as she was unable to:

"get at the cyst" without removing the tube … Dr. Jiwa and [the resident] regret and apologize that the left salpingectomy was inadvertently not recorded (and?) conclude this was human error and wish to ensure [sic] you this was not deliberate. At your post-operative visit Dr. Jiwa did show you photos of the surgery (cyst) to you, recalls you had several questions surrounding anesthesia and being focused on this aspect may have contributed to failing to mention the salpingectomy to you. Dr Jiwa regrets these omissions and extends an apology that this occurred …Dr Jiwa [has] learnt much from this and will alter her practice …

While L.C. acknowledged receiving this letter outlining the AHS Investigation conclusions, she disputed their conclusion that she was focused on questions surrounding the anaesthesia. She told the Tribunal that failing to mention the salpingectomy is not a minor matter, should not just be swept under the rug, and that brushing it off as human error is unacceptable.

Tribunal member Dr. Greenwood asked L.C. what she discussed with Dr. Jiwa in the O.R. after L.C. had chosen not to sign the consent form. L.C. advised that the discussion was brief: she told Dr. Jiwa that she needed to use the toilet, the right side of her abdomen had no pain, and she wanted only the cyst removed. L.C. told the Tribunal that she was not advised that Dr. Jiwa would need to see the cyst during surgery before definitively deciding whether the tube or ovary also needed to be removed. In response to a further question, L.C. was taken to her Complaint of December 15, 2016 where she stated, "Before entering the o.r. [sic], I said to Dr. Jiwa I want only the cyst removed if at all possible …" L.C. confirmed this was her own handwriting and was accurate.

B. Dr. Jiwa's Testimony

Dr. Jiwa testified on her own behalf. Dr. Jiwa earned her medical degree at the University of Western Ontario and completed her five-year residency in obstetrics and gynecology at the University of Alberta in 1999. She is a member of the Royal College of Physicians and Surgeons and a member of the Society of Obstetricians and Gynecologists of Canada. She has practiced for the past 20 years, primarily at the Royal Alexandra Hospital. The Royal Alex is an obstetrical teaching department site for the University of Alberta. Dr. Jiwa teaches obstetrics and gynecology.

On May 3, 2016 L.C.'s family physician referred her to Dr. Jiwa to address her left paraovarian cyst. Dr. Jiwa was provided with L.C.'s past medical history, drug

allergies, ultrasound and MRI. There were also two pelvic ultrasound reports. The first was done in 2010 as follow-up to a scan of her right hip. The second, performed in February 2016, showed what was described as a simple paraovarian cyst. From the provided information, Dr. Jiwa was unable to determine whether the cyst was attached to the ovary, the tube or both.

L.C. attended Dr. Jiwa's office on September 28, 2016. Based on the patient's chart notes and her usual practice, Dr. Jiwa testified she would have spent time discussing with L.C. the details of the pain, its location, that it does not radiate, what makes it worse or better, and the medications used. She would have discussed with L.C. the gynecological aspect: whether there was a relationship between the pain and her menses or intercourse; whether she had any trouble with periods; whether she had normal Pap smear results; any infections or surgeries; what she used for contraception; and any pregnancies, deliveries or complications in delivery. Dr. Jiwa would also have reviewed L.C.'s past medical history, medications and allergies, how the pain impacts her and her family, and whether there is any family history of cancer. A physical exam would have been undertaken. Dr. Jiwa testified that her patient's chief complaint was daily left lower quadrant pain.

Dr. Jiwa testified that she would have explained to L.C. that this type of cyst may not be the cause of her pain, and that it may be reasonable not to do surgery and to try conservative treatment, including pain medication, the birth control pill, and/or pelvic physiotherapy. In addition, she would have reviewed surgery as an option. Dr. Jiwa would have described the surgery as a day laparoscopic surgery with small incisions in the umbilicus and along the pubic hairline. With a camera introduced through the umbilical incision, Dr. Jiwa would visualize the cyst, make a diagnosis, assess its location relative to the rest of the pelvic anatomy, and determine whether it was ruptured and whether it appeared benign, precancerous or probably malignant. These discussions were confirmed by her chart note. Included in Dr. Jiwa's consult notes for L.C. was a tear out sheet of anatomical information to share with her.

Dr. Jiwa testified that the ovary and fallopian tube are in close proximity and together form the adnexa. A paraovarian cyst is typically located close to the ovarian ligament and not actually on the ovary. The fallopian tube may drape over it, making it difficult to see if the cyst originates from the fallopian tube, ovary, or other anatomical structure. Dr. Jiwa discusses with her patients the risks associated with the surgery and anesthetic, as well as potential surgical complications including infection or bleeding at the surgical site, and injury to the bowel, bladder, or blood vessels. Dr. Jiwa typically discusses the usual recovery and, finally, the protocols for booking the surgery, notification of the surgery, and when it will be scheduled.

By letter dated October 3, 2016, Dr. Jiwa reported to L.C.'s family physician that L.C. told her that she had dealt with this pain long enough and was aware of the risks and benefits associated with laparoscopic surgery, including the possibility that a left salpingo-oophorectomy may be necessary. She was advised that L.C.

would prefer that only a cystectomy be performed. L.C. was subsequently booked for a left paraovarian cystectomy with possible left salpingo-oophorectomy.

L.C. contacted Dr. Jiwa's office on November 25, 2016 to say that her symptoms were getting worse and more painful and to request that she have the surgery, that was not yet booked, sooner. As a result, the surgery was set for December 15, 2016. Dr. Jiwa advised that she had other surgeries on that date.

In Dr. Jiwa's experience, the Consent for Surgery or Invasive Procedure is reviewed and signed downstairs with nursing staff in the surgical ward. Dr. Jiwa did not recall being informed that L.C. had requested to speak with her before signing her consent.

While the consent for blood transfusion had been signed, the consent for surgery was not, nor was the provision for withdrawal of consent. The surgery was described in bold and capitalized letters as, "**DIAGNOSTIC LAPAROSCOPY LEFT OVARIAN CYSTECTOMY POSSIBLE LEFT SALPINGO-OOPHORECTOMY**". The second page of the form contains a place for the signature of the witness observing the person providing consent and was here signed by the attending nurse. Below, again on the second page, Dr. Jiwa's signature confirms she explained the details of the surgery to the patient and the patient understands the nature, benefits, risk, consequences, and alternatives. Dr. Jiwa testified that this understanding resulted from the discussion with L.C. in her office; Dr. Jiwa is not in attendance when the surgical consent form is reviewed and signed.

Dr. Jiwa reviews the consent form to ensure that the surgery details are accurate and to note any changes to it. Dr. Jiwa is in the pre-operative area when she signs the form and, at that time, she reviews how the patient is feeling, whether they still have pain and still want the surgery, and what the discharge instructions will be, such as the medications, follow-up for suture removal and possible complications. She noted that a lot of information is shared in a short period of time. Dr. Jiwa testified that at no time did L.C. indicate to Dr. Jiwa that she was withdrawing consent for the cystectomy with possible removal of the tube and ovary.

Dr. Jiwa also reviewed the Alberta Hospital Services Safe Surgery Checklist and the three components: briefing, timeout and debrief. This checklist indicates the surgeon undertakes the briefing where the patient is introduced to all the staff in the surgical room; the patient is asked to identify herself and tell everyone in the room "in her own words" what the procedure is and on which side the surgery will happen; and a number of other critical matters such as allergies, significant medical issues, blood work and confirmation that the patient is not pregnant are reviewed or checked.

A summary discharge report was prepared, in L.C.'s case by the resident, which provided the most responsible diagnosis, the procedure done, the medications for discharge, possible complications and follow-up. The document is intended to summarize, rather than provide detail, in respect to the surgery, which is described

as a diagnostic laparoscopy, removal left paraovarian cyst. Dr. Jiwa confirmed that is an accurate description for the purposes of this summary.

The junior resident prepared the Operative Report, a typical delegation and one which she was trained and competent to perform. The report was dictated on December 17, 2016 and transcribed on December 19, 2016. By that time, Dr. Jiwa was on a break and later on vacation. Her usual practice is to review the Operative Report on her next OR day and provide her electronic signature. She reviewed the Operative report with respect to L.C. on January 19, 2017, noted some blanks that she filled in or corrected, and signed off. She did not notice that there was no mention that a portion of the fallopian tube was removed with the cyst. She did notice that there was no mention of a cyst on the right ovary, but testified that it was a functional, normal cyst that occurs in the cycle of the ovary and would therefore not usually be referenced in the Operative Report.

The follow-up appointment would normally be booked for five or ten minutes. Dr. Jiwa would normally have the paper chart, the pathology report, the OR report, and any social information on hand to remind her who the patient was. On the February 8, 2017 follow up visit, she noted that L.C.'s pain was better and her incisions healed. She performed and noted a normal examination with a plan that L.C. would follow-up with her family physician. As well, Dr. Jiwa recalled that L.C. was concerned and upset and had a significant number of questions about the anaesthetic, which was unusual.

Dr. Jiwa confirmed L.C.'s recollection that Dr. Jiwa referred to the photographs on her file from the surgery and Dr. Jiwa testified that it is critical to review the pathological report. Dr. Jiwa would have gone thru the pictures, pointed out the left cyst wrapped up by the tube, and the ovary a bit further up. She would have said that the cyst was removed but cannot recall whether she told L.C. that the tube was attached and was also removed. She did say that it appeared benign, and the pathology report confirmed this. Dr. Jiwa testified that she would have pointed out the small normal cyst on the right ovary. She told the Tribunal that it is a physiological cyst that evolves through the menstrual cycle and no action was required.

Turning to the Pathology Report that she reviewed with L.C., Dr. Jiwa noted the findings of left fallopian tube and left salpingectomy. However, it was only a portion of the fallopian tube that was removed. The Pathology Report noted it was a four-centimeter portion of a 12-centimeter tube.

By fax on February 28, 2017, the family physician requested that Dr. Jiwa provide a copy of the consult report from the February 8, 2017 visit. On March 1 Dr. Jiwa replied by hand-written note that L.C. had done well post-operatively with minimal pain, was happy with her surgical outcome, and had questions about her anaesthetic record that Dr. Jiwa had tried to answer. Dr. Jiwa noted that there were no complications with L.C.'s anaesthetic.

The family physician followed up with a letter dated March 21, 2017 confirming that her patient had presented to her with her anaesthesia records in hand and seemed quite traumatized by what sounded like a normal anaesthesia experience. Her patient had obtained copies of her pathology and surgical reports and had asked why the Pathology Report states that a salpingectomy was done, but the Operative Report cites only the paraovarian cyst removal. The next day, Dr. Jiwa responded by hand-written note on the March 21 correspondence that said, "The paratubal cyst (cyst between tub and ovary) is best removed by removing the fallopian tube too as it gets blood supply from there. I also left a message for L.C. I hope that helps."

Dr. Jiwa testified that she does not normally leave voice messages and she tried to call L.C. a couple of times but there was no answer. She wanted to let L.C. know immediately and so left a voicemail saying, yes, there was an error, that a portion of the tube was removed, and that she was happy to discuss things further. Dr. Jiwa also invited L.C. to come into the office and to call if she had more questions.

By that time, L.C. had filed her Complaint to the College and did not respond to the message Dr. Jiwa left. On May 3, 2017 she also complained to AHS. The Tribunal was provided Dr. Jiwa's reply to AHS dated May 18, 2017 and the AHS reply to L.C. dated August 5, 2017.

In her letter to AHS, Dr. Jiwa agreed that during the September 28, 2016 attendance she did not talk specifically about the fallopian tube and its role and function, though she had made it clear that she would not know if she would have to take the tube or ovary until she visualized the cyst during the diagnostic laparoscopy. At that time, L.C. was agreeable to her counselling and was accordingly booked for a diagnostic laparoscopy and left ovarian cystectomy, possible salpingo- oophorectomy, as noted in her chart. Dr. Jiwa noted that L.C. was met in the prep room and her consent for surgery reviewed and signed for "Diagnostic laparoscopy, left ovarian cystectomy, possible left salpingo-oophorectomy". Dr. Jiwa explained in her letter that, "[T]he safest way to remove the whole cyst…without causing trauma or compromising the blood supply to the left ovary was by resecting the cyst and fallopian tube together. This technique also prevents rupture of the cyst and therefore prevents the contents from seeding the peritoneal cavity." Dr. Jiwa confirmed that when she reviewed the Operative Report, she "did not notice that the resident had failed to dictate that we removed the left fallopian tube with the cyst." Had L.C. returned her call, Dr. Jiwa advised, she would have apologized for her oversight and offered to prepare an addendum to the Operative Report for clarification.

In its response to L.C., AHS summarized the technical aspects of the surgery and the reason for the removal of the fallopian tube. AHS explained that Dr. Jiwa advised she was unable to get at the cyst without removing the tube as the tube was draped over the cyst and difficult to separate from it. Dr. Jiwa and the resident, regret and apologize that the left salpingectomy was inadvertently not recorded, conclude this was human error and wish to ensure [sic] you this was not deliberate…[they] have learnt much from this and will alter practice,

especially with regards to communicating with patients post-operatively and striving to be accurate and complete with documentation for all OR reporting.

L.C. considered the AHS response to be general and evasive. The Tribunal received her reply to her Patient Advocate dated August 17, 2017. L.C. now advised her Patient Advocate that, "… upon closer examination of the hospital consent form, I saw that my signature is missing from the consent for surgery. I am surprised that this crucial protocol has been overlooked by the hospital medical staff and those who interviewed the surgical team involved in my care."

Dr. Jiwa had not seen the AHS response before it was sent and saw it for the first time as part of the disclosure by the College in these proceedings. Dr. Jiwa confirmed that the letter fairly summarized the discussions that she had with the hospital lead for women's health. AHS did not reprimand Dr. Jiwa but did remind her of the need to be careful and detailed when doing chart work, whether it is an OR report or on the floor seeing patients.

Dr. Jiwa testified that when the omission was called to her attention, she immediately offered to provide an addendum to the Operative Report. As the Complaint had already been filed, the College advised her to wait. The Tribunal received that addendum dated December 8, 2017 to the Operative Report dated December 15, 2016.

Dr. Jiwa testified that it was very distressing to receive the Complaint and that she was hypervigilant with her OR Reports as a result. It is however not practical to redo everything done by someone else and she continues to rely on her residents who continue to do excellent work. In the OR setting, there is not time to immediately review the reports, though it remains her practice to do so in the OR, either then or the next time. As a result of the Complaint, Dr. Jiwa has taken extra courses to ensure that she is up to date with the standards, including what is required of charting and securing informed consent.

L.C. was in attendance during Dr. Jiwa's testimony and Dr. Jiwa conveyed her sincerest apology to the Complainant.

In cross-examination, Dr. Jiwa confirmed that when speaking of an LSO, a left salpingo-oophorectomy, that salpingo refers to the tube and that oophorectomy refers to the ovary. She agreed a salpingectomy is the removal of the entire tube while a partial salpingectomy is removal of part of the tube. In response to questions, Dr. Jiwa reviewed the file photographs from the surgery, identified the ovary, the cyst and the fallopian tube draped over the cyst. She confirmed that after the removal of the tube and the cyst that the ends are not tied back together and that in effect there is a sterilization on the left side.

Counsel for the Complaints Director then took Dr. Jiwa to the Short Stay Discharge Summary that identifies the procedure as, "1. Diagnostic laparoscopy 2. Removal (L) paraovarian cyst". The resident prepared and signed the document and Dr. Jiwa signed as well. The document did not include that a partial salpingectomy had been

performed. Dr. Jiwa testified that the form summarized the operative procedure and is not meant to be detailed but agreed that to be more thorough the partial tube removal could have been mentioned.

Turning to the question of consent, Dr. Jiwa confirmed that as a surgeon she is responsible for obtaining consent. In September, in her office, she explained the risks and benefits of the surgery and L.C. told her that she wanted the surgery and thus Dr. Jiwa had obtained L.C.'s verbal consent. Before the Tribunal, Dr. Jiwa confirmed that the patient can withdraw consent at any time. On the date of the surgery, her practice is to review and confirm that the upcoming surgery was properly noted on the form. She repeated that in L.C.'s case she did not note that the consent line was blank and there is no time to have to go through all those things again in the prep area. Counsel then took Dr. Jiwa to the OR Report and noted that the patient was said to have decided to proceed with a diagnostic laparoscopy and left paraovarian cystectomy. Dr. Jiwa confirmed that this referred to the September consultation and that this information would have been relayed to the resident, but that she could not recall whether she specifically told the resident to include the partial salpingectomy in the description of the procedure.

The Tribunal requested further detail as to the courses Dr. Jiwa took. A document was tendered identifying the Canadian Medical Practice Association on-line courses in respect to charting and informed consent standards. Dr. Jiwa was asked whether she had changed her practice procedure to obtain informed consent because of these events. Dr. Jiwa replied that the coursework confirmed that she is doing what is required. However, in her review of the OR consent sheets she now ensures that she looks to see if the patient signed it.

Dr. Jiwa stated that consent is primarily obtained in the office when she goes over the risks and benefits of the surgery, elicits questions, and makes sure the patient wants surgery rather than conservative treatment or doing nothing. When she, as the most responsible physician, signed the Consent for Surgery form, she was verifying that the details of the upcoming surgery had been explained to the patient and that the patient, in her opinion, understood the nature, benefits, risk and consequences of the surgery, as well as non-surgical treatment options. She also agreed that the patient's consent may be withdrawn at any time.

While the Tribunal accepts that Dr. Jiwa believed that L.C. had consented to the surgery, they asked Dr. Jiwa why she did not know that the patient had concerns. In response, Dr. Jiwa testified that she did not know that L.C. had concerns about her surgery. She knew that the patient wanted to remove the cyst only, knew that they had talked about the cyst possibly "being in a different position and that it can be difficult to get to, that it could rupture, that it could cause bleeding, that it could be malignant or something else, and that we may need to take out the whole ovary and tube with it." Dr. Jiwa testified that, to honour the patient's wishes, she would try to remove only the cyst, and not the ovary.

Dr. Jiwa confirmed that she was unaware that L.C. had not signed the consent on the day of the surgery. However, the patient did give her verbal consent at the

briefing in the OR. This briefing was conducted in the OR, prior to the patient being sedated. At that time, the patient would have said, in her own words, what surgery she was having, that it is on her left side, and that she has a cyst, a paraovarian cyst. She would have said that Dr. Jiwa was going to take out the cyst but that there is a chance that the ovary or the tube could be removed. Dr. Jiwa testified that L.C. would have said this in her own words.

C. Dr. Hauck's Expert Testimony

Counsel for Dr. Jiwa called Dr. Brian Hauck as an expert witness. Dr. Hauck is an obstetrician and gynecologist that has practiced for 32 years, mostly at the Foothills Medical Center in Calgary. There he was Site Leader from 2001 to 2007 as well as Division Chief of Gynecology for the Calgary Health Region. He does not know Dr. Jiwa personally or as a colleague and believed that he could provide the Tribunal with an unbiased and objective opinion. No objection was taken.

Dr. Hauck provided an expert opinion dated May 22, 2019 and a copy of his curriculum vitae. Dr. Hauck testified that he has held executive positions with the Alberta Medical Association (AMA) and the Society of Obstetricians and Gynecologists of Canada (SOGC). The SOGC is the national organization that is responsible for maintaining standards of care, creating guidelines, and holding educational events. Dr. Hauck has provided expert opinions in many cases for the CMPA and the CPSA, as well as for some of the hospitals involved in litigation and in respect to legal issues for the Midwives of Alberta. In all he has provided approximately 75 opinions over the years, some of which have been critical of physicians' care.

In preparing his opinion, Dr. Hauck reviewed Dr. Jiwa's office chart; the Royal Alexandra Hospital Inpatient Operative/Procedure Report with addendum; the Royal Alexandra Hospital inpatient admission dated December 15, 2016 and the Assumed Facts (entered as an Exhibit later in hearing). The main and most relevant points of his opinion were that:

- Dr. Jiwa's assessment of L.C.'s pain issues, and her management of treatment options, surgical consent and surgical procedure were entirely appropriate.
- Dr. Jiwa's removal of the para-tubal cyst with overlying portion of fallopian tube were entirely within the planned procedure and the consent covered this.
- Dr. Jiwa met the standard of what is reasonable and acceptable for an obstetrician/gynecologist in Alberta.

With respect to the issue of consent, Dr. Hauck testified that the consent form states it is for Ovarian Cystectomy, possible Salpingo-oophorectomy, meaning possibly taking the tube and/or ovary. That is what L.C. consented to, that is what L.C. and Dr. Jiwa discussed, and that was what was done. The fact that the patient did not sign the form on the date of surgery was not relevant to Dr. Hauck. In his view, it would have been impossible for L.C. not to have been aware of what she was consenting to. Her knowledge of the planned procedure was reviewed in the

office with Dr. Jiwa, then on admission to the surgery center with admitting staff, and then again with nursing staff in the pre-op area.

In Dr. Hauck's experience, the surgeon discusses the clinical case with the patient. If the plan is to go ahead with the surgery, the surgeon explains the surgery and the associated risks, and answers any questions that the patient has. Dr. Hauck signs his part as the surgeon but has never in his career witnessed the patient signing the consent. He testified there is a rationale for someone else observing the signature as they may appear less threatening or intimidating to the patient than the surgeon might. If the patient voices a concern to the nursing staff, it is customary that the surgeon be notified so that he or she can have a conversation with the patient. In his experience, if on the day of the surgery a patient said that she would not sign the consent until she spoke to the doctor, he would get that message and he would attend and have a conversation with the patient. He would also expect the nurse to record this information in the medical record.

Dr. Hauck confirmed that, in this case, a full salpingectomy was not done. Only the four centimeters of fallopian tube that was draped over the cyst was removed; a normal fallopian tube is ten to fifteen centimeters long. This section of tube was dissected away from the cyst and ovary, to preserve the ovary, and resulted in a partial salpingectomy. Dr. Hauck testified that this was entirely appropriate surgical technique in this case.

Dr. Hauck testified it was proper and necessary that the resident dictate the Operative Report as this is an important part of a resident's training. He went on that the resident was familiar with the case, and that the report was correct in every way, except that she missed describing that a portion of the fallopian tube was removed during the surgery.

He stated that while the Operative Report failed to record that a partial salpingectomy had been performed, it is his opinion that this omission in a 47-year old woman with no plans to preserve fertility is of no clinical significance. He went on that, even in a woman who wished to become pregnant, the removal of the portion of the fallopian tube would still be appropriate. Any attempt to remove the cyst and salvage the fallopian tube would almost certainly result in the tube losing its blood supply, leading to ischemia and necrosis, a serious surgical complication. In situations where a patient wants to conceive, one good tube is better than one good tube and one damaged tube.

Dr. Hauck acknowledged that the dictation might have commented that the right ovary also had a cyst, but that this was a normal follicle on a normal ovary. Thus, it was not an error to omit commenting on it in the surgical report. He also testified that it was appropriate for Dr. Jiwa to review the Operative Report after she returned from vacation; that this time lag was acceptable in this case.

Dr. Hauck testified it is impossible for a surgeon to assume 100% responsibility for the actions of every member of the team. Here, Dr. Jiwa failed to catch a very minor inaccuracy. This was a minor inaccuracy because, in his expert opinion, it

was not significant that four centimeters of fallopian tube were resected, and that this fact was not included in the Operative Report: "It was the appropriate thing to do. The correct surgery was done. There was no mistake here." In this situation fertility was never raised as an issue.

In Dr. Hauck's expert opinion Dr. Jiwa met the standard of care of what is reasonable and acceptable practices for an obstetrician/gynecologist in Alberta. Suggesting otherwise based on her failure to notice this minor inaccuracy would be to hold her to an impossible standard, essentially one of perfection. A surgeon has many reports to sign-off on and reports are delayed, sometimes for weeks. Most reports are accurate with no issues. When an inaccuracy happens, the question must be whether it was with respect to an important issue and in this clinical scenario it was not.

In cross-examination, Dr. Hauck was taken to the consent form where the signature of the Complainant is missing. He agreed that the two-page form is available to the surgeon for review and that he always looks at it but does not make a point of ensuring the patient's signature is in the correct box. Dr. Hauck stated that there is a surgical team, consisting of the surgeon, resident(s), nurses and administrative staff, but would not agree that where a task is assigned to a nurse it is the surgeon's responsibility, as part of the checks and balance of a team, to make sure that the patient's signature is in the right place. Rather, Dr. Hauck testified that at the hospital, in an elective case, he talks to the patient beforehand, sees them in the holding area, and asks for their confirmation as to the surgery that is planned and whether they have any questions. He testified it is not part of his job description to make sure that every little date, time, and box is checked. Rather, he ensures he has spoken to the patient and she has provided her verbal consent. He testified it is not a compromise of care for him and other surgeons not to notice a missing signature.

V. SUBMISSIONS

A. Submissions on Behalf of the Complaints Director

Counsel for the Complaints Director described the issue before the Hearing Tribunal as whether the factual situations described in the two allegations in the Notice of Hearing amount to Unprofessional Conduct. He submitted that the evidence established that the Operative Report did not mention the partial salpingectomy. Secondly, Dr. Jiwa failed to ensure that L.C. had signed the hospital consent form prior to the procedure on December 15, 2016.

Unprofessional Conduct, submitted Counsel, occurs when a physician displays a lack of knowledge or skill and judgment in the provision of professional services. Such conduct can arise from a contravention of the Act, Code of Ethics or Standards of Practice. Regulations under the Statute say that the attending health practitioner shall keep a record of the diagnostic and treatment services provided to each patient. The Regulations require records to be legible, accurate and complete.

The Standard in respect to consent states that the regulated member must obtain a patient's consent prior to providing treatment. The consent may be expressed orally or in writing as appropriate. Further, the regulated member must ensure that information pertaining to the consent process is contained in the patient record, as are operative, procedural and discharge records.

Pointing to *Walsh v Council for Licensed Practical Nurses Counsel*, Counsel suggested that the Tribunal should first look to see if there are written standards and, if not, then look to aspirational statements such as codes of ethics and, finally, evidence of consensus in the profession. Here, in respect to consensus in the profession, Counsel accepted Dr. Hauck's expert opinion evidence. However, Counsel argued that the expert opinion was irrelevant as the Standards and Regulations had, in his words, "occupied the field". Counsel for the Complaints Director characterized Dr. Hauck's evidence as an attempt to push out of the field the Standards set by Council and the Legislature.

Relying on *McInerney v MacDonald*, Counsel argued that physicians are fiduciaries who must act in the patient's best interests and that includes the obligation to create and maintain records, the completeness and accuracy of which are important for the patient to review to ensure that the doctor did not deal improperly with the patient. Here, Counsel described the Complainant's concern as being about an improper dealing with her in how the procedure was conducted. The Complainant, he submitted, thought that only the cyst would be removed and did not know or understand that the tube was also going to be removed.

In any event, Counsel argued that Dr. Hauck's opinion that Dr. Jiwa met the necessary standard fails rational analysis when the evidence is considered. On that evidence, Dr. Jiwa did not look to see if the patient had signed the consent. While Dr. Jiwa reviewed and herself signed the consent document, she failed to notice that the patient's signature confirming consent was absent. Counsel for the Complaints Director argued it was ludicrous for the expert to opine that the respective obligations of the surgical team freed the surgeon herself from ensuring that the form was properly completed.

Turning to the concern as to the Operative Report's accuracy, Counsel for the Complaints Director pointed to the acknowledgement of both Dr. Jiwa and Dr. Hauck of the importance of the description of the surgery to be performed, a description that included a possible salpingo-oophorectomy. Despite this acknowledged importance, the short form Summary Discharge Dr. Jiwa completed and signed on the day of the surgery failed to reference the partial salpingectomy as one of the procedures performed. Counsel speculated that this initial failure contributed to the resident's later failure to include the procedure in her draft OR Report and Dr. Jiwa's subsequent failure to note the omission.

Counsel for the Complaints Director argued that the surgeon cannot be absolved of responsibility despite delegating to the resident the drafting of the OR Report. A few cases dealing with a physician's failure either to keep appropriate records, to obtain

consent, or to properly record consent, were relied on, including those related to *Dr. Metcalfe, Dr. Kumar, Dr. Outerbridge* and *Dr. Henning*.

Counsel for the Complaints Director submitted the evidence established that Dr. Jiwa failed the Complainant in two specific and significant ways. First, the Operative Report did not accurately describe the full procedure performed. The Complainant was interested in having only the cyst removed and wanted to know that only the cyst was removed. Second, while Dr. Jiwa was relying on the consent discussion in her office and assumed that the nurse had obtained the patient's signature on the consent form, the standard, at a minimum, requires that the surgical team, including the surgeon, confirm that there is still consent for the procedure.

On behalf of the Complainants Director, Counsel accepted the evidence that the tube was engaged with the cyst and that its removal, or in this case its partial removal, was medically appropriate. He argued however that it was not the appropriateness of the procedure at issue, but rather the recording and confirming of consent and the record of the procedure. The facts as alleged in the Notice of Hearing were not in dispute, nor were the applicable Standards. Counsel for the Complaints Director concluded the evidence demonstrated that the two failings amounted to Unprofessional Conduct.

B. Submissions on Behalf of Dr, Jiwa

Counsel for the Respondent, Dr. Jiwa, did not dispute that a breach of the Standards of Practice or a contravention of legislation can amount to Unprofessional Conduct. She argued the Hearing Tribunal is tasked with determining whether there was a breach of a Standard of Practice or of legislation and, if so, whether that breach rose to the level of Unprofessional Conduct. In doing so, the Tribunal must consider whether Dr. Jiwa took reasonable steps to avoid a breach, if there was one.

While the Complainant had a number of concerns and made a number of complaints against not only Dr. Jiwa, but other physicians and nurses as well, Counsel submitted there are only two allegations: that Dr. Jiwa failed to record in the Operative Report that she had removed the left fallopian tube in addition to the cyst; and that Dr. Jiwa failed to ensure that L.C. had signed the consent for the procedure.

Counsel for the Respondent did not dispute that the Practice Standard says a regulated member must ensure that the patient record is accurate and complete, but noted the further requirement that they be completed as soon as possible to promote accuracy. Counsel argued this was a clear recognition that 100% accuracy is an aspirational standard and not the expectation. Dr. Jiwa did not breach the standard for ensuring that the OR report was a complete and accurate reflection of all the clinically significant matters that arose during the surgery. Further, argued Counsel, even if technically breached, Dr. Jiwa took all reasonable steps to ensure that the report was accurate and so could not be found guilty of Unprofessional Conduct.

Counsel further argued Dr. Jiwa appropriately delegated matters to the team. Such delegation required only that Dr. Jiwa take reasonable steps to ensure the delegate was properly experienced and instructed. It was standard practice at the teaching hospital for residents to dictate operative notes in cases they were involved in. Dr. Jiwa had worked with the resident on several occasions and found her to be a good, capable resident whose dictation was careful and detailed. Relying on Court decisions, Counsel argued that a surgeon who properly delegates responsibilities is not vicariously liable for the delegate's mistakes, here the resident's omission. In taking reasonable steps to ensure that she was delegating the dictation to someone who had the skills and experience to properly do it, Dr. Jiwa did all that the law and the College should require of a physician.

Counsel further relied on Dr. Hauck's expert opinion evidence that:

- such delegation was not only necessary, it would be dangerous if such delegation were not allowed;
- it is impossible and not appropriate for the attending physician to assume 100% responsibility for every member of the team and the roles they provide;
- the safest system requires that all team members take responsibility for the roles they provide; and,
- 100% accuracy is not achievable and to think otherwise defied common sense.

Counsel further argued that the time taken to record and review the dictation was appropriate. The OR Report of the December 15 surgery was dictated on December 17 and transcribed on December 21 after Dr. Jiwa had left for vacation. Dr. Jiwa reviewed it on her return to the OR on January 19, 2017. Dr. Hauck found that Dr. Jiwa's practice of reviewing the OR report during her next scheduled time in the OR, in this case after her return from vacation, was appropriate.

While acknowledging the inaccuracy of the OR Report, Counsel argued that surgery involves a thousand details that could be reported to ensure the report's accuracy. The omission here was an omission that was of no clinical significance. The error, the failure to record the left partial salpingectomy, was properly described as an inadvertent human error that was regretted and for which the resident and Dr. Jiwa apologized, both earlier in correspondence from the Women's Health site Chief and now personally to the Complainant in Dr. Jiwa's testimony.

Counsel provided the Hearing Tribunal with the *Toane Decision* where the College found that the physician had made an error of attribution in a letter written on behalf of a patient. In that case, the resulting missing phrase, that it had been "reported to him", was a simple and innocent mistake, one that he had apologized for and that the College found was not conduct unbecoming.

Counsel reviewed the cases tendered on behalf of the Complaints Director. She noted these were cases in which the physicians' admitted wrongdoing and the Tribunal should therefore review them cautiously as such cases are often the result of negotiation.

The *Henning Decision* concerned a physician's complete and utter failure to chart and failure to record any informed consent discussion.

The *Outerbridge Decision* concerned not an inadvertent minor inaccuracy of no clinical significance, but rather a deliberately misleading report intended to protect the surgeon. The surgeon's failure to embed anchor pins within the bone, resulting in them sitting proud of the bone was critical. The doctor would have been aware of the potential for post-surgical problems, particularly as his patient was a 19-year old hockey player who had been drafted to the NHL. As a result of the surgeon's conduct, the young patient was unable to play hockey at all.

Counsel for Dr. Jiwa argued that there was no issue whatsoever as to whether informed consent was obtained in this case. Informed consent had first been obtained in Dr. Jiwa's office where Dr. Jiwa described the surgery as left ovarian cystectomy, possible left salpingo-oophorectomy. The risks and benefits and possible alternatives had been discussed and recorded in Dr. Jiwa's chart notes. Noting that the standard allows verbal consent, Counsel then pointed the Tribunal to the pre-operative briefing where the Complainant confirmed the surgery that she was having, not only with Dr. Jiwa in the room but other health care professionals as well. The only reasonable conclusion that can be drawn, argued Counsel, was that the Complainant was indeed confirming that she was having the cyst removed as well as possibly her tube and/or her ovary.

Counsel acknowledged that the confirmation would not have involved the extensive detail that Dr. Jiwa would have gone thru in her office. Counsel noted that the Complaint states: "Before entering the OR, I said to Dr. Jiwa I want only the cyst removed if at all possible". Counsel argued it was thus clear that if the ovary was attached to the cyst then it could be removed and if the tube needed to be removed because it was attached to the cyst then it could be removed, and in fact both the tube and the ovary might have to be removed.

Counsel asserted that the Complainant was not credible in her testimony when, for the first time, she alleged that she deliberately did not sign the consent to procedure and told the nurse in the day surgery area that she would not sign it until she spoke to Dr. Jiwa. If that had occurred the nurse would have made a note of it and contacted Dr. Jiwa or the resident to advise of the issue. The Complainant was further required to state the surgery in the pre-op area and such a dramatic change, if stated, would not have gone unnoticed with so many health professionals involved. Finally, there was no mention of this in the Complaint and indeed the Complainant's email to the Patient Advocate on August 17, 2017 states, "… upon closer examination of the hospital consent form. I saw that my signature is missing from the consent for surgery. I am surprised that this crucial protocol has been overlooked …" Counsel argued that the more reasonable conclusion is that the Complainant inadvertently just signed at the bottom of the page and the nurse failed to check to confirm she had signed in both places.

The issue before the Tribunal then, argued Counsel, is whether it was unprofessional for Dr. Jiwa not to notice that the form was not signed in the right

place. In this regard, it was not just Dr. Jiwa's responsibility to get the form signed and to check that it was signed properly; this is typically a nurse's responsibility. As Dr. Hauck concurred it was not his practice to obtain the patient's signature on the form or to confirm that the nurse properly obtained the patient's signature. Surely, argued Counsel, a surgeon can delegate the signing and witnessing of the hospital informed consent document to a nurse without being found guilty of Unprofessional Conduct.

The *Metcalfe Decision* the Complaints Director relied on concerned a failure to secure consent at all for the procedure. In that case, the physician decided, albeit for good medical reasons, that an infant needed a procedure but, rather than secure the parent's consent, the physician just went ahead without consulting the parents and did surgery on the infant when he knew he did not have the parents' consent to do. Moreover, in that case the physician admitted what had occurred was Unprofessional Conduct.

In the *Kumar Decision* the Complaints Director relied on, the doctor also admitted that he was guilty of Unprofessional Conduct as he deliberately gave blood products to a patient when he did not have consent to do so. Dr. Kumar also went ahead with a risky approach that he had not advised his patient entailed a risk of paralysis and the patient became paralyzed. Again, the case involved a complete failure to obtain consent.

In this instance, Counsel noted, Dr. Jiwa is not charged with failing to obtain informed consent. Rather, the charge is about paperwork. Counsel for Dr. Jiwa reminded the Tribunal that physicians should not be judged in hindsight and that focusing on the result only rather than the manner in which it was performed would inappropriately impose a standard of excellence (*Brough v Yipp*). From *Waters v Wong*, Counsel argued, "The standard does not require perfection… Medicine is not practiced retrospectively, and it may be easy for an expert to be wise after the fact. The focus must be on whether the skill and care used at the time, in light of the known symptoms, was reasonable."

As to what constitutes Unprofessional Conduct, Counsel tendered the *Reddoch Decision* where the Court reviewed whether omission in the management of a patient is a failure to exercise reasonable care and skill when neither the doctor nor three other physicians considered the patient to be gravely ill. Unprofessional conduct is not necessarily a single failure; rather it must have about it, "some quality of blatancy, some cavalier disregard for the patient and the patient's wellbeing." Nor can a physician be found guilty where there exists a responsible and competent body of professional opinion that supports the physician's conduct, judgment, or treatment (*Litchfield*). Counsel argued Dr. Hauck's opinion supports this.

In summary, Counsel urged the Tribunal to follow a commonsense approach that does not fault Dr. Jiwa for an honest and understandable error not rising to the level of Unprofessional Conduct. A standard of perfection has not been expected in the past and should not be expected in this case.

The Tribunal questioned Counsel for Dr. Jiwa. The consent form's heading identifies the surgery as diagnostic laparoscopy, with a left ovarian cystectomy, and possible left salpingo-oophorectomy. Given that level of detail, the Tribunal asked whether the Operative Report should have considered the possibility of a salpingo-oophorectomy as being clinically significant. In other words, if it is clinically significant enough to mention in the consent, would it not be clinically significant enough to mention in the Operative Report?

Counsel replied that the purpose and intention of the form is to secure consent. This aspect of the procedure, being the removal of a four cm portion of the tube in a 47-year old woman was, in the circumstances, not clinically significant. So no, the inclusion of salpingectomy in the list of procedures does not necessarily inform what ought to be in the operative note.

C. Reply Submissions on Behalf of the Complaints Director

When it became time for the Complaints Director's reply, the Tribunal asked Counsel for the Complaints Director to clarify whether the allegation is that there was a documentation error or an error in getting informed consent. Counsel reiterated that in the Complaints Director's view, the surgeon, as part of the surgical team, is part of the checks and balances. As such, when the surgeon reviews the patient's signature, the patient has clearly given consent. Counsel concluded the charge does not deal with informed consent as there is some evidence that L.C. gave informed consent in Dr. Jiwa's office. The charge is about the process and one of the final steps to ensure that the patient and surgeon's expectations align with respect to the procedure to be performed. When pressed as to whether this case is about whether the signature was there, Counsel conceded that ultimately it is the signature that is the physical manifestation of the closure of the process.

In reply on the topic of perfection or common sense, Counsel for the Complaints Director submitted that expecting a simple step to be taken is not asking for perfection, nor 100% accuracy. If a consent form references a possible procedure, it is clinically significant enough that it should be addressed in the Operative Report.

VI. FINDINGS

The Amended Notice of Hearing placed two specific charges before the Tribunal, that:

1. The Investigated Member failed to record in the Operative Report that she had removed the left fallopian tube in addition to the paraovarian cyst.

2. The Investigated Member failed to ensure that the patient has signed the consent for the procedure performed.

Allegation No. 1 - The Investigated Member failed to record in the Operative Report that she had removed the left fallopian tube in addition to the paraovarian cyst.

The evidence establishes that a part of the left fallopian tube was removed and that this was not detailed in the Operative Report. The omission was initially that of the resident. The Investigated Member then failed to note and amend the omission. The Tribunal finds this failure does not rise to the level of Unprofessional Conduct.

The Tribunal finds that a small portion of the left fallopian tube, four cm of what is typically a 10 to 15 cm long tube, was removed. This is more accurately described as a partial salpingectomy rather than as a salpingectomy as described in the pathology report.

The four cm section of the fallopian tube was adhered to the cyst and had to be removed for the cyst to be successfully resected. The Tribunal accepts the testimony of the expert, Dr. Brian Hauck, that in these circumstances removing the cyst alone would require dissection and cauterization to stop the bleeding between the cyst and the fallopian tube. Inevitably, there would be a loss of blood supply to that portion of the fallopian tube, resulting in it becoming ischemic. Recognizing this potentially life-threatening complication, the removal of the four cm of fallopian tube, even in a woman who hoped to become pregnant, was medically appropriate and part of a safe and appropriate removal of the paraovarian cyst.

The Tribunal notes the patient was 47-years old and had indicated that she was not planning a pregnancy. The patient recovered from the surgery without complications and was pleased with the result. The procedure did not cause harm and the patient suffered no damage.

It was not until much later, and because of concerns related to other matters not before the Tribunal, that the patient obtained the medical record and noticed the discrepancy at issue. When the patient's family physician advised the surgeon of the discrepancy, Dr. Jiwa immediately responded by clarifying the procedure performed and offering to discuss the concern with her patient. The patient chose not to accept the invitation to discuss the matter. Dr. Jiwa later prepared an addendum to the OR Report, ensuring that the patient's medical record was complete. Through the hospital, Dr. Jiwa extended an apology to the patient for the error and later personally apologized at the Hearing.

The resident who participated in the surgery dictated the OR Report. The Tribunal accepts that this delegation is entirely appropriate in a teaching hospital. Dr. Jiwa had previously worked with the resident and found her to be detailed and careful in her dictation.

The OR report was dictated within two days of the surgery but, due to the Christmas holidays and the surgeon's own vacation, Dr. Jiwa did not review it until January 19, 2017. The Tribunal accepts that the delay may have contributed to the omission of details, particularly details not seen as clinically significant by the

reviewing surgeon. However, Dr. Hauck testified, and the Tribunal accepts, that the surgeon's practice of reviewing reports at her next OR appearance was appropriate and the delay was not untoward.

The OR report the resident prepared failed to record the partial salpingectomy that was performed. Then, the reviewing surgeon failed to notice the omission when she reviewed the report. The Tribunal heard expert opinion that the OR report was accurate and represented the relevant details of the surgery performed on the patient. The omitted detail, in the expert's opinion, was not clinically significant in the circumstances. The Tribunal does not take issue with that opinion; however, it is noted that the procedure itself was considered significant enough to be referred to in the list of surgical procedures on the consent form.

Accordingly, the Tribunal believes that the inclusion of the partial salpingectomy in the OR report would have been ideal. However, the omission of that detail was not relevant to, nor did it affect, the medical care given. The Tribunal is sympathetic to the suggestion that it is unreasonable to expect perfection in record keeping for the Operative Report. We do not see a conflict between the Standard with its aspiration to accuracy in record keeping, and the expert's testimony that the recording of every detail, regardless of its clinical significance, would be an impossible standard. An expectation of accuracy can co-exist with the recognition that perfection may not be achieved. In the expert's opinion, recording every detail is not the standard expected of an Obstetrician/Gynecologist practicing in Canada. While not determinative, we note that the hospital's own investigation did not fault the Investigated Member for any failure to meet its own standard for medical records.

For these reasons, while Dr. Jiwa failed to detail the partial fallopian tube removal in the Operative Report, the Tribunal finds this does not amount to Unprofessional Conduct.

Allegation No. 2 - The Investigated Member failed to ensure that the patient had signed the consent for the procedure performed.

This allegation concerns whether the patient signed the relevant portion of the consent form, not whether she gave consent. The Tribunal finds that it is factually proven that the Investigated Member did not confirm that the patient had signed the consent form in the section denoting her consent for the surgical procedure, but finds that this does not rise to the level of Unprofessional Conduct.

The evidence established that the Investigated Member obtained and confirmed informed consent. Dr. Jiwa had a thorough discussion with the patient in the office during the initial consultation. She obtained a history, did a physical exam, and reviewed diagnostic imaging to assess the patient's concerns. She discussed with the patient the risks and benefits of the medical options available, including those of conservative treatment and surgery. Dr. Jiwa advised the patient that a surgical procedure may or may not improve her pain, and that the precise parameters of the surgery would not be known until the laparoscopic procedure was undertaken. Until then, it could not be determined whether it was possible to remove only the

cyst or whether it would be necessary to remove the ovary and/or the fallopian tube as well. The evidence was clear that the patient requested and consented to the surgical option and the associated risks inherent in that choice. At the patient's request, the surgery date was expedited.

On the date of the procedure the Complainant attended for the surgery described as Diagnostic Laparoscopy Left Ovarian Cystectomy Possible Left Salpingo-Oophorectomy. The attending nurse reviewed the Consent to Surgery Form with the patient and the name, date and time were completed in each of the two areas requiring the signature of the person providing consent. The patient signed in the second spot, indicating her consent for blood transfusion, but the signature line to give consent for the surgery was left blank. Just prior to the procedure, Dr. Jiwa met the patient and other members of the surgical team in the OR and reviewed the procedure to be undertaken as part of the Alberta Health Services Safe Surgery Checklist. At that time, in the patient's own words, she confirmed that she was aware of the surgical procedure to be performed and asked Dr. Jiwa to remove only the cyst if possible.

In her initial complaint, the complainant had no issue with respect to the absent signature and it appears that she did not notice the absent signature until on or about August 17, 2017. It was not until the hearing that the patient described that she told the attending nurse that she refused to sign the consent before speaking to the surgeon. In her testimony, the patient confirmed the accuracy of her statement in the Complaint that when she spoke to Dr. Jiwa she requested that she "remove the cyst only, if at all possible". Neither the surgeon nor the resident was advised that the patient had refused to sign the consent.

The Tribunal is troubled by the nurse's apparent failure to alert the surgeon of the Complainant's refusal to sign, and by the Complainant's early failure to articulate the deliberation that went into that decision. However, there was not at any time a withdrawal of consent. Therefore, this Tribunal does not find it necessary to question the Complainant's credibility. Rather, we find that the concern raised, only to the nurse, was properly addressed when the Complainant spoke to Dr. Jiwa just before the procedure. Her consent was verbally affirmed in the presence of the surgical team in the pre-operative briefing.

Dr. Jiwa candidly acknowledged that her own signature provided before commencement of the surgery confirming that informed consent had been secured referenced the discussion with the patient in her office. On the date of the surgery, Dr. Jiwa did not attend to the witnessing or signing of the consent. She was not advised that the patient had a concern and had refused to sign. In reviewing the form Dr. Jiwa did not look further down the page to confirm that the patient's signature had been provided in the correct spot. When asked about her current practice, Dr. Jiwa advised that she has subsequently taken professional development courses, including one that addresses standards for securing informed consent. Following the courses, she is comfortable that her practice met and continues to meet the requirements outlined. However, Dr. Jiwa made it clear to the Tribunal that she now confirms that the required signature appears on the form.

The Tribunal notes that the CPSA Standard of Practice for Informed Consent states that a patient's informed consent prior to an examination, assessment, treatment, or procedure may be implied, expressed orally or in writing as appropriate. In this case, the Tribunal is satisfied that the patient provided informed consent orally on more than one occasion and implied such consent in the Operating Room just prior to the procedure.

The Standard also states that a regulated member may delegate responsibility for obtaining informed consent to another healthcare professional only when confident the delegate has the appropriate knowledge, skill, and judgment to meet the expectations of the Standard. There was no evidence before the Tribunal that the hospital staff responsible for getting the patient's signature were other than knowledgeable and skilled and there was no evidence that it was reported to the surgeon that the patient did not sign.

The Tribunal accepts the submission of Counsel for the Complaints Director that reviewing the form, including checking to ensure that the patient has signed, is not particularly onerous. It could be a completion of the necessary review between surgeon and patient and, as such, would be part of the checks and balances in place. Dr. Jiwa's current routine to double-check that the form contains the patient's signature implicitly accepts those premises. The question for the Tribunal, however, is whether Dr. Jiwa's failure to check for the signature in this instance amounted to Unprofessional Conduct.

As noted above, and in light of the expert testimony we heard, we find that failure to check for the signature does not represent a breach of the standards required, and does not indicate the necessary absence of skill, knowledge or judgment to establish Unprofessional Conduct, or conduct that would be seen to harm the integrity of the profession.

Finally, the Tribunal accepts that a series of errors taken together may reflect cavalier disregard for a patient and a patient's well-being and thus constitute Unprofessional Conduct. In this case, having found that each allegation individually does not constitute Unprofessional Conduct, the Tribunal also finds that the two errors, even taken together, do not amount to such Unprofessional Conduct.

VII. ORDERS/SANCTIONS

Having reviewed the evidence and testimony, and having heard Counsels' submissions, the Tribunal finds that Unprofessional Conduct has not been established on a balance of probabilities. We hereby order that the charges against Dr. Gul Jiwa be dismissed. Having found that no Unprofessional Conduct has been established, no sanction shall issue.

Signed on behalf of the Hearing Tribunal by the Chair

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Dr. Stacy J. Davies

COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF

A HEARING UNDER THE *HEALTH PROFESSIONS ACT*, RSA 2000, c C-7

REGARDING THE CONDUCT OF DR. GULNAZ JIWA

AND IN THE MATTER OF A

DECISION OF THE HEARING TRIBUNAL OF

THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

CORRIGENDUM TO THE DECISION OF THE HEARING PANEL

The signature line is amended to read: "Signed on behalf of the Hearing Tribunal by the Chair this 29th day of May, 2020" .

Signed on behalf of the Hearing Tribunal by the Chair this 26th day of November, 2020

Dr. Stacy J. Davies