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. BRIANNE HUDSON

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

## INTRODUCTION

The Hearing Tribunal held a hearing into the conduct of Dr. Brianne Hudson. The members of the Hearing Tribunal were:

Dr. Randy Naiker of Edmonton as Chair, Dr. Lakshmi Puttagunta of Edmonton and Mr. Lloyd Hickman of Lethbridge (public member). Mr. Greg Sim acted as independent legal counsel for the Hearing Tribunal.

In attendance at the hearing was Mr. Craig Boyer, legal counsel for the Complaints Director of the College of Physicians & Surgeons of Alberta. Also present were Dr. Brianne Hudson and Ms. Taryn Burnett, legal counsel for Dr. Hudson.

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

## ALLEGATIONS

The allegations to be considered by the Hearing Tribunal were set out in the Notice of Hearing.

1. That on April 26, 2015 you did fail to adequately assess your patient, given his presenting history and complaints on that date and from his prior visits to the emergency department of the Queen Elizabeth II Hospital on April 22 and 23, 2015;

2. That on April 26, 2015 you did fail to document in the chart of your patient, one or more of the following;

    a. an accurate measurement of his heart rate,

    b. any record of the history of your patient's characterization of his pain, radiation of pain, and aggravating and alleviating factors.

    c. any record regarding your review of lab work obtained during or as a result of his attendances on April 22 and 23, 2015,

    d. any reference as to whether you patient presented with guarding in relation to his abdominal pain,

    e. results of reassessment after treatment provided to your patient,

    f. return to care instructions provided to your patient,

    g. recommendations for his presenting symptoms, and

    h. consideration of further investigation such as repeat of previous lab work or ordering of diagnostic imaging.

3. On April 26, 2015, you did put in the chart of your patient, inappropriate and subjective comments that your patient was dramatic and immature for his age.

## I. PRELIMINARY MATTERS

There were no preliminary matters presented by the parties.

## EVIDENCE – EXHIBITS

By Agreement, the parties entered the Exhibit Book containing Exhibits 1 through 11, the Agreed Statement of Facts entered as Exhibit 12 and the Joint Submission and Admission Agreement entered as Exhibit 13.

The Exhibit Book contained the following items:

| | |
|---|---|
| Exhibit 1: | Notice of Hearing dated May 4, 2016. |
| Exhibit 2: | Complaint Reporting Form from Ms. [redacted] dated May 14, 2015 |
| Exhibit 3: | Letter of response from Dr. Brianne Hudson dated June 23, 2015 |
| Exhibit 4: | Grant of Administration of Estate dated July 27, 2015 |
| Exhibit 5: | Autopsy report dated July 15, 2015 |
| Exhibit 6: | Letter from Dr. Sam Dube dated June 5, 2015 |
| Exhibit 7: | Queen Elizabeth II Hospital records dated April 22-27, 2015 |
| Exhibit 8: | Medical chart from Dr. Sam Dube |
| Exhibit 9: | Opinion of Dr. James McIntyre dated December 7, 2015 |
| Exhibit 10: | Letter from Dr. James McIntyre dated March 2, 2016 |
| Exhibit 11 | Curriculum Vitae of Dr. James McIntyre |

There was no witness testimony in this Hearing.

## EVIDENCE – SUMMARY

Agreed Statement of Facts

In the Agreed Statement of Facts, both parties agreed that Dr. Hudson is an emergency room physician practicing at the Queen Elizabeth II Hospital in Grande Prairie, Alberta and she was on duty on April 26, 2015 when she saw and assessed Mr. [redacted] Mr. [redacted] died on April 27, 2015 and the College received a complaint from [redacted] on May 15, 2015, regarding Dr. Hudson's care of Mr. [redacted] The complaint was investigated and referred to a hearing before the Hearing Tribunal.

Complaint by Ms. [redacted]

In her letter of complaint, Ms. [redacted] stated that [redacted] Mr. [redacted] presented to the emergency department at the Queen Elizabeth Hospital in Grande Prairie, Alberta on April 22, 2015. He was seen by a Dr. Yao, diagnosed with gastroenteritis, given IV Zofran and a prescription for Gravol and discharged home. Mr. [redacted] was also noted to have had an elevated blood pressure on April 22, 2015.

Ms. [redacted] complaint stated that Mr. [redacted] remained unwell and he presented to the emergency department again on April 23, 2015. His vital signs were taken and his blood pressure remained elevated. Ms. [redacted] said that Mr. [redacted] was too weak to explain his condition and she had to explain that he was in for the same symptoms as the previous day. Ms. [redacted] explained that the wait to be admitted was unbearable for Mr. [redacted] and his family members decided to tell the nursing staff they were taking him home.

Ms. [redacted] explained that Mr. [redacted] remained unwell and presented to the emergency department for a third time on April 26, 2015. Ms. [redacted] said Mr. [redacted] was too weak to stand or to go to the bathroom on his own and it was evident that he was in overwhelming pain with visible distension of his stomach. Mr. [redacted] was admitted to a bed in the emergency department where he was placed on a normal saline IV and where he waited for several hours to see a physician. This was Mr. [redacted] only encounter with Dr. Hudson. Dr. Hudson quickly diagnosed Mr. [redacted] with gastroenteritis, gave him a prescription for Zofran and a referral to his family physician to have his blood pressure assessed once he had recovered. Dr. Hudson then discharged Mr. [redacted] home.

Mr. [redacted] attempted to take the prescribed medications but was unable to keep them down and remained unwell, became extremely weak and called an ambulance himself the following day. He subsequently passed out in the garage of his home where his breathing stopped and family members administered CPR until EMS arrived. Paramedics continued CPR for approximately 40 to 45 minutes with no response.

On April 28, 2015, the medical examiner informed the family that the cause of death was a volvulus. On April 30, 2015 Dr. Hudson telephoned the family to express her regret at her medical decisions in Mr. [redacted] care.

Dr. Hudson's Response to the Complaint

In her letter of response, Dr. Hudson identified herself as a family physician working in Grande Prairie since July 2013. Her practice includes emergency medicine, family medicine, inpatient care and she has a special interest in HIV medicine.

She describes Mr. [redacted] as an 18-year-old male who presented to the emergency department on April 26, 2015 with a CTAS score of 3. He was noted to be tachycardic with a heart rate of 143 and hypertensive with a blood pressure of 151/117. Dr. Hudson noted that when she reviewed the triage sheet it indicated Mr. [redacted] had been in four days previously for dehydration due to vomiting and diarrhea. She decided to order an IV fluid bolus to see if it would help Mr. [redacted] tachycardia as she knew it would be some time before she would be able to see him.

Dr. Hudson assessed Mr. [redacted] at 14:30 hours. She documented that he had had seven episodes of vomiting and three episodes of diarrhea in the past 24 hours however he reported that the IV fluid treatment had made him feel much better. Dr. Hudson noted that Mr. [redacted] blood pressure remained elevated but his mother explained to her that his blood pressure had been high for months and he was to follow up with his family physician. Dr. Hudson believed that this was a chronic issue and was not necessarily pertinent to his acute illness. She also noted that his heart rate sounded a bit fast but did not count it at the time and could not recall if he was on any type of monitor at that point. She stated that his abdomen was not distended and despite some groaning upon palpation of the left lower quadrant, his abdomen was benign to palpation.

Dr. Hudson reviewed lab work from the previous visit and noted that his CBC had barely been abnormal. Based on his general appearance, history and absence of physical findings on examination, Dr. Hudson diagnosed Mr. [redacted] with gastroenteritis. She explained to him and his family that his labs from the last visit were not too concerning and that she felt he was safe to go. She offered him an IV dose of Zofran prior to leaving the Department, which he initially refused, but subsequently accepted upon reconsideration. Dr Hudson provided a note to be off work and advised him that it was important to follow-up with his family physician regarding his high blood pressure.

When Dr. Hudson went back to her desk to finish Mr. [redacted] chart she estimated that his heart rate had been in the 90s at the time of her examination. She did not seek out the separate nurse's chart to verify Mr. [redacted]'s vital signs during the remainder of his stay in the emergency department.

Dr. Hudson was shocked to learn that Mr. [redacted] had returned to the ER the following day in a cardiac arrest and subsequently died. She was distraught that a patient she had seen one day prior presented to the ER the next day with a fatal outcome.

Upon review of the physician and nurses charts, she was very upset when she saw the record of his vital signs. It showed that Mr. [redacted] was consistently tachycardic with the heart rate between 120 to 140. She stated that she would never have sent this patient home if she had recognized his tachycardia persisted during his stay in the emergency department.

Dr. Hudson identified several factors which she believed in combination led to her decision to discharge Mr. [redacted]

1. Split physician and nursing charts – this contributed to her missing the patient's abnormal vital signs.
2. Unrecognized abnormal vital signs – Dr. Hudson initially recognized that Mr. [redacted] was tachycardic upon arrival at emergency department but she did not check his nursing chart prior to discharge, nor did Mr. [redacted] nurse communicate his abnormal vital signs to Dr. Hudson during the patient's stay in the emergency department.
3. Poor communication between the nurse and herself - in addition to the abnormal vital signs, nursing documentation of aggressive vomiting prior to discharge was not communicated to Dr. Hudson.
4. Unusual patient presentation - This was a young patient reporting three bowel movements with the absence of abdominal distention on examination which was not typical for a bowel obstruction.
5. Patient receiving treatment prior to the encounter - the patient reported benefit with IV fluids and seemed keen to leave the Department. This contributed to Dr. Hudson believing Mr. [redacted] was safe for discharge.
6. Challenging patient personality-Dr. Hudson stated that twice during their encounter Mr. [redacted] requested a wheelchair, which she presumed was so he could leave the department. Additionally, he refused her initial offer of Zofran stating that he did not think he needed it. This all culminated in her underestimating how sick he actually was.

Dr. Hudson stated that this case was devastating for her and that she has made some important changes to her practice to prevent this from happening again:

1. Accurately document vital signs and check vitals prior to discharge.
2. Investigate 'bounce backs' - Dr. Hudson has learned to be even more cautious about patients who return to the emergency department. Her new practice is to ensure that she has ordered routine investigations on every patient who returns to the ER, providing it is appropriate to do so considering their presenting complaint.
3. Be cautious of the patient who has received treatment prior to the encounter – Dr. Hudson recognizes that patients may improve with treatment they receive prior to her face-to-face

assessment. Yet they may still have significant pathology and she has learned to be extra diligent about checking vital signs, communicating with nursing staff, and considering investigations in these patients.

4. Be cautious of challenging patients-Dr. Hudson has learned how easy it can be to miss a diagnosis in the challenging patient and to be wary with a lower threshold for ordering investigations in these patients. She also understands the importance of good communication with nursing staff as they may pick up information that she may miss.

Dr. Hudson extended her deepest sympathies to Mr. [redacted] family.

<u>Autopsy Report</u>

In the official autopsy report, the immediate cause of death was ruled to be volvulus of the colon. A significant factor contributing to the death but not causally related was noted to be fentanyl toxicity. The report states that available medical reports indicated that fentanyl was not a therapeutic intervention provided to Mr. [redacted]

<u>Letter from Dr. Sam Dube</u>

In the letter from Dr. Dube, dated June 5, 2015, he states that he had known Mr. [redacted] for many years and rarely saw him for anything other than upper respiratory tract infections 1 to 2 times per year. In January 2015, he started seeing Mr. [redacted] for anxiety and depression of a mild to moderate degree. The letter indicates that ongoing stress between Mr. [redacted] and his parents regarding his schooling and future plans was a major stressor. Mr. [redacted] denied suicidality or any street drug abuse. He was started on Xanax 0.25 mg every six hours as needed and Zoloft 50 mg once daily. The Zoloft was increased to 100 mg daily on March 22, 2015.

Dr. Dube stated that on or about April 23, 2015 Mr. [redacted] mother brought him to Dr. Dube's home. Dr. Dube was advised that Mr. [redacted] had been suffering from diarrhea, vomiting and abdominal pain since April 20, 2015 and that Mr. [redacted] had been seen at the hospital on April 22 but then progressively deteriorated. Dr. Dube observed him to be very weak, and unable to stand without support. His blood pressure was 150/115 with a pulse rate of 120 bpm. Dr. Dube noted diffuse tenderness and guarding on examination of the abdomen. He directed Mr. [redacted] mother to take Mr. [redacted] to the local hospital emergency room as soon as possible. This was Dr. Dube's last visit with Mr. [redacted]

<u>Expert Opinion of Dr. James McIntyre</u>

The Complaints Director arranged for Dr. James McIntyre, a full-time emergency medicine physician working at the Red Deer Regional Hospital to review the complaint letter, Dr. Hudson's response, and ED records on the dates of April 22, 23rd and 26th 2015 and provide his opinion on Dr. Hudson's care.

In his opinion, Dr. McIntyre noted that Dr. Hudson did not provide appropriate documentation throughout Mr. [redacted] care. She did not document initial vitals on the physician chart, although she did document a heart rate of 90 from a subjective measurement. Furthermore, the history portion of the emergency record did not contain a documented history of the symptoms including characterization of pain, radiation, aggravation and alleviating factors, or all pertinent red flags.

There was no documentation showing a review of previous lab work from earlier in the week, no documentation acknowledging the abnormal vital signs from the nurse, nor any documentation acknowledging the patient had vomited large amounts of bile during the hospital stay. Physical exam documentation indicated a single point of abdominal tenderness, but otherwise soft. There was no documentation in regards to guarding.

Dr. McIntyre notes that Dr. Hudson stated that she did give Zofran and IV fluids, however there does not appear to be any documentation stating that Dr. Hudson had reassessed the patient after her treatment and notes that there were no orders or documentation in regards to analgesic.

In regards to discharge instructions Dr. McIntyre comments while it was appropriate for Dr. Hudson to emphasize that Mr. [redacted] blood pressure needed to be followed up, there was no documentation in regards to returning to care instructions, or other recommendations for his current symptoms that he presented with.

Dr. McIntyre was of the opinion that when a patient presents for the third time to an emergency department in one week, a physician needs to be extra vigilant. In this setting, it would have been appropriate to repeat the previous labs and to consider urinalysis or the necessity for stool cultures. Consideration of other imaging such as x-ray/ultrasound/CT depending on the differential would also be appropriate. It would appear that this was not considered in this case based on the documentation. He felt that with this patient's presentation, a more thorough workup would have been appropriate even if this patient may have been difficult to assess. He also acknowledges that there may have been communication errors between different members of the healthcare team in this case.

In a further letter dated March 2, 2016 Dr. McIntyre provided the Complaints Director with a comprehensive differential diagnosis list that could account for Mr. [redacted] presentation. He further stated that a history and physical examination of the patient allows a physician to narrow the differential down for investigation.

He continued that if the volvulus was suspected, one could confirm this diagnosis with imaging such as x-ray and/or CT. As these investigations are performed, the patient should be made NPO and their symptoms managed. Once the diagnosis is confirmed a consult to general surgery for treatment should be made.

## II. SUBMISSIONS

Submissions by Mr. Boyer

In his opening submissions, Mr. Boyer advised the Hearing Tribunal that Dr. Hudson would not be disputing allegations number one and two and that assuming the Hearing Tribunal accepted Dr. Hudson's admissions on allegations one and two, the Complaints Director would not be proceeding on allegation 3.

Mr. Boyer summarized the factual evidence set out above and made reference to section 70 of the *Health Professions Act*, which mandates that, a Hearing Tribunal may not act unless the admission is acceptable to the Hearing Tribunal. He continued that the Tribunal must determine whether the evidence presented is sufficient to support the admission and it was his position that there is not a question about the adequacy of the evidence for allegations one and two.

Mr. Boyer stated that if the Tribunal accepted the admissions, he would proceed to the issue of sanction.

Submissions by Ms. Burnett and Statement by Dr. Hudson

Ms. Burnett began her submission stating that Dr. Hudson has admitted unprofessional conduct with respect to allegation number one and allegation number two. She advised the Tribunal that Dr. Hudson would like to address the Tribunal.

Dr. Hudson stated she spent many hours reflecting on this case. She stated that the death of a loved one, particularly when that loved one is young and when the death is unexpected, is the most tragic thing a person has to endure.

She continued that there could be no greater pain on this earth than the pain a mother feels when she loses her child and acknowledged that she had cried many tears at the mere thought of the immensity of Mrs. [redacted] losing her son.

Dr. Hudson has acknowledged and has taken responsibility for the mistakes made when she treated Mr. [redacted] She also acknowledged that this was a challenging case due to multiple factors. A transverse colon volvulus is an exceedingly rare medical condition and Mr. [redacted] had an atypical presentation with no risk factors for this disease.

However, she acknowledged that she failed to recognize that Mr. [redacted] had an exceedingly high heart rate. If she had recognized this abnormality she stated that she would never have discharged him home. She cited the charting system in the emergency department as part of the reason why she missed this. She explained that separate charts were kept for doctors and nurses and on that day, she chose to estimate Mr. [redacted] heart rate rather than spending the time to find the nurse's record. With that, she expressed deep regret for not crosschecking the nurses' chart that day.

She continued that since that day she has never estimated a patient's vital signs ever again. She promised that she would never do this again for the remainder of her career.

Dr. Hudson also admitted that she failed to order basic investigations for Mr. [redacted] knowing that he was seen in the emergency department for the same complaint. She acknowledges that she should have been more questioning of his initial diagnosis and should have ordered blood tests and an x-ray to look for other potential causes of his symptoms.

Dr. Hudson expressed that she would like both the [redacted] family and the College to know that she has learned some very important lessons from this case. She is now very focused on patient vital signs and is careful to appropriately investigate any patient with abnormal vital signs. She is also very cautious about bounce back patients and routinely orders investigations on any patient who is bouncing back to the emergency department with the same complaint.

She also acknowledged that she is much more wary of patients who she perceives to be challenging or difficult admitting that her gut feeling about whether a patient is sick or not can be completely wrong. Additionally, she has learned to be much more careful with patients who have received treatment prior to her assessment, and despite their subjective report of improvement, they may still have a life-threatening illness.

Dr. Hudson addressed the family stating that she thinks about Mr. every day that she works in the emergency department. Experience from his case has helped her to identify rare, unexpected diagnoses in other patients. She recognized and acknowledged the sentiment that she, other health care providers, the hospital and the healthcare system as a whole has failed their loved one. She acknowledged that his case has forever changed the way that she practices.

She also extended the notion that she never intended to do harm, and that she is a human being and does make mistakes. She stated that she is a person with good intentions, who tries very hard to do what is right. She asked them to understand that being an emergency physician is an extremely difficult job with many sick patients and many pressures. It is within this environment that it is impossible for a physician to never make a mistake.

Dr. Hudson admitted she failed Mr. She would like his family to know that she takes responsibility and is truly sorry. She acknowledged the suffering that they have endured since his death and knows that the suffering will continue for a very long time.

Under questioning from the Tribunal, Ms. Burnett confirmed Dr. Hudson's admission to allegations one and two and confirmed that Dr. Hudson was admitting that the allegations were proven and amounted to unprofessional conduct.

## III. FINDINGS

After hearing from both parties and reviewing evidence presented as Exhibits 1 through 12, the Tribunal felt that there was sufficient evidence to support Dr. Hudson's admission of Allegation 1 and Allegation 2. The Tribunal agreed that Dr. Hudson's conduct constitutes "unprofessional conduct" which is defined in s. 1(1)(pp) of the *Health Professions Act*, R.S.A. 2000, c. H-7 to include a lack of judgment in the practice of the profession as well as conduct that harms the integrity of the profession.

In particular, the Tribunal accepts that despite the complicating factors that Dr. Hudson outlined a more thorough assessment, workup and documentation with extra vigilance would have been appropriate. When Dr. Hudson saw Mr. he was presenting to the emergency department for the third time in one week and Dr. Hudson ought to have ordered investigations and considered the differential diagnosis and the need for imaging to rule out serious pathology. The Tribunal also accepts that Dr. Hudson's documentation was inadequate. She did not document an accurate measurement of Mr. 's heart rate, a history of Mr. 's characterization of his pain, radiation of pain and aggravating and alleviating factors, any review of Mr. 's previous lab work, any indication in regard to abdominal guarding, any indication of return to care instructions regarding his presenting complaints or any recommendations for his presenting complaints.

## IV. ORDERS / SANCTIONS

The Tribunal heard submissions from both Mr. Boyer and Ms. Burnett regarding sanctions for Dr. Hudson. A joint submission on sanctions was presented.

The jointly-submitted sanctions were:

a) that Dr. Hudson shall receive a reprimand;

b) that Dr. Hudson, at her own cost, shall participate in the College's Practice Visit Program, and follow all reasonable recommendations arising from the Practice Visit, which may include changes in practice and/or further training or upgrading of skills and knowledge;

c) in the event the Complaints Director and Dr. Hudson are unable to agree on the nature, scope or duration of any change in practice or upgrading recommended by the Practice Visit Program, the Hearing Tribunal shall retain jurisdiction to determine any outstanding issue;

d) that Dr. Hudson be responsible for the costs of the investigation, the hearing and the determination and implementation of any recommendations arising out of the Practice Visit Program.

Submissions on Sanction by Mr. Boyer

Mr. Boyer stated that the jointly-submitted sanctions have come with consideration of a number of factors. He referenced the case of *Jaswal v. Newfoundland Medical Board* (1996), 42 Admin L.R. (2d) 233 which serves as the authority for factors to be considered when determining sanction. He stated that the factors outlined in the *Jaswal* case were considered when coming to the jointly-proposed sanctions.

Mr. Boyer stated that Dr. Hudson is in the early part of her professional career and that she is not naïve but is a newer physician. Mr. Boyer also noted that there has been no previous history of complaints against Dr. Hudson. Dr. Hudson has acknowledged what has occurred, favouring lesser sanctions, while still focusing on rehabilitation. Mr. Boyer also noted that while Dr. Hudson has acknowledged that she should have done more to investigate, this was not an easy diagnosis in this patient with this age and the presenting condition. This must be considered when determining the appropriate sanctions. Mr. Boyer stated that Dr. Hudson's admissions have saved the family the stress and grief of testifying. This was also a factor that must be considered when assessing the jointly-submitted sanctions.

Mr. Boyer referred to three cases that demonstrate that the sanctions being proposed are within the range of previous decisions where physicians were given sanctions for a similar type of conduct. He cited the Dr. Samuel case in which Dr. Samuel failed to attend a young patient at the hospital. In that case, there was a reprimand and payment of costs.

In the case of Dr. Metcalfe, a young patient was undertaking a procedure for an undescended testicle. Upon discovering that the testicle was in poor condition, Dr. Metcalfe removed it without the consent of the parents. He was subsequently given a reprimand and ordered to pay costs. He was also ordered to take further training on informed consent.

In the case of Dr. Tlhape, an elderly patient who was a former physician was attended solely by nursing staff in an extended care facility. This occurred over a period of several months. The physician received a reprimand, went through a practice review program, was ordered to implement changes that would come out of that assessment program and ordered payment of costs.

Mr. Boyer also stated that sanctions generally are intended to cover two issues: deterrence and rehabilitation. He further explained that these are directed at both the individual physician and the profession at large.

Mr. Boyer spoke first to the issue of a reprimand. He argued that a reprimand is not simply a slap on the wrist. It is a significant sanction, and it is a permanent blot on a professional's record. Therefore, the proposal of a reprimand as part of the sanction is not minor or insignificant.

Mr. Boyer also stated that costs are a significant component and consideration when determining sanction. He stated that Dr. Hudson has accepted responsibility for the full costs of the process and the monitoring.

Mr. Boyer continued that Dr. Hudson has addressed rehabilitation in her frank admission and acknowledgement that her practice has changed and she is forever focused on ensuring the best quality of care. He further stated that the College has a mechanism through the Practice Visit Program to ensure that her practice is monitored and is a very strong mechanism of ensuring the public interest.

Mr. Boyer argued that the Hearing Tribunal should defer to the joint-submission on sanctions, citing the Supreme Court of Canada's decision in *R. v. Anthony-Cook*, 2016 SCC 43 in which the Court confirmed the public interest test for determining whether to accept a joint-submission. That test holds that a decision-maker should not depart from a joint submission on sanction unless the proposed sanctions would bring the administration of justice into disrepute or would otherwise be contrary to the public interest. This preserves the high degree of confidence parties may have that a joint submission will be accepted and makes it possible for parties to come to joint submissions.

Mr. Boyer acknowledged that the Anthony-Cook case was a criminal case, but stated that the criminal law regarding joint submissions is also applicable to professional discipline proceedings.

Submissions on Sanction by Ms. Burnett

Ms. Burnett referred the Tribunal to Dr. Hudson's response to the complaint to the College, which demonstrates Dr. Hudson's insight and reflection on this case early on in the proceedings. She continued that Dr. Hudson has found this case devastating but has made some important changes to her practice to ensure it does not happen again.

Ms. Burnett also noted that Dr. Hudson, upon finding out about the tragic outcome of Mr. [redacted] reached out to the family to express her condolences.

Ms. Burnett also stated that Dr. Hudson was not required to say anything in light of the evidence and admissions that were put forward. However Dr. Hudson found it very important to make her statement to the Tribunal and to address Mr. [redacted] family, who were present in the gallery.

Dr. Hudson also wished to let the College know that this has affected her and will continue to in terms of how she practices. This goes beyond anything that comes out of the joint submission and is something that Dr. Hudson will have to live with every day.

Regarding the issue of reprimand, Ms. Burnett referred to *Forster v. Saskatchewan Teachers' Federation* (1992), 89 D.L.R. (4th) 283 (Sask C.A.). In *Forster*, the Saskatchewan Court of Appeal noted that the ability of any person to carry on her profession and to maintain her professional reputation untarnished is of primary importance and a reprimand on a person's professional record is a matter of extreme consequence. This speaks to the severity of having a reprimand.

Ms. Burnett also stated that Dr. Hudson completed her residency in 2013 and has worked as a family physician since that time. She is at the beginning of a very long career and has shown that she will take all the steps necessary to ensure that something like this does not happen in the future.

In response to a question from the Hearing Tribunal, Mr. Boyer explained that the College's Practice Visit Program was part of the Continuing Competence Program. Mr. Boyer explained that there would be a senior and experienced emergency room physician attending in Grande Prairie pulling charts at random of the patients that Dr. Hudson would have seen in her practice. There would be a review of the presenting complaint diagnosis and thoughts regarding investigations. The assessor can identify gaps in knowledge or whether further training or upgrading is required.

Mr. Boyer added that if a physician refused to follow recommendations from a Practice Visit, they could be facing a new charge of unprofessional conduct for failing to cooperate with the Practice Visit Program. This however would not be efficient because it would create a completely separate process. In order to avoid inefficiency, the joint submission provides for the Hearing Tribunal to retain jurisdiction to resolve any disagreements arising from the Practice Visit program.

Mr. Boyer stated that there is no finite number of charts that need to be audited and stated that the assessor typically determines this quantity. He stated that the assessments are typically done within several months with the goal of getting a sufficient number of charts to be reviewed to give the assessor a confident cross-section picture of Dr. Hudson's practice.

Decision on Sanctions

The Tribunal has carefully considered the seriousness of Dr. Hudson's conduct in this matter and the other factors in *Jaswal v. Newfoundland Medical Board*. The Tribunal accepts that Dr. Hudson has demonstrated significant insight and remorse over her medical treatment of Mr. [redacted] Her acknowledgement and apology was accepted as genuine and sincere.

The Tribunal recognizes that Dr. Hudson is a newer physician who is early in her career. While there may have been circumstances that made diagnosing and treating Mr. [redacted] difficult, Dr. Hudson has accepted responsibility for her conduct and is remorseful for the outcome. The impact that this has had and her willingness to ensure this does not reoccur is recognized by the Tribunal.

The Tribunal accepts and acknowledges that a reprimand is a significant sanction and will have an impact on Dr. Hudson for the rest of her career. The Tribunal feels this will satisfy the requirement for deterrence.

The Tribunal also accepts that the participation in the College's Practice Visit Program will adequately and safely address the issue of rehabilitation for Dr. Hudson.

Given the evidence presented and the Joint Submission and Admission Agreement presented, this hearing Tribunal feels that the public interest would be best served by accepting the joint submission on sanction.

Taking these factors into consideration, the Tribunal has accepted the joint submission on sanctions and makes the following orders:

a) that Dr. Hudson shall receive a reprimand;

b) that Dr. Hudson, at her own cost, shall participate in the College's Practice Visit Program, and follow all reasonable recommendations arising from the Practice Visits, which may include changes in practice and/or further training or upgrading of skills and knowledge;

c) in the event of the Complaints Director and Dr. Hudson are unable to agree on the nature, scope or duration of any change in practice or upgrading recommended by the Practice Visit Program, the Hearing Tribunal shall retain jurisdiction to determine any outstanding issue;

d) that Dr. Hudson be responsible for the costs of the investigation, the hearing and the determination and implementation of any recommendations arising out of the Practice Visit Program.

Signed on behalf of the Hearing Tribunal by the Chair

Dated: February 13, 2017

Dr. Randy Naiker