COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

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

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. KEVIN MAILO

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA
August 25, 2022

I. INTRODUCTION

1. The Hearing Tribunal held a hearing into the conduct of Dr. Kevin Mailo on August 25, 2022. The members of the Hearing Tribunal were:

   Ms. Anita Warnick of Calgary as Chair (and public member);
   Dr. Kim Loeffler of Edmonton;
   Dr. David Sheppard of Stettler;
   Mr. James Lees of Edmonton (public member).

2. Ms. Natasha Egan acted as independent legal counsel for the Hearing Tribunal.

3. Appearances:

   Ms. Stacey McPeek, legal counsel for the Complaints Director;
   Dr. Kevin Mailo;
   Ms. Karen Pirie, legal counsel for Dr. Mailo.

II. PRELIMINARY MATTERS

4. Neither party objected to the composition of the Hearing Tribunal or its jurisdiction to proceed with the hearing. There were no matters of a preliminary nature. The hearing was open to the public, and there was no application to close the hearing.

III. CHARGES

5. The Notice of Hearing listed the following allegations:

   a) You demonstrated a lack of skill or judgment in the care provided to your patient, [redacted], on June 6, 2015, in that you did fail to contact the patient after she had left the hospital to inform your patient that the radiologist recommended further imaging given the suspicion of hip fracture.

   ALL OF WHICH is contrary to the provisions of the *Health Profession Act,* RSA 2000 c. H-7 ("HPA") as amended, the Regulations, Standards of Practice or Bylaws enacted pursuant thereto, constituting unprofessional conduct.

IV. EVIDENCE

6. The hearing proceeded based on the Admission and Joint Submission Agreement of July 6, 2022 ("Joint Submission") and the Agreed Exhibit Book ("Exhibit Book") attached thereto. No witnesses were called to testify.

7. The Tribunal reviewed the Joint Submission and Exhibit Book agreed to by both parties. These documents set out the series of events that lead to the issuance of the Notice of Hearing as follows:

   a) the Complaints Director received a complaint from the Complainant on September 18, 2017 regarding the care provided by Dr. Mailo at the Emergency Department of the Strathcona Hospital (the "Complaint").

   b) The Complaints Director directed an investigation which resulted in an investigation report being provided to the Complaints director.

   c) Believing he had the Complainant's verbal consent, the Complaints Director agreed with Dr. Mailo to Terms of Resolution of the Complaint dated February 2, 2019 and Dr. Mailo fulfilled the Terms of Resolution.

   d) The Complainant objected to the Terms of Resolution, did not provide written consent to the Terms of Resolution, and asked for a review by the Complaints Review Committee.

   e) The Complaints Review Committee issued a decision dated September 2, 2020 directing that the Complaint be referred to a Hearing before the Hearing Tribunal.

   f) The Hearings Director issued a Notice of Hearing dated December 7, 2021 for a hearing to be held on August 25, 2022 at 9:00am.

   g) Dr. Mailo was served with the Notice of Hearing on December 21, 2021 and, pursuant to s. 70 of the HPA, admits the allegation in the Notice of Hearing as being true, and admits that such conduct amounts to unprofessional conduct.

8. The Exhibit Book contained the following documents, all of which were considered by the Tribunal in its deliberation of this matter:

   a) Notice of Hearing dated December 7, 2021;
   b) Complaint Form from the Complainant dated September 18, 2017;
   c) Response from Dr. Mailo dated November 17, 2017;
   d) Emergency Room chart for the Complainant for June 6, 2015;
   e) Letter from Dr. Mailo dated July 9, 2018;
   f) Terms of Resolution dated February 4, 2019;
   g) Certificate of Attendance dated April 25, 2019;
   h) Letter from Dr. Mazurek to Dr. Caffaro dated June 17, 2019;
   i) Letter from Dr. Flook to Dr. Mailo dated June 17, 2019;
   j) Complaints Review Committee decision dated September 2, 2020;
   k) Expert opinion dated February 11, 2021;
   l) Expert opinion dated April 9, 2021; and
   m) Personal Learning Plan prepared by Dr. Mailo dated June 15, 2021.

V. SUBMISSIONS ON THE ALLEGATIONS

Complaints Director

9. Ms. McPeek, on behalf of the Complaint Director, gave an overview of the facts that led to the Joint Submission and entered the Exhibit Book as Exhibit 1.

10. Ms. McPeek highlighted important parts of the evidence from the Exhibit Book. She noted that the Complainant initially presented to the Emergency Room following an incident with her horse that led to an injury. She was examined by Dr. Mailo and x-rays were ordered. These were initially thought to be normal by Dr. Mailo and he conveyed that to the Complainant.

11. Ms. McPeek acknowledged that there is some conflicting evidence with respect to whether Dr. Mailo discharged the patient or whether she left against medical advice. She submitted that although this evidence is conflicting, what is not conflicting is the evidence that relates directly to the charge before the Tribunal.

12. The evidence, Ms. McPeek submitted, which relates directly to the charge before the Tribunal, is that following the x-rays there were two radiology reports on the Complainant's right hip. These were available to Dr. Mailo within an hour of the x-rays although there is some dispute in the chart as to whether they were available to Dr. Mailo before the patient left. Both reports indicated suspicion of a fracture to the right acetabulum and both recommended further CT scans.

13. There is no evidence that Dr. Mailo contacted the Complainant after she left to discuss the possibility of the fracture or to suggest that she have a CT scan.

14. The expert report provided to the College indicated that the history, physical examination and investigations met an acceptable standard of care, that not appreciating the suspicious findings on the x-ray did not breach the standard of care but that the lack of patient follow-up following the radiology reports did not meet the standard of care.

15. The expert report provided by Dr. Mailo stated that Dr. Mailo was under no obligation to follow up with respect to the results of the imaging but acknowledges that it is never wrong, and often prudent, to follow up.

16. Ms. Mc Peek submitted that Dr. Mailo admits that his conduct as set out in the Notice of Hearing constitutes unprofessional conduct pursuant to s.1(1)(pp)(i) in that it "displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services."

17. She further stated that his conduct would also fall under "conduct that harms the integrity of the regulated profession" pursuant to s.1(1)(pp)(xii) of the HPA in that patients who attend the ER and have imaging completed will expect the physician to advise them of results, including recommendations of other

specialists that were consulted. When this isn't done, there is resulting harm to the integrity of the medical profession.

Dr. Mailo

18. Ms. Pirie, legal counsel for Dr. Mailo, verified that Dr. Mailo admits that the allegations in the Notice of Hearing constitute professional misconduct under the HPA.

19. Ms. Pirie clarified that Dr. Mailo's position is that although the radiology report may have been created shortly before the patient left the ER, it was not actually printed until about 6 or 7 hours later, after Dr. Mailo had left his shift.

20. Dr. Mailo readily acknowledges that there is no documentation that was reviewed in the final form and that he did not follow up with a phone call or otherwise with the patient. Although there are some "systemic issues" that impacted this scenario, Dr. Mailo takes responsibility for the lack of follow-up with the Complainant since he was the most responsible physician at the time that he saw her.

21. As a result of those issues, Dr. Mailo readily took a number of courses and reevaluated his practice to ensure that this type of scenario cannot be repeated. Nonetheless, he would like the panel to recognize that there were issues here that were outside his control.

VI. QUESTION FROM HEARING TRIBUNAL AND ADDITIONAL SUBMISSIONS FROM THE PARTIES

22. The Hearing Tribunal carefully considered the submissions of the parties and noted that The Complaints Director had submitted that the conduct to which Dr. Mailo admitted constituted professional misconduct under both s.1(1)(pp)(i) and s. 1(1)(pp)(xii) of the HPA. The Hearing Tribunal invited additional submissions from parties regarding how the conduct admitted to has affected the integrity of the profession.

23. Prior to providing submissions, Ms. McPeek informed the Tribunal, on behalf of both parties, that the "Terms of Resolution" provided to the Tribunal as part of the original Exhibit Book was an earlier version sent in error. The Tribunal was then sent the correct Exhibit Book ("Corrected Exhibit Book") during the hearing by the Hearings Director's office.

24. Ms. McPeek reiterated that patients who attend the ER and have imaging completed will expect the results will be shared with them, including consultations with other specialists. She submitted that when that reasonable expectation is not met it can ultimately harm the profession.

25. Ms. Pirie submitted that to avoid the Complainant testifying and having a full hearing that might address, at a more direct level, whether this situation harms the integrity of the profession, the decision was made that Dr. Mailo would accept that it was unprofessional conduct.

26. After further consideration, the Tribunal asked Ms. Pirie to clarify more directly whether or not Dr. Mailo was admitting to professional misconduct under both s.1(1)(pp)(i) and s. 1(1)(pp)(xii) of the HPA as Ms. McPeek submitted. Ms. Pirie confirmed that Dr. Mailo agreed that his conduct amounted to professional misconduct under both sections of the HPA.

VII. DECISION OF THE HEARING TRIBUNAL

27. The Hearing Tribunal notes that the difference between the Exhibit Book and the Corrected Exhibit Book relates only to the "Terms of Resolution" at Tab 6. These minor changes are not important to the ultimate decision arrived at by the Tribunal. They merely reflect the parties' agreement on the evidence at that particular stage of the investigation. The Tribunal's independent determination in this matter was arrived at following a careful review of evidence which both preceded and followed that particular agreement between the parties.

28. The Hearing Tribunal carefully reviewed and considered the documents contained in the Joint Submission and Corrected Exhibit Book and the submissions of both parties.

29. The Hearing Tribunal finds that the allegations in the Notice of Hearing are factually proven and that the evidence does support Dr. Mailo's admission. The Tribunal also finds that Dr. Mailo's conduct constitutes unprofessional conduct under s. 1(1)(pp)(i) and s. 1(1)(pp)(xii) of the HPA.

VIII. FINDINGS AND REASONS

30. The Tribunal finds that there is sufficient evidence to support Dr. Mailo's admission of the conduct and that the allegation in the Notice of Hearing was proven on a balance of probabilities. The Hearing Tribunal also found that the admitted conduct does constitute unprofessional conduct

31. The evidence before the Tribunal, including the emergency department chart for the Complainant (the "Chart"), the expert report of February 11, 2021 and the expert report of April 9, 2021 indicated that Dr. Mailo saw the Complainant at the Strathcona Emergency Department following an accident involving a horse. The Complainant and Dr. Mailo have differing views regarding Dr. Mailo's bedside manner and the way in which Dr. Mailo conveyed to the Complainant that he would prefer she describe the mechanism of her injury in

layman, as opposed to medical, terms. The Tribunal notes that this issue did not form part of the allegation in the Notice of Hearing.

32. The Tribunal reviewed the evidence suggesting that the Complainant was able to mobilize with crutches and understood that she could leave the emergency department.

33. Dr. Mailo indicates that had the Complainant remained in the ER for her full assessment and discharge planning, Dr. Mailo would have conducted additional assessments and followed up with in 48-72 hours.

34. Dr. Mailo's Chart note indicates that the Complainant left the ER against medical advice but there is an additional note in the Chart, which Dr. Mailo states was not made by him, indicating that the Complainant had been discharged by Dr. Mailo.

35. The Complainant alleges that Dr. Mailo told her that if she could walk on crutches for the nurse she could leave the ER. Dr. Mailo agrees that this would have been consistent with his clinical practice.

36. The Complainant's Chart, both expert reports, and Dr. Mailo's admission, make it clear, and the Tribunal accepts, that the radiology reports contained suspicious findings for an acetabular fracture. Regardless of when or why the Complainant left the ER, Dr. Mailo admits that there is no evidence that he attempted to contact the Complainant with the results of these radiology reports. This is consistent with the Complainant's own recollection and complaint.

37. The Tribunal agrees that the lack of follow-up provided to the Complainant in respect of the radiology reports clearly displays a lack of knowledge of, or lack of skill or judgement in, the provision of professional services pursuant to s.1(1)(pp)(i) of the HPA. The Tribunal further agrees that it is appropriate for Dr. Mailo, as the physician responsible for the Complainant's care, to take responsibility for that lack of follow-up irrespective of any systemic issues which may have contributed to the failure.

38. The Tribunal further considered whether or not Dr. Mailo's admitted failure to ensure follow-up with the Complainant "harms the integrity of the regulated profession" pursuant to s.1(1)(pp)(xii). The Tribunal agrees with the submissions of the Complaints Director that patients have a reasonable expectation that imaging results will be shared with them. The responsible physician has a duty of care to ensure that this communication occurs and that failure to do so harms the integrity of the profession.

IX. SUBMISSIONS ON SANCTION

Complaints Director

39. Ms. McPeek, on behalf of the Complaints Directors reviewed the proposed sanction and entered the Joint Submission as Exhibit 2. The sanctions proposed by the parties are as follows:

    a) a reprimand;
    b) completion of the Successful Patient Interactions course offered by SAEGIS;
    c) preparation and fulfilment of a Personal Learning Plan; and
    d) payment of investigation and hearing fees.

40. Ms. McPeek outlined the test in *R. v. Anthony-Cook*, 2016 SCC 43 regarding the public interest. She submitted that the Tribunal should not depart from a joint submission unless the proposed penalty would bring the administration of justice into disrepute or would otherwise be contrary to the public interest. This is a stringent test because, for joint submissions to be possible, the parties need a high degree of confidence that they will be accepted. The parties are in the best position to know the circumstances of the specific member and the strengths and weaknesses of their positions. Ms. McPeek highlighted that it is particularly important that the Tribunal not tinker with the agreement because both parties may have waived things that they have a right to in order to reach agreement.

41. Ms. McPeek further drew the Tribunal's attention to *Bradley v. Ontario College of Teachers*, 2021 ONSC 2303 which confirms that the public interest test applies to professional discipline matter such as this hearing.

42. With respect to sanction, Ms. McPeek noted that the fundamental purpose in a professional regulatory context is to ensure that the public is protected from unprofessional conduct of its members. To achieve this, the Tribunal is tasked with ensuring that the public has confidence in the profession and in the CPSA to regulate the profession. It must ensure that the sanction sends an appropriate message to other members of the profession that the conduct was unacceptable and that it is proportionate to the conduct in order to prevent a specific member from allowing the conduct to recur.

43. Finally, Ms. McPeek highlighted the list of non-exhaustive factors to consider when making a decision on sanction from *Jaswal v. Newfoundland Medical Board*, (1996), 42 Admin L.R. (2d) 233. She submitted that one aggravating factor is the impact on the patient. In this instance, she submitted that the Tribunal should only consider the impact as it relates to the proven charge, that is, how the lack of follow-up delayed potential intervention. She submitted that there is no evidence suggesting that the delay resulted in a worse outcome for the Complainant and suggests that the Tribunal will likely give this factor limited weight.

44. With respect to mitigating factors, Ms. McPeek noted Dr. Mailo's limited experience at the time of the incident, lack of prior complaints and that this was a single incident with no evidence of a greater pattern. She further highlighted that Dr. Mailo acknowledged the conduct early on and has worked with the Complaints Director at the outset and continuing through to the hearing.

45. Ms. McPeek suggested that an additional mitigating factor is Dr. Mailo's demonstrated commitment to learning from the experience by completing the SAEGIS course without delay and by demonstrating cooperation and achievements in quality improvement process within the individual practice review. She drew the Tribunal's attention to Dr. Mailo's letter to the Complaints Director at pg. 72 of the Corrected Exhibit Book wherein he notes that that his site now operates on Connect Care (an electronic medical record system or EMR) and that he receives results from both the EMR and IMPAX (a diagnostic imaging software). This letter also contains details regarding increased correspondence, consultation and collaboration with other healthcare providers in the patient's circle of care aimed at reducing the risk of a missed result.

46. Ms. McPeek submitted that there is evidence that the outcome would have remained unchanged because at the time of making the complaint the Complainant had received a CT scan, been referred to an orthopedic surgeon, had the surgery booked, but then cancelled the arrangement.

47. Ms. McPeek reviewed six cases which she submits are not identical but which may assist the Tribunal in determining what a range of reasonable sanctions would be. In each case there was a clear denunciation of the conduct and a focus on the practitioner learning and receiving the skills neccessary to prevent similar incidents from occurring.

48. Finally, Ms. McPeek suggests that the reprimand proposed seeks to satisfy the importance of both specific and general deterrence in that it denounces Dr. Mailo's specific conduct but also sends a message generally to the profession. She submits that the course and personalized learning plan seek to protect the public by providing Dr. Mailo with the opportunity to reflect on what occurred and to give him better skills and tools to deal with similar issues going forward. Ms. McPeek states that these types of complaints can sometimes be seen as successes where complaints do not result in significant harm to a patient but ultimately bring about better medical practice in Alberta.

49. With respect to costs, Dr. Mailo would have been responsible for the costs of implementing any of the suggestions from the personalized learning plan. In addition, his cooperation is a factor that suggests less costs are appropriate. The parties agree that two-thirds of the costs are appropriate with regard to the cases provided and the guidance provided in *Jaswal*.

Dr. Mailo

50. Ms. Pirie on behalf of Dr. Mailo thanked Ms. McPeek for a fair presentation on the sanction, on the *Jaswal* factors that are relevant, and the case law.

51. She reiterated that Dr. Mailo took this complaint early in his career as an opportunity for reflection and to engage in educational activities which help to improve and continue the high level of care that he was striving for.

52. Ms. Pirie also noted that it has been seven years since this encounter and having occurred so early in his career we can be hopeful that this has then further assisted him in laying a good foundation for the care that has been provided since and will continue in the future.

53. The combination of learning activities in which he engaged, plus the costs of a hearing which the Complaints Director had not felt was necessary to begin with, will more than adequately address any issue in relation to either specific or general deterrence.

X. QUESTION FROM HEARING TRIBUNAL AND ADDITIONAL SUBMISSIONS FROM THE PARTIES

54. The Tribunal requested clarification that the intent of the parties is that a copy of the decision will serve as a reprimand. The parties agreed that it should.

55. The Tribunal also asked for an estimate of the actual quantum of costs to be paid by Dr. Mailo and same was provided by the parties.

XI. FINDINGS AND DECISON ON SANCTIONS

56. The Hearing Tribunal adjourned to carefully consider the submissions of the parties and the factors that are typically considered when determining sanction in the professional regulatory area. Sanctions must be in the public interest and are designed to protect the public from unprofessional conduct by regulated members. Both deterrence and rehabilitation are relevant factors to consider in determining whether a proposed sanction is appropriate and in the public interest.

57. The Hearing Tribunal was also mindful that significant deference is to be given to Joint Submissions. It is of the view of the Tribunal that the sanctions proposed will not bring the administration of justice in the professional regulatory context into disrepute.

58. The Tribunal agrees with Ms. McPeek's review of the *Jaswal* factors as they relate to this instance and agrees that the weight she suggests be given to each of those reviewed is appropriate. The Tribunal is of the view that the sanction proposed falls within the range of acceptable sanctions having regard

to the factors set out in *Jaswal*, the relevant Standards of Practice, the caselaw provided and Dr. Mailo's admitted conduct.

59. The Tribunal notes that this matter has carried on for 7 years and has undoubtedly been painful and difficult for both Dr. Mailo and the Complainant. The Tribunal recognizes that Dr. Mailo has not sat idol during this time and has proactively completed the education and individual practice improvements asked of him whole-heartedly.

60. The evidence before the Tribunal and the submissions of the parties indicate that there were systemic problems at play which contributed to the break-down of communication and Dr. Mailo's failure to inform the Complainant of the imaging results. The Tribunal appreciates the evidence provided by the parties regarding the specificity of the measures taken by Dr. Mailo to remedy these issues and prevent an incident like this from happening in the future. The Tribunal is also satisfied that the education and practice improvements undertaken by Dr. Mailo have served to rehabilitate him and improve his practice.

61. The reprimand and costs proposed are appropriate in these circumstances as a consequence for Dr. Mailo's unprofessional conduct. The reprimand will also serve to remind the profession that such conduct can have real and lasting consequences for patients.

62. The Tribunal finds that the Joint Submission on Sanction are reasonable and fair to both Dr. Mailo and Complainant.

XII. ORDERS

63. Accordingly, the Hearing Tribunal accepts the Joint Submission Agreement and makes the following orders pursuant to s. 82 of the HPA:

    a) Dr. Mailo shall receive a written reprimand in the form of a copy of this Tribunal's written decision.

    b) Dr. Mailo shall attend and complete the Successful Patient Interactions course offered by SAEGIS. The course completed on April 25, 2019 in Edmonton satisfies this requirement.

    c) Dr. Mailo shall prepare and fulfill a Personal Learning Plan regarding follow-up on investigations generated in the Emergency Department. The confirmation letter of June 17, 2019 from Deputy Registrar Karen Mazurek confirming that Dr. Mailo has implemented the required practice quality improvements following a number of competence interventions satisfies this requirement.

    and

d) Dr. Mailo shall be responsible for two-thirds of the costs of the investigation and hearing, payable on terms acceptable to the Complaints Director.

Signed on behalf of the Hearing Tribunal by the Chair:

Ms. Anita Warnick

Dated this 26 day of September, 2022.