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. NIRUPA SRIKISSON

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

I. INTRODUCTION

1. The Hearing Tribunal held a hearing into the conduct of Dr. Nirupa Srikisson (the "Regulated Member") on December 14, 2021. The members of the Hearing Tribunal were:

   Dr. Eric Wasylenko of Okotoks as Chair;
   Dr. Neelan Pillay of Calgary;
   Ms. Archana Chaudhary of Edmonton (public member);
   Ms. Juane Priest of Calgary (public member).

   Ms. Mary Marshall acted as independent legal counsel for the Hearing Tribunal.

   Also present were:

   Mr. Craig Boyer, legal counsel for the Complaints Director;
   Dr. Nirupa Srikisson;
   Ms. Karen Pirie, legal counsel for Dr. Nirupa Srikisson.

II. PRELIMINARY MATTERS

2. 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. There was no application to close the hearing.

III. CHARGES

3. The Amended Notice of Hearing dated December 10, 2021 ("Notice of Hearing") listed the following allegations:

   1. You did demonstrate a lack of knowledge or lack of skill or judgment in the provision of professional services to your patient, [redacted], in failing to arrange timely diagnostic imaging between October 12 and November 15, 2018 to investigate your patient's abdominal pain complaints.
   2. You failed to create an adequate patient record for the visit with your patient, [redacted], as required by the College of Physicians and Surgeons of Alberta Standard of Practice regarding Patient Record Content, on one or more of the following dates; September 14, October 12, November 1, and December 6, 2018.
   3. On or about January 20, 2019, you did make changes to the record for your patient, [redacted], without clearly noting those changes were late entries contrary to the College of Physicians and Surgeons of Alberta Standard of Practice concerning Patient Record Content for visits on one or more of the following dates; September 14, October 12, November 1, and December 6, 2018.

4. The Regulated Member acknowledged and admitted the allegations as set out in the Notice of Hearing ("the Allegations") and that they constituted unprofessional conduct as set out in the *Health Professions Act* ("HPA").

IV. EVIDENCE

5. The following Exhibits were entered into evidence by agreement of the parties during the hearing:

Exhibit 1: Agreed Exhibit Book Containing Tabs 1 to 14

- **Tab 1:** Notice of Hearing dated August 23, 2021, page 1
- **Tab 1.1:** Amended Notice of Hearing dated December 10, 2021, page 4
- **Tab 2:** Complaint form dated July 16, 2019, page 6
- **Tab 3:** Alberta Health Services letter to the College of Physicians and Surgeons of Alberta dated August 8, 2019 enclosing the Leduc Community Hospital records, page 11
- **Tab 4:** Alberta Health Services letter to Katherine Damron, dated August 13, 2019 enclosing the Royal Alexandra Hospital records, page 29
- **Tab 5:** Letter from Dr. Nhung Tran-Davies letter to College of Physicians and Surgeons of Alberta dated September 8, 2019, page 50
- **Tab 6:** Letter from Dr. Nirupa Srikisson to Katherine Damron dated September 11, 2019, page 52
- **Tab 7:** Electronic medical record audit report provided to the CPSA on October 15 2019, page 55
- **Tab 8:** Letter from Dr. Nirupa Srikisson dated February 9, 2020 to Dr. Gordon Giddings, page 66
- **Tab 9:** Letter from Dr. Nirupa Srikisson dated March 12, 2020 to Dr. Gordon Giddings, page 67
- **Tab 10:** Patient chart from Dr. Nirupa Srikisson for [redacted], deceased, page 68
- **Tab 11:** Expert opinion from Dr. Leigh Beamish dated October 16, 2020, page 94
- **Tab 12:** Certificate of Completion of Medical Record Keeping Course from University of Calgary dated September 15, 2021, page 98
- **Tab 13:** College of Physicians and Surgeons of Alberta Standard of Practice regarding Patient Record Content, page 99

Tab 14: Impact Statement from [redacted] dated December 13, 2021, page 101

Exhibit 2: Signed Admission and Joint Submission Agreement

V. SUBMISSIONS REGARDING THE ALLEGATIONS

6. Counsel for the Complaints Director submitted that the presented evidence supports the admission by the Regulated Member for all three allegations.

7. Regarding the first allegation, counsel for the Complaints Director submitted that the Regulated Member did not meet professional standards for the timeliness of investigation for abdominal complaints. The expert opinion provided as evidence stated that the standard of care was not met, and therefore section 1(1)(pp)(i) in the definition of unprofessional conduct within the HPA is proven.

8. Regarding the second allegation, counsel for the Complaints Director linked the Regulated Member's failure to adhere to Standards of Practice dealing with the quality of charting to the definition of unprofessional conduct in the HPA. Counsel referred to the expert opinion as confirming the inadequacy of the charting. Noted were additions to the record on January 20, 2019, proven by the audit log, to place information that was missing from the chart records for previous visits, as well as other information that the expert asserted was not included and that should have been to meet the standard.

9. Regarding the third allegation, counsel for the Complaints Director addressed the way in which late entries to the chart record were handled by the Regulated Member. Counsel submitted that while late entries can be appropriate, in the instances cited, they fell below the standard as described in the CPSA's Patient Record Content Standard of Practice. Specifically, the Regulated Member did not note within the subsequent entries that the entries were created late or that they were changes to the prior record.

10. Further, the expert opinion questioned the accuracy of some of the late entries, such as blood pressure and pulse readings, due to the passage of time between the visits and when those entries were completed in the record.

11. Counsel for the Complaints Director submitted that the evidence presented including the EMR audit log, the Standards, the expert opinion as well as the admission by the Regulated Member proves that the conduct described in the Allegations represents unprofessional conduct.

12. Counsel for the Regulated Member submitted that the definition of unprofessional conduct contained in the HPA section 1(1)(pp)(i) is included in the first allegation, and that the Regulated Member has admitted to that charge, and so that particular subsection of the HPA applies.

13. Counsel for the Regulated Member submitted that Allegations 2 and 3 relate to the HPA section 1(1)(pp)(ii). The Regulated Member has admitted that the charting did not meet the relevant Standard of Practice.

14. Counsel for the Regulated Member submitted that other subsections of the HPA regarding the definition of unprofessional conduct do not apply to the Allegations. Regarding subsection 1(1)(pp)(iii) there is no indication of what other enactments might apply. Regarding subsection 1(1)(pp)(xii) the Allegations do not contend that the conduct harms the integrity of the profession and so this subsection does not apply.

15. Counsel for the Complaints Director agreed with counsel for the Regulated Member that only subsections 1(1)(pp)(i) and 1(1)(pp)(ii) are applicable to the Allegations as admitted in the Admission and Joint Submission Agreement.

VI. FINDINGS REGARDING THE ALLEGATIONS

16. The Hearing Tribunal reviewed all of the evidence to determine whether the Regulated Member's admission of unprofessional conduct should be accepted. The Hearing Tribunal determined that there was sufficient evidence to determine that the Allegations in the Notice of Hearing were proven, and that the conduct constitutes "unprofessional conduct" pursuant to section 1(1)(pp) of the HPA. The rationale for the Hearing Tribunal's findings is set out below.

Allegation #1

17. The Hearing Tribunal found that Allegation 1 was proven. The Regulated Member demonstrated a lack of skill and judgment in the provision of services to her patient by failing to arrange timely diagnostic imaging referable to the patient's symptoms, between October 12 and November 15, 2018. As noted in the expert opinion, the Regulated Member noted a plan to arrange for appropriate tests in response to the presenting symptoms. However, those tests were not arranged, and it is unclear from the records where the process breakdown occurred. A discrepancy in the usual process of ordering through the EMR occurred, and the Regulated Member reported they were arranged by paper ordering this single time, a situation the expert found to be unusual. The tests were eventually ordered after the patient inquired about them subsequently. The expert expressed the opinion that it is the Regulated Member's responsibility to ensure that test results are reviewed and that timely follow-up regarding results occurs. Further, the expert expressed the opinion that the 20 days it took to review the eventual ultrasound and order a follow-up CT scan did not meet the standard of care considering the investigations were about an abdominal mass identified on the ultrasound. The Hearing Tribunal found the expert opinion compelling. In that the Regulated Member failed to exhibit the required skill and judgment in the provision of services to this patient, her actions met the criteria for unprofessional conduct as described in the HPA section 1(1)(pp)(i).

Allegation #2

18. The Hearing Tribunal found that Allegation 2 was proven. Evidence in the EMR log demonstrates inadequate charting referable to significant symptoms. For the December 6, 2018 visit, no records were created until just over six weeks later. The September 14, 2018, October 12, 2018 and November 1, 2018 visits were amended on January 20, 2019, demonstrating that the Regulated Member recognized the inadequacy or inaccuracy of those chart entries. In the September 14, 2018 visit record, no blood pressure reading was recorded. As noted in the expert opinion, inserting into the record readings for vital signs many weeks or months later calls into question the accuracy of the information. This evidence demonstrates contravention of the CPSA's Standard of Practice regarding Patient Record Content (the "Standard"). Contravention of this Standard as proven constitutes unprofessional conduct on the part of the Regulated Member.

Allegation #3

19. The Hearing Tribunal found that Allegation 3 was proven with reference to visits on September 14, 2018, October 12, 2018, November 1, 2018 and December 6, 2018. The EMR audit log admitted into evidence demonstrates that the late and amended entries created on January 20, 2019 were not properly denoted as late or amended entries as the Standard requires. This is not simply a technical breach. Accuracy in denoting a late or amended entry and indicating who created the entry assists in the proper longitudinal care of patients, especially when multiple care providers are involved in a person's care. The contravention of the Standard constitutes unprofessional conduct with reference to the HPA section 1(1)(pp)(ii).

VII. SUBMISSIONS ON SANCTION

20. After the Hearing Tribunal advised the parties of its findings in relation to the Allegations, the Hearing Tribunal invited the parties to make submissions with respect to sanctions. The parties presented a Joint Submission Agreement regarding sanctions (the "Joint Submission").

21. Counsel for the Complaints Director reviewed the general principles underlying sanctions, those being deterrence and rehabilitation. Deterrence relates both to the individual physician and their future actions, and to the profession at large.

22. Counsel for the Complaints Director presented a Brief of Law on Joint Submissions. He submitted that a Hearing Tribunal should attach great deference to joint submissions, recognizing that the parties would have to be diligent in addressing all the issues before them in meeting the purpose of sanctions. Only in circumstances where the Hearing Tribunal decides the

sanctions produce a demonstrably unjust and inappropriate result can the Hearing Tribunal consider rejecting the joint submission on sanctions.

23. Counsel turned to *Jaswal v. Medical Board (Nfld.), 1996 CanLII 11630 (NL SC)*, "*Jaswal*", to argue that of the factors determining sanction, other cases involving similar circumstances should be determinative of appropriate sanction in this case.

24. Counsel for the Complaints Director cited the following decisions in support of the Joint Submission regarding the proposed penalty:

    a. *Halse (Re)*, 2020 CanLII 45161 (AB CPSDC)

    b. *Hudson (Re)*, 2017 CanLII 32151 (AB CPSDC)

    c. *Tlhape (Re)*, 2016 CanLII 74172 (AB CPSDC)

25. He described the relevant details of the three decisions, and described the reprimands, practice reviews, practice changes and assigned costs contained therein.

26. In *Halse*, the physician failed to order diagnostic imaging tests in a timely manner to diagnose concerning symptoms. In that case, a practice review was ordered, with changes to practice arising from the practice review's recommendations to be implemented, as well as a portion of costs.

27. In *Hudson*, a patient had returned to an emergency department for a third time with the same symptoms, but the physician did not order appropriate diagnostic tests. In that case, a practice review was ordered, with a requirement to undertake changes as recommended by the review, along with a reprimand and payment of costs.

28. In *Tlhape*, the physician did not properly assess nor ever attend a patient who was under the physician's care over the course of several months. The patient subsequently died without being seen by the physician. A practice assessment was ordered, with a requirement to implement any recommended practice changes arising from the assessment, as well as a reprimand and payment of costs.

29. The Regulated Member had previously undergone a CPSA Individual Practice Review (IPR) related to another matter. Both counsel agreed that the assessor would ideally be the same person for the IPR proposed in the Joint Submission. Oversight through the office of the Complaints Director assures coordination and potential merging of these IPRs in the interests of the sanction objectives. Timeliness of this IPR's initiation and completion will be assured through oversight by the office of the Complaints Director, with timing discretion to be exercised by the Complaints Director considering any extenuating circumstances.

30. Counsel for the Regulated Member noted that a portion of the education component, namely completion of the University of Calgary records keeping course has been accomplished by the Regulated Member.

31. The other education portion of the proposed sanctions addresses ethics training. This training is to address requisite understanding of the ethical foundations for appropriate health records entry. This component of the sanctions entails requirement of achievement of a passing grade in the ethics course that has been specifically identified by the Complaints Director. In the event the Regulated Member does not achieve a passing grade, a one-on-one ethics remedial training initiative will be arranged.

32. The Joint Submission proposes an assignment of costs that is somewhat lower than in other cited cases. The justification for this deviation from comparable cases is the additional steps being proposed that will result in additional costs to the Regulated Member and that will also better assure that the Regulated Member remains a valuable contributor to medical care for the served population.

33. Counsel for the Regulated Member also submitted that the Regulated Member has already undertaken some practice improvements that will be available for the IPR to assess regarding their sufficiency.

34. Finally, in agreeing to the Joint Submission, counsel for the Regulated Member submitted that the Regulated Member has saved the complainant from having to testify, and has also reduced the hearing time that would otherwise be required. Counsel expressed hope that the Hearing Tribunal would view the Regulated Member's admission and interest in practice improvements as evidence of her commitment to patient care.

VIII. ORDER AND REASONS FOR ORDER

35. After hearing submissions from the parties, the Hearing Tribunal accepts the Joint Submission presented by the parties.

36. The Hearing Tribunal decided this course of action for the following reasons:

    a. The terms of the Joint Submission are appropriate for the purpose of achieving the objectives of deterrence and rehabilitation.

    b. The terms of the Joint Submission are consistent with comparable decisions.

    c. The Hearing Tribunal accepts that, where the parties present a Joint Submission on sanction, the Hearing Tribunal is required to give serious consideration to the Joint Submission and should only interfere with the proposal of the parties if it is unfit or contrary to the public interest. The proposal submitted by the parties is reasonable given that the terms are in the range of established precedent cases and are not inappropriate based on the facts of this case.

d. The Complaints Director will have a longer term oversight role to assure improvements in knowledge and practice with this Regulated Member, can retain timing flexibility in the contouring of improvement assessments, and can return to this Hearing Panel if unsatisfied with the Regulated Member's compliance with the sanctions in the Joint Submission.

e. The assignment of costs recognizes appropriately the additional efforts and costs undertaken by the Regulated Member in improving her knowledge and practice. It also recognizes her admission and agreement which has reduced testifying burden for the complainant and hearing time.

f. The Regulated Member has acknowledged and admitted the facts and that the facts constitute unprofessional conduct. The Regulated Member has already undertaken some practice improvements, will undertake further education and will participate in an ongoing IPR. The Hearing Tribunal is satisfied that the Regulated Member is committed to improving her practices. Therefore, a reprimand will not further the aims of the Hearing Tribunal's decision and sanctions.

37. The Hearing Tribunal hereby orders pursuant to section 82 of the HPA:

a. That Dr. Srikisson shall, at her own expense, undergo an Individual Practice Review (IPR) to address the concerns identified in the Complaint investigation, shall be conducted by the same assessor as was involved in the IPR for College file 170307.1.1 if that assessor is available, and may be combined with a current IPR being conducted of Dr. Srikisson's practice only if combining the IPRs is agreeable to the Deputy Registrar who is responsible for the Continuing Competence program;

b. That Dr. Srikisson shall be enrolled in the IPR by January 15, 2022 and complete the initial assessment by May 15, 2022, and these deadlines may be extended by the Complaints Director if she is satisfied that the then current circumstances require an extension of the deadline; and

c. The Complaints Director shall receive a copy of the IPR report from the assessor.

d. Dr. Srikisson shall, to the satisfaction of the Complaints Director, implement changes to her practice and any upgrading, as may be recommended or identified in the IPR report.

e. If there is disagreement between the Complaints Director and Dr. Srikisson on the nature or degree of practice changes to be implemented, that the Hearing Tribunal shall retain authority to make that determination including whether any practice permit conditions should be imposed.

f. That Dr. Srikisson shall take the medical records keeping course from the University of Calgary (completed on September 15, 2021) and the

PROBE ethics and boundaries course (https://www.cpepdoc.org/cpep-courses/probe-ethics-boundaries-program-canada/ to be completed by June 30, 2022;

g. If Dr. Srikisson does not receive a passing grade for the PROBE ethics and boundaries course, the Complaints Director may direct Dr. Srikisson, at her own cost, to complete additional one-on-one remedial ethics training with Dr. Brendan Leier, or such other expert as chosen by the Complaints Director; and

h. That Dr. Srikisson shall be responsible for 60% 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 this 4th day of January, 2022.

Dr. Eric Wasylenko