RE: THE MATTER OF AN APPEAL PURSUANT TO S. 45(1) OF THE REGIONAL HEALTH SERVICES AND S. 8(1) OF *THE PRACTITIONER STAFF APPEALS* REGULATIONS WITH RESPECT TO THE RESPONDENT'S DECISION FOR THE IMMEDIATE SUSPENSION OF THE APPELLANT

BETWEEN:

DR. MUSBAH MUFTAH ABOUHAMRA

APPELLANT

AND:

PRAIRIE NORTH REGIONAL HEALTH AUTHORITY

RESPONDENT

DECISION OF THE PRACTITIONER STAFF APPEALS TRIBUNAL

Christina J. Glazer, Q.C. appeared and acted on behalf of the Appellant

Christopher c. Boychuk, Q.C. appeared and acted on behalf of the Respondent

A. INTRODUCTION

1. This is an appeal by Dr. Musbah Muftah Abouhamra, (the "Appellant"), pursuant to Section 45 of *The Regional Health Services Act* (the "Act") of a decision of the Board of the Prairie North Regional Health Authority (the "Board'") dated May 24, 2015 wherein the Board found as follows at paragraph 34:
    a. The immediate suspension of Dr. Musbah Muftah Abouhamra's appointment as a member of the Active Medical Practitioner Staff of the Prairie North Heath Region and his privileges at the Lloydminster Hospital, effective December 18, 2014, is confirmed;

b. The matter is referred to the Discipline Committee for consideration and recommendation in accordance with the process outlined in Part VIII of the Prairie North Regional Health Authority ("PNRHA") Practitioner Staff Bylaws (the "Bylaws"); and

c. The suspension of Dr. Musbah Muftah Abouhamra's appointment as a member of the Active Medical Practitioner Staff of the Prairie North Health Region and his privileges at the Lloydminster Hospital will continue pending the outcome of the Board's consideration of the recommendation of the Discipline Committee pursuant to Section 74 of the PNRHA Practitioner Staff Bylaws.

2. The Notice of Appeal dated June 11, 2015 appeals the decision of the Board on the following grounds:

   a. The decision is not in compliance with the requirements of S. 76 of the Prairie North Regional Health Authority *Practitioner Staff Bylaws* (the "Bylaws") in that the evidence considered by the Respondent's Senior Medical Officer (the "SMO"), and subsequently by the Respondent's Board, did not establish that the Appellant's conduct, performance or competence exposes or is reasonably likely to expose patients or others to harm or injury, is likely to be detrimental to the delivery of quality patient care, and immediate action, in the form of a suspension to protect patients or to avoid detriment to the delivery of quality patient care.

   b. The Respondent's Board failed to apply the appropriate legal test when it upheld the Appellant's suspension pursuant to Section 76 and 80 of the *Practitioner Staff Bylaws*.

   c. The Respondent ignored the uncontroverted evidence showing that all cases under review related to obstetrics and not gynecology, and ignored expert evidence of the important distinction between these disciplines thereby choosing to suspend the Appellant's gynecology privileges without any evidence whatsoever to support such a suspension.

d. The Decision is contrary to the law, and the evidence, and raises a reasonable apprehension of bias for the following reasons;

   i. The Respondent's Board ignored the uncontroverted evidence showing that the Appellant was suspended at the direction of the SMO for the PNRHA without notice of the investigation, or of the issues, and without being given any opportunity to respond;

   ii. The Respondent's Board refused the Appellant's request for production of the reports of quality assurance and critical incident reviews conducted in the cases under review, yet the Decision relies upon the SMO's verbal and unsubstantiated representations that interim suspension was necessary because the Appellant had not learned from the quality assurance or critical incident reviews;

   iii. The Respondent's Board ignored and failed to consider or give any weight to the uncontroverted factual and expert evidence showing procedural improprieties and systemic bias, which tainted the process leading up to suspension including: the SMO's failure to pursue an external assessment of the Appellant's competencies by independent external parties; the SMO's use of the quality assurance process to target the Appellant even in cases where the outcome was affected by systemic variables and multiple caregivers; the SMO's use of a collection of cases that were gathered over a protracted period of time and involved complications as opposed to issues of physician competency to justify interim suspension; the SMO's self appointment to multiple roles as investigator, expert witness, sole decision maker, and gatekeeper of information and reports gathered, but not disclosed to the Appellant, months in advance of the suspension.

e. The Respondent's Board disregarded and failed to consider the Appellant's expert opinions from reputable specialists in obstetrics and gynecology who reviewed the medical records for the cases under review and concluded the Appellant had met the standard of care in each case.

f. The Respondent's Board ignored the law regarding the inappropriate use of an interim suspension in the presence of conflicting opinions between reputable specialists regarding the appropriate standard of care.

g. The Respondent's Board ignored the long accepted legal principle that where there is more than one recognized method of diagnosis or treatment, a physician is not negligent in selecting one of the approved methods even though that method may not be favored by certain other practitioners;

h. There was no evidence of insufficient evidence before the Board to establish a reasonable likelihood of harm or injury or that immediate action was required.

i. The SMO and the Respondent's Board failed to consider or implement alternative measures available to address concerns pending a Hearing.

3. The Notice of Appeal requests the following relief:

   a. The Decision of the Respondent be quashed and the immediate suspension of the Appellant's obstetrical and gynecological privileges be set aside.

B. JURISDICTION OF THE TRIBUNAL AND NATURE OF THE APPEAL

4. The jurisdiction of this tribunal is set out in *Dr. J.G. van der Merwe v. Regina Qu'Appelle RHA* - August 18, 2011, a case heard by the Practitioner Staff Appeals Tribunal, at paragraphs 5 and 7 as follows:

> The jurisdiction of this tribunal is derived, in part, from Section 45(1) of the Act which provides:
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> > "**45**(1) A person who is aggrieved by a decision of a regional health authority or an affiliate made in relation to the following matters may, in accordance with the regulations, appeal the decision to a tribunal established by the regulations:

a) the appointment of the person to the practitioner staff or the reappointment, suspension, or termination of appointment of the person;

b) the disciplining of the person as a member of the practitioner staff;

c) the granting of privileges to the person as a member of the practitioner staff, or the amending, suspending or revoking of privileges granted to the person."

Pursuant to Section 64 of the Act, the Practitioner Staff Appeals Regulations (the "Regulations") were enacted which provide, inter alia:

> "**8**(1) A practitioner who is aggrieved by a decision of a board with respect to a matter set out in subsection 45(1) of the Act may appeal that decision to the tribunal by serving a notice of appeal on the tribunal and a copy of the notice of appeal on the respondent within 30 days after the day on which the practitioner is served with a copy of the decision."
> .....
>
> "**11**(1) An appeal to the tribunal shall be conducted as a hearing *de novo*.
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> (2) At a hearing, the appellant and the respondent have the right to appear before the tribunal and may, at their own expense, be represented by counsel."
> .....
>
> "**12**(1) At a hearing, the tribunal may accept any evidence that it considers appropriate and is not bound by rules of law concerning evidence."

5. There were no objections by either party to this appeal with respect to the Tribunal's jurisdiction to hear this matter. There was also no objection by either party that the nature of this appeal is a hearing *de novo* pursuant to Section 11(1) of the Regulations; however, both parties agreed to proceed with a hearing on the record and no witnesses were called as it was an expedited appeal (as requested in the Notice of Appeal). Both

the Respondent and the Appellant were represented by counsel. Both counsel agreed to proceed with the appeal by providing oral and written submissions to the Tribunal and no viva voce evidence was presented to the Tribunal on the hearing date of September 16, 2015.

C. EVIDENCE BEFORE THE TRIBUNAL

6. At the appeal hearing, both counsel agreed to the following written evidence being considered by the tribunal:
    a. Binder A entitled, "Documents filed at Board Hearing on Behalf of Dr. Abouhamra" which consists of eight tabs as set out in the Index of Documents for the Appellant.
    b. Binder B entitled, "Documents filed at Board Hearing on Behalf of Prairie North Regional Health Authority" which consists of 12 tabs as set out in the Index of Documents for the Appellant.
    c. Written Submission on behalf of the Respondent dated September 10, 2015
    d. Briefs of Law and Argument on behalf of the Appellant, Musbah Abouhamra, dated May 18, 2015 and August 7, 2015.
    e. Book of Authorities on behalf of the Appellant, Musbah Abouhamra
    f. Decision and Reasons in the Matter of a hearing by the Board of the Prairie North Regional Health Authority to review the immediate suspension of Dr. Musbah Muftah Abouhamra dated May 24, 2015
    g. Binder C entitled, "Full patient charts for cases under Review" which was separated into three binders and which contains the patient charts for the five cases. These binders were not before the Board.

h. Correspondence dated July 31, 2015 from Femi Olatunbosun, MD to Christine J. Glazer, Q.C.

7. As indicated, both counsel agreed to not call viva voce evidence, but rather to proceed on the basis that the evidence called at this hearing would consist only of the written material filed before the Board. However, there was insufficient coordination between counsel with respect to these materials such that the naming and numbering of written exhibits was inconsistent as between the Appellant's materials and the Respondent's materials. On occasion, counsel referred to evidence during the course of argument, which evidence was not before the Board initially and not in any of the materials filed. As a result, it became a challenging task for the Tribunal to set out an accurate chronology of events leading up to the suspension of Dr. Abouhamra, which therefore necessitated a lengthy and in-depth review of the materials prior to reviewing same for the purposes of writing this decision.[1]

D. EVIDENCE / FACTS

8. Lengthy oral submissions were presented by counsel for both parties, which are summarized in their written brief / submission. The following has been distilled from the materials provided.

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[1] *In this matter, it would have been beneficial to the Tribunal for counsel to have provided materials which were orderly (preferably chronological) and which fully contained the evidence to be reviewed in an accurate fashion. It would have assisted greatly had the parties agreed on how to refer to each patient. For example, one case was referred to as Patient 4 by the Respondent and referred to as Case #1 or "H.N." by the Appellant. Further, it is noted that the materials in Binder A are not in order and this made it difficult for the Tribunal to review the materials and follow along with the various patients. The Appellant's affidavit at paragraph 123 sets out attached and marked as Exhibit "CC" the case summary of E.A. The exhibit "CC" is actually the case of the fetal demise or patient "C.C." Again at paragraph 136 of the Appellant's affidavit, the case summary for C.C. is not found at Exhibit "DD" but is actually at tab "CC". A similar error occurs with regards to the case summary for C.W. The Tribunal notes that it would have been helpful to be provided with all materials prior to the hearing date, as additional materials were provided at the hearing, including the Board Decision. The Notice of Appeal by the Appellant was not in any of the materials.*

9. The Appellant is a specialist in obstetrics and gynecology and obtained his medical degree in Libya in 1988. The Appellant trained and worked in the area of general surgery for six years before immigrating to Canada where he entered into a Residency Training Program in obstetrics and gynecology in Calgary, Alberta from 1999 to 2003. The Appellant completed his Canadian Fellowship exams and then commenced work in 2003 in Lloydminster with his wife, a fellow doctor, and he has had hospital privileges in the PNRHA for 12 years.

10. Five cases were brought to the attention of the SMO between September 2013 and December 2014 as each patient suffered complications. Dr. Prollius was the SMO at the relevant times and continues to be the SMO. The PNRHA submits that the SMO reviewed cases and received concerns which dealt with the Appellant's ability to handle complications experienced by patients. The PNRHA submits that there were four common issues throughout the five cases with the Appellant's ability to manage complications, which are as follows:
    a. The lack of charting. The PNRHA submitted that the progress notes of the Appellant are very scant, even when dealing with serious complications.
    b. The failure of the Appellant, when called by nursing staff when there is a patient in distress, to respond appropriately, in particular, in a high risk situation.
    c. The failure of the Appellant to attend to the patient and assess the gravity of risk.
    d. Even when attending, the interventions that were done by the Appellant were not done in a timely fashion

11. The first case that was brought to the SMO's attention is referred to as Patient 5 by the Respondent and Case #2 or "N.W." by the Appellant. For the sake of consistency, this Decision will refer to the patients by their initials. N.W. was admitted on September 13, 2013 in early labor. The Appellant was the delivering physician. N.W. experienced post-partum hemorrhaging post-delivery which required a hysterectomy to control the bleeding. The SMO had concerns with the Appellant's care which was provided to N.W.

These concerns were brought to the Appellant's attention via letter dated October 8, 2013. In the letter of October 8, 2013, the SMO identifies several issues which contributed to the morbidity which N.W. suffered and the SMO requested comments in reply.[2] The Appellant obtained legal counsel and submitted a reply to the SMO's letter on December 6, 2013. A Critical Incident Review (or Critical Incident Conference) was subsequently held with regards to N.W. on January 28, 2014. The Critical Incident Review Report was provided to the Appellant's counsel on March 31, 2014 and outlined a list of recommendations at pages 5 and 6. The recommendations were directed toward multiple disciplines and not only the Appellant.[3]

12. The second case that was brought to the SMO's attention is referred to as Patient 4 by the Respondent and Case #1 or "H.N." by the Appellant. This was a case of infant hypoxic brain injury that occurred in November of 2013. The Appellant first saw the patient on November 30, 2013 and she was under the care of another physician. The Appellant was consulted regarding concern with the fetal heart rate. This case involved the interpretation of the electronic fetal monitoring strips. The Appellant states he did attend a Quality Assurance Meeting with respect to H.N. but not a Critical Incident Review. The Appellant states he knew nothing about any concerns with this case; however, the Respondent's submissions were that within the Quality Assurance Process,

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[2]*The Appellant's Brief of Law and Argument dated August 7, 2015 at paragraph 15 sets out the SMO's letter. This contained a "Root Cause Analysis" and a number of action plans (attached as Exhibit "H" to the Appellant's affidavit), including conduct of an audit of five cases of the Appellant that preceded the case of N.W. and that the SMO advised a report of this audit would be prepared and provided to the Appellant. However, Exhibit "H" to the Appellant's affidavit sworn on May 9, 2015 only contains the letter of October 8, 2013 to the Appellant and his spouse, and 3 pages entitled "Review."*

[3]*The Appellant's affidavit sworn on May 9, 2015 also sets out that a Quality Assurance meeting was also held with respect to N.W. No concrete evidence was provided to this Tribunal as to what distinguishes the two processes (Critical Incident Conference / Review versus Quality Assurance Meeting) and when a Quality Assurance Meeting is held. Evidence was provided about the Critical Incident Review process and the use of the Critical Incident Reports. All five cases before the Tribunal fell within the definition of "critical incident" within the meaning of Section 58 of the Regional Health Services Act. However, the evidence was not clear as to what circumstances initiate the need for a Quality Assurance Meeting.*

any concerns that did exist would have been brought to the Appellant's attention in the Quality Assurance Meeting. The Appellant states that in the Quality Assurance Meeting, he was told the baby was doing well. However, the Respondent's Power Point presentation to the Board verifies that the baby established severe brain injury (HIE Stage 3) on day nine of life along with multiple other life-long complications.

13. As a result of the two cases, N.W. and H.N., the SMO, by correspondence to the College of Physicians and Surgeons dated January 17, 2014, requested an external opinion to assess physician competency. On July 11, 2014, six months later, Dr. Shaw of the College of Physicians and Surgeons replied, essentially explaining the process and asking for further information. Dr. Shaw followed up with a further letter on August 29, 2014. The SMO replied to Dr. Shaw by email on September 3, 2014 that as of September 3, 2014, discharge summaries had not been prepared by the Appellant for the two patients and the SMO was unable to provide these to Dr. Shaw as requested. In this email, the SMO provided more thorough information about his concerns. The SMO attached two reviews (which are not attached to the email in the materials provided to the Tribunal). The SMO indicated in his email that since the case of N.W. and H.N., the Appellant had been involved in four different instances where the care could be questioned and he provided some details about each case. The SMO indicated that the Appellant has been involved in all of the Critical Incident Reviews and the Appellant stated "I would not do anything different." The SMO included a review of some charts which were done by the Clinical lead for Obstetrics in Lloydminster and advised she also expressed frustration over the Appellant "when his opinions clash with best practice and influences the culture of susceptible nurses and physicians" (which were also not attached to the email in the materials provided to the Tribunal). The SMO advised he was going to obtain an independent review of the latest four critical incidents.

14. The Appellant sets out that he did not prepare a discharge summary with respect to N.W. as he instead completed a comprehensive operating room report. The patients had been discharged in September and November of 2013. The Appellant states that these cases were never directed to him to address concerns with his care; however, the Appellant states that Critical Incident Reviews did occur. The Appellant admits that he did attend Quality Assurance Meetings for H.N., N.W., C.W. and E.A. The Appellant's Brief of Law sets out the Appellant was unaware of any concerns. However, the Appellant's affidavit at paragraph 72 sets out that he was advised of concerns and the SMO's disagreement with certain aspects of his management of the patients in the Quality Assurance Meetings for H.N., N.W. and C.W. The SMO was not present for the Quality Assurance Meeting that the Appellant attended with respect to E.A.

15. The SMO obtained an external review of N.W., H.N. (both referred to above) and a third case which the Respondent refers to as Case Number 5 – Sepsis in September of 2014 or Patient 3 and what the Appellant refers to as Case #3- Maternal Death, or "C.W." C.W. was admitted on September 27, 2014 and an unfortunate maternal death occurred. A Quality Assurance Meeting of C.W. was held. Evidence does not indicate if or when a Critical Incident Review was held.

16. The SMO solicited two independent experts to assess the situation. The reports of those experts with respect to the three cases were received by the SMO in October of 2014. Dr. van Rensburg and Dr. Almas completed reviews of the cases and confirmed the SMO's views on the mismanagement by the Appellant of N.W. and H.N. The expert reviews identified concerns consistent with the SMO as follows:
    a. The inadequacy of the charting of the Appellant;
    b. The failure of the Appellant to attend promptly when called by nursing staff;
    c. The failure to attend and assess the patient; and
    d. The failure to recognize the gravity of the patient's condition and to order out appropriate interventions.

17. Paragraphs 30, 31, 33 and 34 of the Respondent's written submission summarizes the expert's review of patients N.W. and H.N. and both noted concerns with the Appellant's management of these patients. The external reviews also identified concerns with respect to C.W. although they noted that the Appellant's management of the patient would not have affected the outcome. Dr. Alma's external review noted concerns with the Appellant's lack of proper charting and failure to respond to nursing calls for assistance and failure to attend and assess patient C.W. Dr. van Rensburg's external review of patient C.W. did not find any specific concerns.

18. The fourth case that came to the attention of the SMO is referred to as Patient 2 – postpartum hemorrhage – October 2014 by the Respondent and Case #4 or "E.A." by the Appellant. This case occurred shortly after the external reviews of the three cases above. This patient was admitted on October 26, 2014 and involved a postpartum hemorrhage. The SMO reviewed this case as the SMO practices in the same specialty as the Appellant. The SMO identified concerns which were consistent with the other cases, that being a lack of proper documentation by the Appellant, a failure by the Appellant to respond to nursing calls to attend and assess the patient and a failure by the Appellant to recognize the severity of the patient's condition. A Critical Incident Review was held with respect to E.A. and the same occurred after the Appellant's suspension. The SMO discussed the concerns about E.A. with the Appellant prior to the suspension.

19. Shortly thereafter, a fifth case came to the attention of the SMO. This case is referred to as Patient 1 – uterine rupture – December 2014 by the Respondent and Case #5 or "C.C." by the Appellant. This patient was admitted on December 2, 2014 and resulted in a fetal demise. The SMO again personally conducted a review of this case as he is in the same specialty as the Appellant. The SMO's review found the same issues with the Appellant's management of the case as in the previous cases.

20. The Respondent submits that with the exception of C.C., all concerns were raised directly with the Appellant both within the context of the Quality Assurance Meeting and/or Critical Incident Reviews, as well as in telephone calls and in one instance a separate meeting with the Appellant. Further, concerns in writing were provided to the Appellant with respect to N.W. The Appellant's affidavit admits to attending Quality Assurance Meetings with respect to N.W., H.N., C.W. and E.A. The Appellant also attended Critical Incident Reviews with respect to N.W., H.N. and E.A.

21. As a result of the external reviews of N.W., H.N. and C.W. and the SMO's review of C.C and E.A., the SMO formed the opinion that the Appellant's performance had a reasonable likelihood of exposing patients to harm or injury and that immediate action must be taken to protect the patients of the Respondent, pursuant to Section 76(1) of the Bylaws. Section 76 of the Bylaws sets out:

    76(1) Notwithstanding anything in these Bylaws, the SMO or the chief executive officer may immediately suspend the appointment of a member or the member's privileges in circumstances where in the opinion of the SMO or chief executive officer:

    a) The conduct, performance or competence of a member exposes, or is reasonably likely to expose patient(s) or others to harm or injury, or is reasonably likely to be detrimental to the delivery of quality patient care provided by the regional health authority; and

    b) Immediate action must be taken to protect the patient(s) or others or to avoid detriment to the delivery of quality patient care.

    (2) The SMO or the chief executive officer shall immediately advise the member of the suspension.

    (3) Within forty-eight (48) hours of the immediate suspension, the SMO or chief executive officer who suspended the member shall provide the member with written reasons for the suspension, which shall constitute a referral under clause 65(5)(d).

22. The SMO immediately suspended the appointment of the Appellant. The Respondent submits that the suspension was based on consistent concerns which arose when a patient was suffering complications. The concerns regarding the Appellant were identified as follows:

    a. Inadequate charting;
    b. The failure to respond appropriately to nursing calls including the failure to assess patients and intervene at appropriate times;
    c. Lack of ability to identify high risk factors and put in appropriate patient management plans in the case of high risk patients; and
    d. The failure to appropriately manage the complications when they arose.

23. On December 18, 2014, the Appellant received the notice of suspension. On December 20, 2014, the Appellant was served with a Notice of Hearing and written reasons for the suspension under cover of letter dated December 19, 2014, which is in accordance with Section 76(3) of the Bylaws. The Appellant was also provided with the documents relied upon by the SMO including copies of the patient charts for each of the five cases; the written external reviews of Dr. Almas and Dr. van Rensburg; and additional documents filed in the Binder. The external review by Dr. van Rensburg with respect to C.W. was subsequently provided to the Appellant's counsel.

24. Pursuant to Section 77 of the Bylaws, such matters are to be set for a Board Hearing within 14 days of the immediate suspension. The matter was set down for a hearing on December 30, 2014, however, was subsequently adjourned at the request of the Appellant.

25. The Board hearing occurred on May 20, 2015 and it is the Board Decision that brings the matter to the Tribunal.

E. ANALYSIS OF GROUNDS OF APPEAL

a. **The Decision is not in compliance with the requirements of S. 76 of the Prairie North Regional Health Authority *Practitioner Staff Bylaws* (the "Bylaws") in that the evidence considered by the Respondent's Senior Medical Officer (SMO), and subsequently by the Respondent's Board, did not establish that the Appellant's conduct, performance or competence exposes or is reasonably likely to expose patients or others to harm or injury, is likely to be detrimental to the delivery of quality patient care, and immediate action, in the form of a suspension to protect patients or to avoid detriment to the delivery of quality patient care.**

With respect to the first ground of appeal, in order for the wording to make sense, the Tribunal has reworded it as follows:

a. The decision is not in compliance with the requirements of S. 76 of the Prairie North Regional Health Authority Practitioner Staff Bylaws in that the evidence considered by the Respondent's Senior Medical Officer (the "SMO"), and subsequently by the Respondent's Board, did not establish that the Appellant's conduct, performance or competence exposes or is reasonably likely to expose patients or others to harm or injury, is detrimental or is likely to be detrimental to the delivery of quality patient care, and therefore, immediate action, in the form of a suspension to protect patients or to avoid detriment to the delivery of quality patient care was not required.

26. Section 76 is set out above in paragraph 21. The Tribunal dismisses this ground of appeal as the evidence establishes that the SMO did reasonably form the opinion that the conduct, performance or competence of the Appellant exposed or was likely to expose patients or others to harm or injury or was reasonably likely to be detrimental to the delivery of quality patient care provided by the PNRHA and that immediate action must be taken to protect the patients or others, or to avoid detriment to the delivery of quality patient care.

27. At the time of the suspension, December 18, 2014, the SMO had received the results of an external review of three separate cases, which identified concerns with the Appellant's management of the cases. The first two cases occurred in September and November of 2013. The third case arose in September of 2014. The external reviews were received by the SMO in early October of 2014. Shortly after receiving the external reviews, two more cases came to the attention of the SMO in October and December of 2014 which identified similar concerns to those reviewed by the external reviewers. Based on this information, the SMO formed a reasonable opinion that immediate action must be taken to protect the patients or to avoid detriment to the delivery of quality patient care. The key time frame is at the date of suspension. The Tribunal agrees with the Respondent that the opinion of the SMO to immediately suspend the Appellant was reasonable based on the information before him at the time of the suspension. The concerns raised with the management of patients by the Appellant were consistent and duplicated in multiple cases. The SMO is qualified to review the Appellant's cases and due to the emergency of the situation, the SMO was entitled to complete his own reviews of patients E.A. and C.C. and there is no requirement to submit them for external review.

28. The Tribunal finds that Section 76 of the Bylaws were complied with and dismisses this ground of appeal.

b. The Respondent's Board failed to apply the appropriate legal test when it upheld the Appellant's suspension pursuant to Section 76 and 80 of the *Practitioner Staff Bylaws*.

29. The Board's decision at paragraph 8 sets out that at the Board Hearing, the Appellant submitted that the test for an immediate suspension was one of "imminent risk" or "imminent danger" to a patient. The Board found that this is too narrow a test and is not consistent with the wording of Section 76. The Board found that in assessing the imposition of the immediate suspension, the Board must do so in light of the Bylaw provisions. The Board went on to outline the reasons for the immediate suspension and

the concerns raised with the Appellant's management of the cases presented, including a review of the external reviews by Dr. Almas and Dr. van Rensburg and the review of the expert reports filed by the Appellant. The Board found that even those expert reports filed by the Appellant were not entirely supportive of the Appellant's performance. The Board found recurring themes in all of the reports reviewed. The Board noted that it considered the fact that an immediate suspension has the potential for a serious impact on an individual physician but that patient safety must take priority. The Board took into account that differing views may be presented concerning the management of any case. However, it found repeated incidents relating to the Appellant's failure to attend and assess the gravity of risk in a timely fashion, thus making earlier intervention impossible. Finally, it found that the Appellant failed to comply with region policies, including those relating to effective charting.

30. The Tribunal finds that the Board did apply the appropriate legal test when it upheld the Appellant's suspension pursuant to Section 76 and 80 of the Practitioner Staff Bylaws and dismisses this ground of appeal.

31. The Appellant submitted case law for the authority that Regional Health Authorities do not have the jurisdiction to determine whether a physician is competent and that a suspension is a last resort. It is the position of the Tribunal that the Board did not make a decision as to whether or not the Appellant was incompetent and the matter was referred to the discipline committee for further review. This is an interim suspension of the Appellant and not a final decision. The discipline committee hearing allows for the direct examination and cross-examination of the committee members who have more medical training and who are better able to review the Appellant's management of the cases. The basis for the SMO's opinion pursuant to Section 76 of the Bylaws was present.

c. The Respondent ignored the uncontroverted evidence showing that all cases under review related to obstetrics and not gynecology, and ignored expert evidence of the important distinction between these disciplines thereby choosing to suspend the Appellant's gynecology privileges without any evidence whatsoever to support such a suspension.

32. Evidence presented to the Board and the Tribunal indicates that the concerns regarding the Appellant are his management of high risk and complicated cases, failure to attend to patients in a timely manner, failure to adhere to policies in relation to proper charting and failure to provide early intervention. While there may be a difference in the actual practice of obstetrics and gynecology as described in the April 7, 2015 letter of Dr. Olatunbosun, the concern of the SMO and the Board was in relation to the Appellant's over all care of patients and patient management, particularly in any critical and pressing medical situation. Therefore this Tribunal finds that the suspension with respect to both gynecology and obstetrics was appropriate and dismisses this ground of appeal.

d. The Decision is contrary to the law, and the evidence, and raises a reasonable apprehension of bias for the following reasons;

i. The Respondent's Board ignored the uncontroverted evidence showing that the Appellant was suspended at the direction of the SMO for the PNRHA without notice of the investigation, or of the issues, and without being given any opportunity to respond;

33. The Tribunal dismisses this ground of appeal. As previously set out in this Decision, it was noted that there was evidence that the Appellant was provided with notice of the concerns.

34. The Appellant attended Quality Assurance Meetings with respect to H.N., N.W., C.W. and E.A. The Appellant attended a Critical Incident Review with respect to N.W. and E.A. The

evidence is not clear as to whether or not Critical Incident Reviews occurred with respect to H.N and C.W; however, the Respondent's evidence was that all of the cases fell within the definition of a "critical incident" pursuant to Section 58 of the Act and critical incident reports are prepared by the Quality Care Committee. The use of critical incident reports is not permitted during an investigation of a critical incident pursuant to Section 58(5) and (6) of the Act and the Respondent did not rely on the reports; nevertheless the Appellant was at all times aware of the issues raised in these cases.

35. The Appellant also had notice of the concerns with respect to the first case, N.W., and was provided with an opportunity to respond and did so with the assistance of legal counsel.

36. The Respondent's evidence is that the SMO also spoke with the Appellant in a meeting and had telephone calls with the Appellant advising of concerns. The evidence is that disclosures were made to the Appellant within the processes in place and the Appellant's response to the concerns were that his management of the patients was appropriate; he was not prepared to do anything different; and he attributed the issues to the nursing staff.

37. Section 76 of the Bylaws outlines the procedure for suspension. There is no requirement in the Bylaws to have a formal hearing or formal notice prior to the SMO making a decision to suspend. In the Van der Merwe decision, a distinction was made between the procedure in the Bylaws for discipline matters and interim suspensions. The obligations with respect to discipline matters are not imposed upon the SMO for interim suspensions. In Van der Merwe the majority of the Board found that the SMO missed a number of opportunities to set up alternate means of insuring patient safety and addressing the risks. In the matter before this Tribunal, there is evidence that the SMO did discuss the concerns with the Appellant, and the Appellant failed to take any

responsibility for the same or acknowledge that any of his actions required a review. In Van der Merwe, the Appellant was willing to take steps to address the SMO's concerns.

ii. The Respondent's Board refused the Appellant's request for production of the reports of quality assurance and critical incident reviews conducted in the cases under review, yet the Decision relies upon the SMO's verbal and unsubstantiated representations that interim suspension was necessary because the Appellant had not learned from the quality assurance or critical incident reviews;

38. The evidence does not suggest that the Respondent's Board refused the Appellant's request for production of the reports of quality assurance and critical incident reviews. The evidence is that the Appellant was in attendance at the meetings and reviews and he was aware of the concerns by his attendance. The evidence is that at the time of the suspension on December 18, 2014, two of the Critical Incident Reviews with respect to N.W. and E.A. had not been prepared; therefore, disclosure of the Reviews was not possible. While the circumstances of the situations with N.W. and E. A. were factors leading to the suspension of the Appellant, reviews were not relied on to support that suspension. The evidence is that Critical Incident Reviews are not to be used during an investigation as the purpose of them is not fault finding. The information in the Reviews is privileged. The evidence is that the Appellant's counsel first asked for copies of the Quality Assurance Meetings or Critical Incident Reviews on May 6, 2015, which is some time after the suspension. The Tribunal agrees with the Board's decision that the SMO had formed a reasonable opinion based on the five cases before him. The Tribunal dismisses this ground of appeal.

iii. The Respondent's Board ignored and failed to consider or give any weight to the uncontroverted factual and expert evidence showing procedural improprieties and systemic bias, which tainted the process leading up to suspension including: the SMO's failure to pursue an external assessment of the Appellant's

competencies by independent external parties; the SMO's use of the quality assurance process to target the Appellant even in cases where the outcome was affected by systemic variables and multiple caregivers; the SMO's use of a collection of cases that were gathered over a protracted period of time and involved complications as opposed to issues of physician competency to justify interim suspension; the SMO's self appointment to multiple roles as investigator, expert witness, sole decision maker, and gatekeeper of information and reports gathered, but not disclosed to the Appellant, months in advance of the suspension.

39. The Tribunal dismisses this ground of appeal for reasons already identified. The Tribunal does not find any evidence of procedural improprieties or systemic bias which tainted the process. All procedures according to the Bylaws were followed. The SMO did obtain external assessments of three cases. Due to the timing of the last two cases and the consistent concerns that were present in all of the cases, the SMO had a reasonable concern for immediate patient safety and the quality of patient care that required immediate action. It is acknowledged that the outcome of each case is not necessarily attributable solely to the actions of the Appellant and systematic variables do come into play. However, these variables and the direct impact of the Appellant's actions are better assessed by the expertise of the discipline committee. Consistent concerns about the Appellant's conduct were present in each case, although each case standing alone might not have resulted in the outcome; there was a cumulative effect. The SMO was in the same specialty as the Appellant and had an obligation and right to review the Appellant's cases. The SMO arranged for external reviews of the three cases, which confirmed the SMO's concerns. The SMO received the external reviews in October of 2014, and the next two cases which caused concerns happened shortly thereafter. As a result, the SMO felt that he had no alternative but to take immediate action. The Tribunal dismisses this ground of appeal.

(e) The Respondent's Board disregarded and failed to consider the Appellant's expert opinions from reputable specialists in obstetrics and gynecology who reviewed the medical records for the cases under review and concluded the Appellant had met the standard of care in each case.

40. The relevant time is the date of the suspension, December 18, 2014. The Bylaws set out the basis for the suspension. The Tribunal finds that at the relevant time, the evidence before the SMO led the SMO to have a reasonable opinion that immediate action must be taken to protect patient safety.

41. The Appellant's expert opinions, obtained after suspension, differ from the external reviews obtained by the SMO prior to suspension. However, it is noted that even the Appellant's expert opinions still do find concerns with the Appellant's management of his patients. A full review of the Appellant's management of the patients is best left to the Discipline Committee. The Tribunal dismisses this ground of appeal.

(f) The Respondent's Board ignored the law regarding the inappropriate use of an interim suspension in the presence of conflicting opinions between reputable specialists regarding the appropriate standard of care.

42. The Board considered the fact that there will be conflicting opinions between specialists regarding the appropriate standard of care. At the time of the suspension, the SMO is found to have had a reasonable opinion that patient safety was at risk. This ground of appeal is dismissed.

(g) The Respondent's Board ignored the long accepted legal principle that where there is more than one recognized method of diagnosis or treatment, a physician is not negligent in selecting one of the approved methods even though that method may not be favored by certain other practitioners;

43. Neither the SMO nor the Board alleged negligence on the part of the Appellant. This ground of appeal is dismissed.

h. There was no evidence or insufficient evidence before the Board to establish a reasonable likelihood of harm or injury or that immediate action was required.

44. The Tribunal dismisses this ground of appeal as the evidence establishes that the SMO did reasonably form the opinion that the conduct, performance or competence of the Appellant exposed or was likely to expose patients or others to harm or injury or was reasonably likely to be detrimental to the delivery of quality patient care provided by the PNRHA and immediate action must be taken to protect the patients or others or to avoid detriment to the delivery of quality patient care.

i. The SMO and the Respondent's Board failed to consider or implement alternative measures available to address concerns pending a Hearing.

45. As previously indicated, the Bylaws were complied with. There was no evidence with respect to the manner of alternative measures that were available. This ground of appeal is dismissed.

F. CONCLUSION:

46. For the reasons described above, this Tribunal upholds the decision of the Prairie North Regional Health Authority Board as follows:

a. The immediate suspension of Dr. Musbah Muftah Abouhamra's appointment as a member of the Active Medical Practitioner Staff of the Prairie North Health Region

and his privileges at the Lloydminster Hospital, effective December 18, 2014, is confirmed;

b. The matter is referred to the Discipline Committee for consideration and recommendation in accordance with the process outlined in Part VIII of the PNRHA Practitioner Staff Bylaws; and

c. The suspension of Dr. Musbah Muftah Abouhamra's appointment as a member of the Active Medical Practitioner Staff of the Prairie North Health Region and his privileges at the Lloydminster Hospital will continue pending the outcome of the Board's consideration of the recommendation of the Discipline Committee pursuant to section 74 of the PNRHA Practitioner Staff By aws.

DATED this 22nd day of December, 2015.

Practitioner Staff Appeals Tribunal

Leslie T. K. Sullivan, Q.C.

Dr. Suresh Kassett, Member

Shelley Cannon, Vice-Chairperson