

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Chantal Proulx, Designated Vice-Chair, Presiding
Deborah Coyne, Board Member
Leslie Kirke, Board Member*

* Ms. Kirke did not participate in the final decision

Heard January 28, 2011 at Toronto, Ontario

IN THE MATTER OF A COMPLAINT REVIEW UNDER SECTION 29(1) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, c.18, as amended

B E T W E E N:

E.J.W.

Applicant

and

M.G.C., MD, D.J.L., MD, M.J.O., MD and S.W.T., MD

Respondents

Appearances:

The Applicant:	E.J.W.
For the Applicant:	Susan Gans, Counsel
For the Respondents:	Alexi Wood, Counsel
For the College of Physicians and Surgeons of Ontario:	Pearl Wood (by teleconference)

DECISION AND REASONS

I. DECISION

1. It is the decision of the Health Professions Appeal and Review Board to confirm the decision of the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario with respect to Dr. O. and Dr. T. and to return to the Committee its decision with respect to Dr. C. and Dr. L. with the requirement that it

reconsider its assessment of the complaints respecting Dr. C. and Dr. Livingston in accordance with these reasons.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by E.J.W. (the Applicant) to review a decision of the Inquiries, Complaints and Reports Committee (the Committee) of the College of Physicians and Surgeons of Ontario (the College). The decision concerned a complaint regarding the conduct and actions of M.G.C., MD; D.J.L., MD; M.J.O., MD; and S.W.T., MD (the Respondents). The Committee investigated the complaint and decided to take no further action.

II. BACKGROUND

3. The Applicant's father, Douglas DeGuerre (the patient), was a resident in the Veteran's Wing at Sunnybrook Health Sciences Centre (SHSC). The Respondents each provided care to the patient during his stay at SHSC.
4. The patient had a complex medical history and he was receiving hemodialysis. On September 10, 2008, the patient was admitted to the Emergency Department (ED) at SHSC due to the progression of ischemia in his legs. On September 17, 2008, the patient underwent bilateral above knee amputations as a palliative measure due to the presence of sepsis and severe pain.
5. In the days following his surgery, the patient's condition deteriorated and on September 22, 2008, a Do Not Resuscitate (DNR) order was instituted. The patient passed away later that day from complications of congestive heart failure and renal failure.
6. Dr. C. (anaesthesiologist), Dr. L. (internal medicine), Dr. T. (nephrology) and Dr. O. (nephrology) were all part of the medical team who provided care to the patient after his admission to the ED and subsequent to the patient's surgery.

7. The Applicant was appointed as the Substitute Decision Maker (SDM) for the patient.

The Complaint

8. The Applicant expressed many concerns about the care the patient received from the Respondents following his surgery on September 17, 2008. For ease of reference, the Board will list the various complaints pertaining to each Respondent separately.

Dr. C.:

- did not inform the Applicant that her father was deteriorating;
- wrote a DNR order on the patient's chart without the Applicant's consultation or permission; and
- refused the patient resuscitative treatment on September 22, 2008.

Dr. L.:

- co-signed an unauthorized DNR order and failed to follow SHSC policies regarding DNR orders;
- denied treatment, knowing that it would cause the patient's death; and
- allowed an inexperienced junior resident to care for the patient without proper supervision.

In addition, Dr. L. failed to:

- adequately document a complete assessment, medical history, pre-operative surgical assessment, and daily progress notes;
- advocate for the patient or develop and communicate a pre/post-operative care plan that included arrangements for care and medications;
- adequately manage the patient's dialysis treatment;
- arrange for an ICU bed for the patient in a timely manner;
- order IV infusion to be controlled by an infusion pump;

- advise and make arrangements for the use of an epidural analgesic and a central line for post-operative pain control; and
- adequately communicate with the Applicant.

Both Drs. O. and T. failed to:

- monitor fluid levels, and
- adequately administer hemodialysis.

The Committee's Investigation and Decision

9. In the course of its investigation, the Committee reviewed the following information and documents:

- letters of complaint from the Applicant and subsequent communications;
- letters of response from all the Respondents;
- medical records from Dr. Livingstone and SHSC;
- records from the Office of the Chief Coroner;
- policies from SHSC;
- CPSO policy #1-06 - Decision-making for the End of Life;
- correspondence from McCarthy Tétrault LLP, Counsel for all Respondents;
- correspondence from Ru Taggar, SHSC; and
- an independent opinion of a medical expert regarding the care provided by the Drs. O. and T..

10. The Committee investigated the complaint and decided to take no further action.

III. REQUEST FOR REVIEW

11. Dissatisfied with the decision of the Committee, in a letter dated June 10, 2010, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

12. After conducting a review of a decision of the Committee, the Board may do one or more of the following:
 - a) confirm all or part of the Committee's decision;
 - b) make recommendations to the Committee;
 - c) require the Committee to exercise any of its powers other than to request a Registrar's investigation.
13. The Board cannot recommend or require the Committee to do things outside its jurisdiction, such as make a finding of misconduct or incompetence against the member, or require a referral of allegations to a discipline hearing that, if proved, would not constitute either professional misconduct or incompetence.

V. ANALYSIS AND REASONS

14. Pursuant to section 33(1) of the *Health Professions Procedural Code* (the *Code*), being Schedule 2 to the *Regulated Health Professions Act, 1991*, the mandate of the Board in a complaint review is to consider either the adequacy of the Committee's investigation, the reasonableness of its decision, or both.
15. The Board reviewed the Applicant's request for a review, as well as the Record of Investigation (the Record), which includes all the information and documents the Committee considered. The Board had the benefit of written submissions from both Counsel for the Applicant and Counsel for the Respondents. At the Review, the Applicant, Counsel for the Applicant and Counsel for the Respondents made oral submissions that assisted the Board in its deliberations.

16. On March 17, 2011, Counsel for the Applicant forwarded to the Board a copy of the decision issued by Madam Justice Himel in *Rasouli v. Sunnybrook Health Sciences Centre and Cuthbertson*, 2011 ONSC 1500. In a letter dated April 4, 2011, Counsel for the Respondents submitted that the case was irrelevant and reiterated that the case did not alter the standard of the profession, and even if it did, that alteration would be for the College to consider in future cases. On July 13, 2011, Counsel for the Applicant forwarded a copy of the decision from the Ontario Court of Appeal in *Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482. The Board reviewed the cases and the parties' submissions and concluded that the outcome of *Rasouli* was not relevant to this particular matter since it post-dated the Committee's decision.

Adequacy of the Investigation

17. An adequate investigation does not need to be exhaustive. Rather, the Committee must seek to obtain the essential information relevant to making an informed decision regarding the issues raised in the complaint.
18. At the Review, Counsel for the Applicant clarified that she was making submissions on behalf of the Applicant in respect of those aspects of the complaint regarding Drs. C. and L.. The Applicant made submissions pertaining to her complaint in respect of Drs. O. and T..
19. Counsel for the Applicant argued that the investigation was inadequate for the following reasons:
- a) the Committee failed to investigate why Dr. C. was not able to utilize the conflict resolution options that were available to him regarding the DNR order;
 - b) the Committee failed to consider whether it had the jurisdiction or expertise to make a determination concerning the patient's best interest and the existence of a prior capable wish; and

- c) the Committee did not investigate the inconsistency in the letters of response from Drs. L. and C. regarding Dr. L.'s telephone call with Dr. Jennifer Ahmed, a resident on the team. Similarly, the Committee did not conduct an investigation into the patient's condition at the time Dr. C. entered the patient's room on September 22, 2008.
20. Counsel for the Applicant suggested that the Committee should have spoken to Dr. Ahmed to ascertain the instructions she received from Dr. L. and to clarify what information she relayed to Dr. C.. Counsel submitted that Ryan Smith, RT, the respiratory therapist in the patient's room on September 22, 2008, should have been interviewed to obtain clarification pertaining to the patient's condition and required treatment.
21. Counsel for the Respondents argued that the issue in this case is whether the Respondents met the standard of practice. The issue in regard to this standard turns on the patient's medical condition when the DNR order was put in place and subsequently when CPR and resuscitative care were refused. Counsel submitted that it therefore was adequate for the Committee to rely on the medical charts, the letters from the Applicant, the submissions from the Respondents and the relevant College and SHSC policies.
22. At the Review, Counsel for the Respondents submitted that the statements from Drs. C. and L. regarding the phone call with Dr. Ahmed were not inconsistent. Further, she argued that even if the statements were inconsistent, the Committee had Dr. Ahmed's chart notes and nothing further would have been gained by talking to her. In summary, Counsel argued that the investigation was adequate and thorough; therefore no further investigation, documents or information were necessary for the Committee to reach its decision.
23. The cruxes of the Applicant's initial letter of complaint deal with the DNR order, which she alleged was placed on the patient's chart without her approval, and the events surrounding the patient's death on September 22, 2008.

24. Following the patient's surgery, the Applicant, as the SDM for the patient, asked a resident to note in the patient's chart that he was "full code", meaning that all possible measures would be taken to revive him and sustain his life. Dr. C., in his letter of response, indicated that, in his opinion, it was an error for a "full code" to be noted on the patient's chart. Dr. C. "decided that it was essential to reinstate the DNAR [sic] order ..." and noted that the decision to reinstate the DNR order reflected the consensus of doctors caring for the patient.
25. It was submitted that Dr. C. intended to discuss this matter with the Applicant and he left a message on the Applicant's answering machine asking her to call Dr. L.. In his letter of response, Dr. C. noted that a deterioration in the patient's "condition was, at this point, certain to occur with time, but I did not consider it to be imminent." Dr. C. indicated that his understanding of the hospital policy was that "families are to be consulted, but that they do not have the authority to determine the medical decision in question." He went on to say, "I very much regret that, in this case, events overtook our usual process of communication and the routes for conflict resolution that are available within the hospital."
26. In his letter of response, Dr. L. indicated that he was not in the hospital in the early evening of September 22, 2008 when he received a telephone call from Dr. Ahmed, a resident on the team, who advised him that the patient "had acutely developed respiratory distress." Dr. L. inquired whether Dr. C. had communicated with the Applicant regarding the DNR order. Since Dr. C. did not reach the Applicant, Dr. L. advised Dr. Ahmed that he would try to reach Dr. C.; and in the interim, the patient's respiration should be supported. Dr. L. was unable to reach Dr. C.. When Dr. L. called Dr. Ahmed to advise her that he had been unable to contact Dr. C., Dr. Ahmed advised him that Dr. C. was in the patient's room with the Applicant.
27. In his letter of response, Dr. C. noted that he was paged on September 22, 2008 and was asked to provide assistance to the patient and to see the Applicant. According to Dr. C.,

- Dr. Ahmed explained that the Applicant was asking for resuscitation efforts but Dr. L. directed that the DNR order be maintained, which is contrary to the response from Dr. L..
28. The Board is mindful that an investigation must be adequate rather than exhaustive. The Board finds that the Committee's investigation generated sufficient information concerning the relevant events to allow the Committee to adequately assess the circumstances surrounding the DNR order, the events of September 22, 2008 and the care provided by the Respondents and their conduct. The Committee had the Applicant's letter of complaint and the subsequent communications, the letters of response from all of the Respondents, the medical records from Dr. L. and SHSC, the relevant policies of the SHSC, and the CPSO policy #1-06. The Board is satisfied that Dr. Ahmed's chart notes were sufficient for the Committee to reach its decision and that nothing further would have been gained from interviewing her.
 29. The Board accepts that Ryan Smith may have been able to provide additional information pertaining to the type of treatment the patient received on the evening of September 22, 2008. However, the Board finds that this information was not necessary to ensure an adequate investigation since the issue before the Committee turned mostly on whether Dr. L. and Dr. C. were obliged to obtain the Applicant's consent to remove the DNR order.
 30. The Board finds that the arguments raised by Counsel for the Applicant regarding the conflict resolution options and the jurisdiction or expertise of the Committee to make a determination concerning the patient's best interest are more pertinent to the issue of reasonableness and will be considered below.
 31. Accordingly, the Board finds that the investigation into the Applicant's complaints was adequate.

Reasonableness of the Decision

32. In considering the reasonableness of the Committee’s decision, the question for the Board is not whether it would arrive at the same decision as the Committee, but whether the Committee’s decision can reasonably be supported by the information before it and can withstand a somewhat probing examination. In doing so, the Board considers whether the decision falls within a range of possible, acceptable outcomes that are defensible in respect of the facts and the law.
33. The Board will address the submissions pertaining to Drs. C. and L. and then consider the arguments pertaining to Drs. O. and T..

The Committee’s Findings Regarding Drs. C. and L.

34. Counsel for the Applicant argued that the Committee’s decision was unreasonable because, in arriving at its conclusion, the Committee failed to consider the statutory framework in place in Ontario regarding consent to treatment, set out in the *Health Care Consent Act*¹ (HCCA). It was submitted that the Committee considered the clinical observations of Drs. C. and L. pertaining to the patient’s condition and the opinion of the hospital’s ethicist, but failed to consider that in Ontario, no treatment can take place without a patient’s consent or the consent of his or her SDM.² Counsel submitted that the patient was offered a plan of treatment that included “full code” status, which Dr. Bellini confirmed on September 18, 2008 and which Dr. Aoun confirmed on September 19 and 21, 2008. Counsel argued that, since a “full code” was offered to the patient as part of his treatment plan and it was accepted on several occasions, consent from the SDM was required to withhold or withdraw “full code” status. It was argued that in the event that a health care practitioner believed the SDM was not making decisions in accordance with his/her obligations, the practitioner could complete a Form G application and submit it to the Consent and Capacity Board (CCB) for a ruling.

¹ *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A

² Section 10 of the *Health Care Consent Act*, supra.

35. Counsel for the Applicant submitted that the decision of the Committee was unreasonable because, in concluding that a DNR order was in the patient's best interest, the Committee disregarded the law in Ontario and placed itself in the role of the CCB. Further, Counsel argued that the Committee failed to explain the relevant provision of the policies it considered in reaching its conclusion.
36. Counsel for the Respondents submitted that there is no legal requirement in the *HCCA* for physicians to attend before the CCB when they believe that treatment is futile or not medically indicated. Counsel further indicated that no Court in Ontario has required physicians to appear before the CCB before entering a DNR order in a patient's chart. In addition, Counsel argued that the role of the College is to establish and maintain the standards of the profession, not to determine appropriate legal standards. Counsel took the general position that, since Drs. C. and L. complied with the policies of the SHSC and the College, the decision of the Committee to take no further action is reasonable.
37. The Committee concluded that the DNR order that Dr. C. wrote and Dr. L. co-signed, was required on September 22, 2008 because of the patient's condition. The Committee concluded that Dr. C.'s actions were appropriate and consistent with the DNR order. The Committee reviewed the Record and concluded that the patient's "death was inevitable and resuscitative measures would have been futile and not in his best interest." It noted that the Division of General Internal Medicine and SHSC's ethicist had reviewed the case, and both "determined that the order written by [Dr. C.] was clinically and ethically appropriate in this circumstance." The Committee goes on to state that, although the Applicant was the patient's SDM, "she was not in a position to demand that her father receive treatment that his physicians did not feel were medically appropriate." The Committee concluded that it would take no further action regarding Drs. C. and L. pertaining to the DNR order.
38. For the reasons that follow, the Board finds that the decision of the Committee to take no further action regarding the actions of Drs. C. and L. is not reasonable. The Committee had to address, and did not address, whether it was appropriate in the circumstances for

Dr. C. to place a DNR order on the patient’s chart and execute it in light of the fact that the SDM did not consent to it. The Board is of the opinion that the question before the Committee was not whether the patient’s death was inevitable and whether the resuscitative measure would have been beneficial. The question before the Committee was whether it was within the standard of practice of the profession for such order to be made without consent from the SDM. In other words, who makes decisions relating to the patient’s plan of treatment?

39. The Board is of the view that, before the Committee could conclude that the DNR order was clinically and ethically appropriate, it had the obligation to explain and justify its decision more fully. In this particular case, the Board believes the Committee was obliged to consider and address the statutory framework in Ontario (notably the *HCCA*), the relevant sections of CPSO Policy #1-06 and the pertinent SHSC policies.

40. Section 1 of the *HCCA* outlines the various purposes of the *Act*:

1. The purposes of this Act are,

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

...

(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about treatment, admission to a care facility or a personal assistance service, and

...

41. Pursuant to section 10(1) of the *HCCA*, doctors are required to obtain consent before administering treatment. Section 2(1) of the *HCCA* defines the term “treatment” as “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment...”

42. The term, plan of treatment, means a plan that:
- (a) is developed by one or more health practitioners,
 - (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
 - (c) provides for the administration to the person of various treatments or course of treatments and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition. (emphasis added)
43. The scheme of the *HCCA* provides that a SDM could be appointed if a patient is incapable of providing consent to treatment. Section 37 of the *HCCA* states: “if consent to a treatment is given or refused on an incapable person’s behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Consent and Capacity Board for a determination as to whether the substitute decision-maker complied with section 21.” Section 21 of the *HCCA* deals with the principles for giving or refusing consent, as well as the best interests of the patient.
44. The Board observes that the Record before the Committee contained CPSO Policy #1-06 - Decision-making for the End of Life. Yet in reaching its decision, the Committee failed to indicate how this policy was applied to the particular circumstances of this matter. For example, the Board is unclear as to how the Committee reconciled its interpretation of subsections (a) to (g) of CPSO Policy #1-06 (set out below) with the conflict resolution provisions of the SHSC policy titled “Decision-making and Conflict Resolution Regarding Futility in the Use of Life Support.”
- a) Principle 1. End-of-life care must strive to address the physical, psychological, social and spiritual need of patients, and where appropriate

their families, with sensitivity to their personal, cultural and religious values, goals, beliefs and practices.

- b) Principle 3. The patient or substitute decision-maker ... should have the opportunity to participate in informed discussions about the care options that may optimize the quality of the patient's life while he or she is living with a life-threatening illness, and when dying.
 - c) Quality Care at the End of Life: Many factors influence decision-making for people who face life-threatening illnesses ... Patient choices can change as the disease progresses and as the end of life approaches.
 - d) Advance Care Planning: When patients become ill and as illness progresses, physicians should ensure that the patient's advance care instructions and wishes are reassessed with patients or substitute decision-makers...
 - e) When it is clear from available evidence that treatment will almost certainly not be of benefit or may be harmful to the patient, physicians should refrain from beginning or maintaining such treatment. Any recommendation not to initiate life support, or to withdraw life support should be discussed with the patient or substitute decision-maker ... If the patient or substitute decision-maker ... specifically requests the physician to provide or continue the treatment notwithstanding the recommendations of the health care team, the physician should turn to the conflict resolution measures discussed in Part 4.1 of this policy in an effort to achieve consensus.
 - f) Conflict Resolution: When it becomes evident in the course of making decisions for the end of life that there is disagreement over appropriate treatment between patients or substitute decision-makers ... and health care providers, physicians should ensure that appropriate conflict resolution processes are followed.
 - g) Conflicts between health care providers and authorized substitute decision-makers arising from questions of whether the substitute decision-maker has followed the principles set out in the *Health Care Consent Act* can be addressed to the Office of the Public Guardian and Trustee.
45. The Board recognizes that in the particular circumstances of this case, there was such a sudden and rapid decline in the respiratory condition of the patient that the Applicant and the Respondents did not realize that there was a conflict until what tragically turned out to be the final moments of the patient's life. Despite the presumably exceptional circumstances, the Board is of the view that, in determining whether the Respondents met

the acceptable standards of their profession in insisting that the DNR decision of the physician trumped the wishes of the SDM, it was incumbent on the Committee to address explicitly the application of all the relevant policies and legislation. Accordingly, for these reasons, the Board finds that the Committee's decision with respect to Dr. L. and Dr. C. was unreasonable.

The Committee's Findings Regarding Dr. Oliver

46. In the Applicant's communication with the College, she expressed several concerns pertaining to the care the patient received from Dr. O. following the patient's surgery of September 17, 2008. The Applicant indicated that Dr. O. failed to properly measure the patient's fluid levels, his dry weight was not measured pre- and post-operatively, he did not receive a Foley catheter after the operation and his fluid intake and output was not calculated every twenty-four hours.
47. At the Review, the Applicant argued that the Committee's decision to take no further action was not reasonable because Dr. O. did not meet the standard of care of a specialist in his field. The Applicant submitted that Dr. O. was ultimately responsible for the patient's dialysis; however, he withheld dialysis on September 22, 2008 because the Rapid Response Team (RRT) put a DNR order on the patient's chart.
48. Counsel for the Respondents argued that the Committee's decision was reasonable because the Committee considered the information in the Record, including the report of the independent expert.
49. The Committee concluded that the care that Dr. O. provided was reasonable and appropriate. In reaching its decision, the Committee considered the response from Dr. O. and the report from an independent expert. The Committee relied extensively on the independent expert's report and noted that the patient was assessed at least once a day by the nephrology team, decisions relating to treatment were made in conjunction with other physicians responsible for the patient's treatment and the prescription adjustments were

appropriate. The independent expert further suggested that the time and frequency of the patient's hemodialysis was adequate. The Committee addressed the Applicant's concerns regarding the lack of measuring the patient's weight.

50. The Board finds that there was a reasonable basis for the Committee to conclude that the care the patient received from Dr. O. was "reasonable and appropriate." The Committee considered the Applicant's complaint, the response of Dr. O., the reports in the Record and the opinion of the independent expert. The Board finds that the decision to take no further action concerning Dr. O. is reasonable since it falls within a range of possible, acceptable outcomes based on the information before the Committee.

The Committee's Findings Regarding Dr. Tobe

51. The Applicant raised concerns about the care Dr. T. provided to the patient on September 21 and 22, 2008. More specifically, the Applicant believed Dr. T. denied the patient dialysis on both days despite the patient showing signs of respiratory distress and high potassium levels. The Applicant confirmed that the patient was receiving hemodialysis three times a week on Tuesday, Thursday and Saturday.
52. At the Review, the Applicant argued that the Committee's decision was not reasonable because Dr. T. did not meet the standard of care of a specialist in his field. The Applicant submitted that Dr. T. was ultimately responsible for the patient's hemodialysis; however, he withheld dialysis on September 22, 2008 because the RRT put a DNR order on the patient's chart.
53. Counsel for the Respondents argued that the Committee's decision was reasonable because the Committee considered the information in the Record, including the independent expert's report. The Committee considered the patient's schedule for hemodialysis and that he was not scheduled for a treatment until Tuesday.

54. The Committee concluded that the care provided by Dr. T. was acceptable. It considered Dr. T.'s response and the independent expert's report, which noted that Dr. T.'s "management met the standard of practice." The Committee considered the Coroner's report, which "suggested that missed or delayed dialysis treatments worsened [the patient's] diagnosis." However, the Committee considered the patient's blood test results, which showed that his potassium had been reduced and that "dialysis had been ordered and was being set-up when [the patient] suddenly passed away." It concluded that the nephrology team carefully assessed the patient and adequately monitored his fluid levels. As a result, the Committee concluded that there was "no evidence to suggest that Dr. T. withheld treatment to cause [the patient] distress." It decided to take no further action regarding this complaint.
55. The Board finds that it was reasonable for the Committee to take no further action regarding Dr. T.. The Committee considered the Applicant's complaint, the response of Dr. T., the information in the Record, and the independent expert opinion. The Board therefore finds that the decision of the Committee falls within a range of possible, acceptable outcomes based on the information before the Committee.
56. The Board wishes to express its sympathy to the Applicant on the death of her father.

VI. DECISION

57. Pursuant to section 35(1) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991*, the Board confirms the decision of the Committee with respect to Dr. O. and Dr. T. and returns to the Committee its decision with respect to Dr. C. and Dr. L. with the requirement that it reconsider its assessment of the complaints respecting Dr. C. and Dr. L. in accordance with these reasons.

ISSUED January 19, 2012

Chantal Proulx
Chantal Proulx

Deborah Coyne
Deborah Coyne