Report of the Independent Committee of Inquiry

Into the Situations of Drs. Gabrielle Horne, Michael Goodyear & Bassam A. Nassar at the Capital District Health Authority & Dalhousie University

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Before the Committee had finalized its work, the third member of the Independent Committee of Inquiry, Dr. David Sackett (McMaster University), became ill and subsequently passed away. Drs. Sharp and Schrank take responsibility for the final version of the report and wish to acknowledge the outstanding contribution to the work of this Committee provided by Dr. Sackett.

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Executive summary

This Inquiry began as an examination of the employment-related problems experienced by three physicians practicing in unrelated specialties and holding joint appointments at the Faculty of Medicine of Dalhousie University and the Capital District Health Authority (CDHA) in Halifax, Nova Scotia. These problems involved, among many other matters, (1) the right of these academics to criticize the actions of certain colleagues, (2) their right to advocate for changes in medical treatments despite the resistance of some of their colleagues to such changes, and (3) their right to determine freely with whom they would collaborate in their medical research. These problems remained unresolved for an egregiously long time. The consequences of these events were profoundly damaging to the three physicians both personally and professionally despite the fact that, when their cases eventually received fair impartial hearings much later on, they were exonerated of any wrongdoing. Their stories, and the lessons learned from these case studies, are presented in Chapters 5, 6, and 7 of this Report. This Committee concluded that the problems faced by the three physicians were systemic and require systemic corrections.

In each of these three cases, disciplinary actions were taken against the doctors in a variety of career-threatening ways including a letter of reprimand, a charge of harassment, attempts to terminate a doctor's Dalhousie University appointment, variation of the hospital privileges required to practice medicine, and suspension of hospital privileges, a serious disciplinary measure that disallows a doctor from performing any of the normal activities of an academic physician. Although the disciplinary actions in each case had obvious serious implications for the careers of these doctors, the actions were imposed before proper investigation of the charges. When the issues in dispute were eventually examined, either by the Court or by panels charged with determining the facts and the appropriateness of the discipline imposed, the facts turned out to be different from what had been alleged at the start of the disciplinary process, and the discipline was judged to be inappropriate. Years later, all three doctors were eventually exonerated. Indeed, in the second and the third cases, both involving variation of hospital privileges, the Board of Capital District Health Authority ruled that these doctors should be restored to the status they held immediately before the disciplinary variations were imposed.

The Committee of Inquiry found that each case began, not with some egregious action, but with some interpersonal disagreements with colleagues over matters that appear to be within the bounds of what might reasonably be expected to arise from time to time in an academic tertiary-care medical environment. What sets apart the three cases considered by this Inquiry is the extent to which the available policies and procedures failed to recognize and defend the fundamental importance of academic freedom in academic medical environments and proved incapable of resolving these disputes, and in many ways served to exacerbate and broaden the disputes. In each of the three cases studied the disputes expanded in both scope and intensity and dragged on for an unconscionably long time, spawning a range of other disputes and a torrent of documents on ever-widening matters, leaving an ever-worsening trail of damage to individuals and the institutions.

The Committee also found that the disputes themselves and the escalating damage created by these unresolved disputes resulted from a collective and systemic failure of policy, process,

and academic administrative culture at CDHA/Dalhousie University and cannot fairly be attributed to individual errors of commission, omission, or judgment.

The Committee identified at the heart of these cases a number of fundamental flaws in the bylaws, policies, procedures, academic medical culture, and documents that together provide the foundation on which the Capital District Health Authority and Dalhousie University conduct their joint affairs. In particular, the Committee found that: (1) none of the essential requirements to guarantee the right to academic freedom for academic physicians at Dalhousie University and Capital District Health Authority was met; (2) the important concept of collegiality was misunderstood and misapplied; (3) the high standard of fairness required to protect the rights of physicians facing a variation or suspension of their hospital privileges was not met; (4) formal dispute resolution processes leading to a final and binding decision using fair procedures in a timely manner were lacking. These matters are discussed in Chapter 2 of this Report.

The Committee found that many of these flaws arose from the Bylaws of the Capital District Health Authority and the Affiliation Agreement, a complex, multifaceted document that was intended to establish the parameters of collaboration between Dalhousie University and CDHA. An analysis of these foundational documents is provided in Chapter 3 of this report.

Taken together, these documents require physicians who are members of the Dalhousie University Faculty of Medicine to maintain their academic appointment at Dalhousie University, their clinical appointment and hospital privileges as Medical Staff at CDHA, and their income through the Alternate Funding Plan or similar group practice plans. Each of these three domains is governed by different policies, which the Affiliation Agreement attempts to connect. This multi-layering of policies creates a complex structure of duties and responsibilities that are not always easily understood or consistent with each other. A problem arising in any one of these three domains can be career-threatening, as it was in each of the three cases studied.

One of the many problems the Committee identified in the Affiliation Agreement is the failure to acknowledge academic freedom as a fundamental right of medical faculty. Indeed, the Agreement makes no mention of academic freedom at all. As a result, academic freedom plays no formal role in the relationship between Dalhousie University and Capital District Health Authority.

Medical Staff at CDHA are deemed to be private contractors and the standard practice is for them to derive most or all of their remuneration from the Alternate Funding Plan (AFP) or similar group practice plans. This arrangement places extraordinary power regarding income of individual members of the Medical Staff in the hands of CDHA Division and Department Chiefs. An academic work environment in which academic freedom is not protected, in which formal dispute resolution mechanisms are lacking, and in which remuneration relies on the administration's good will is, on its face, unsatisfactory — at the very least fostering a sense of unease and vulnerability.

That perception of vulnerability is exacerbated by the fact that medical faculty do not have a process for tenuring despite having academic appointments at Dalhousie University. Tenure protects academic freedom by guaranteeing that an appointment can be terminated only for just and sufficient cause. Rather than tenure, medical faculty appointments are subject to periodic

performance evaluations, a process known as Continuing Appointment with Periodic Review (CAPR). In the three cases examined by this Committee, these reviews gave rise to disputes but did not provide any satisfactory means for addressing or resolving disagreements about performance assessments.

One of the criteria for a successful periodic review is collegiality. All three medical doctors were alleged to be deficient in collegiality. Yet "collegiality" is left undefined in the foundational documents, and there was no apparent consistency in the understanding of the term "collegiality." As used in various documents that the Inquiry examined, the term "collegiality" appears to be most frequently used as a measure of congeniality. It is perceived to be an important attribute for faculty members and active medical staff, leading to effective functioning of the department, although what it is, exactly, is never defined. It is true that, in a clinical environment, teamwork is important. Lack of "collegiality" was seen to threaten that teamwork; but not all clinical environments require that level of teamwork. "Collegiality" as it was used at the start of the disciplinary process in all three cases examined by this Committee was a conveniently vague and undefined term that allowed the three medical doctors whose cases the Inquiry studied to be considered deficient by their Department Chiefs in broad, unspecific, but negative ways that related to perceptions of personality rather than to professional competence.

The Committee of Inquiry also identified serious problems with the Medical Staff Disciplinary Bylaws, both as they existed at the beginning of this Inquiry and in their later iteration. Among other matters, the Disciplinary Bylaws involve the circumstances under which a medical doctor's hospital privileges may be varied and the procedures that must be followed when a variation of privileges is imposed. The Disciplinary Bylaws played a central role in two of the three cases considered by this Committee. An analysis of these Disciplinary Bylaws is provided in Chapter 4. The Committee found that the Disciplinary Bylaws are in many ways unsuited to productive solutions to disputes about the performance of physicians. Unfortunately, there appear to be no dispute-resolution procedures at CDHA other than these seriously flawed Disciplinary Bylaws.

It needs to be clearly understood that a variation of privileges is an extremely serious matter for a physician, and therefore should require a very high standard of procedural fairness and proof. A summary variation of privileges carries the stigma that some form of egregious behaviour has taken place, and should therefore be reserved for those egregious cases. That high standard was not met in the cases examined by this Inquiry. Despite the fact that the charges had not been proved, the disciplinary actions remained in place until the cases received their final hearing by the Board of CDHA. The length of time it took for the matters in dispute to be heard in a forum that provided procedural fairness and natural justice created a profound injustice for the two medical doctors whose hospital privileges were varied.

Under the Disciplinary Bylaws in place at the time of the variation of hospital privileges of the two medical doctors, the disciplinary action imposed by the Department Chief was first supposed to be considered by the District Medical Advisory Committee (DMAC) within twenty-one days, and subsequently the matter was to be dealt with by the Privileges Review Committee (PRC) within a further twenty days. These time lines were themselves subject to variation as happened in two of the cases examined by this Inquiry. Instead of the forty-one days allowed by the Disciplinary Bylaws, the processes mandated by those Bylaws stretched out for years.

According to the Disciplinary Bylaws in place at the beginning of the events described herein, once the PRC makes a report and recommendations to the Board of CDHA, the Board must then hold a formal hearing to determine whether or not to uphold the variation of privileges. While the Board hearing must be based upon both procedural fairness and natural justice, the Disciplinary Bylaws specify that neither the PRC nor the DMAC is required to observe such constraints, and they did not. The effect was that neither of the two doctors whose privileges had been varied had an opportunity to question the evidence presented against them, carry out cross-examination of witnesses, or provide evidence in their own defence until the CDHA Board hearings took place at a much later time. In one case, procedural fairness and natural justice were denied for almost four years; in the other case, procedural fairness and natural justice were denied for nearly six years.

The allegations made against these two doctors were ultimately found by the Board of CDHA not to be grounds for variation of privileges. Despite this exoneration, irreparable damage was done to the careers of these doctors. In the view of the Committee of Inquiry, this miscarriage of justice is a direct result of serious flaws in the Bylaws and other statutory documents defining the relationship of faculty members in the Dalhousie University Faculty of Medicine with the University, CDHA, and the Alternate Funding Plan.

Chapter 8 of this report provides a summary of the main events, their causes and their consequences. In Chapter 9, the Committee makes a series of recommendations to address the concerns raised throughout the report. In April 2015, the Capital District Health Authority was amalgamated with other health authorities to form the Nova Scotia Health Authority (NS Health). Under the provisions of the legislation establishing NS Health, the bylaws made by the Capital District Health Authority remain in effect and apply to NS Health until such time as they are replaced with new by-laws made by NS Health. This provides an ideal opportunity for the recommendations of this Committee to be reviewed and implemented by the new Nova Scotia Health Authority. These recommendations include:

1. that a new Affiliation Agreement between Dalhousie University and Nova Scotia Health Authority be negotiated to establish an equal partnership as a more appropriate foundation for their joint activities;

2. that a formal Policy on Variation of Privileges be established to deal with the rare occasions when there is an actual or imminent danger of harm to patients, staff, students, and/or the general public;

3. that performance concerns that do not relate directly to such imminent danger of harm should be dealt with according to a newly formulated Discipline Policy that provides the protections of natural justice and procedural fairness;

4. that a formal Grievance Policy be established for prompt, final, and binding resolutions of disputes that arise concerning the application, administration, or interpretation of the Bylaws, policies, rules, and regulations;

5. that medical staff/Dalhousie faculty have contractual protections similar to those of other Dalhousie faculty, and in particular that all Continuing Appointments with Periodic Review (CAPR) be converted into tenure-stream appointments;

6. that medical staff/Dalhousie faculty have representation by an organization that is formally recognized by both Nova Scotia Health Authority and Dalhousie University, and that has enforceable representation rights and the resources to be effective;

7. that new national resources be established to assist with defining and assessing clinical practice standards, to provide active support and training to assist individuals and groups to achieve and maintain these standards, to assist with performing practice audits or establishing appropriate panels to perform effective external independent reviews and assessments of clinical practice, and to help with the management and investigation of cases in which there are disputes about practice standards;

8. that immediate steps be taken to bring reasonable and just closure to the three individual cases that initiated and underpin this Inquiry.

Chapter 1 | Introduction

Appointment of the Independent Committee of Inquiry

Dr. Gabrielle Horne requested assistance from CAUT following a variation in her assignments and working conditions by the Queen Elizabeth II Health Sciences Centre (QEII HSC) in October, 2002, an alteration which Dr. Horne perceived as likely to impair her ability to conduct her scientific research and treat her patients. QEII HSC subsequently was amalgamated with other medical facilities in the Halifax region to form the Capital District Health Authority (CDHA), also known as Capital Health. In March 2003, CAUT established an Independent Committee of Inquiry (The 2003 ICI) to investigate. During the course of their investigation, the Committee encountered issues of faculty rights, ethics and academic freedom beyond those initially raised by Dr. Horne, and involving additional faculty members. The Committee decided that the amount of work required was beyond what they could undertake and resigned in November 2003. They destroyed all documents and other records of their inquiry.

In January 2004, CAUT established the current Independent Committee of Inquiry, with a broader mandate. The members of the Committee of Inquiry (the "Committee") were selected and asked to serve on the basis of their expertise and experience. The members of the Committee appointed were Dr. David Sackett (McMaster University), Dr. Bernice Schrank (Memorial University of Newfoundland), and Dr. Allan Sharp (University of New Brunswick, Fredericton) as Chair.[1] The members of the Committee did not seek this appointment and served as volunteers without remuneration. However, the expenses of the members of the Committee were reimbursed by CAUT.

Unfortunately, while the final version of this report was being edited, Dr. Sackett became ill and subsequently passed away. Consequently, he was unable to approve the final version of this report, although he had made extensive contributions throughout the long deliberations of this Committee and particularly to all of the earlier drafts and the recommendations. Drs. Schrank and Sharp take responsibility for this final report and wish to acknowledge the outstanding contribution to the work of this Committee provided by Dr. Sackett.

Terms of Reference of the Independent Committee of Inquiry

Written Terms of Reference for the Independent Committee of Inquiry were provided to the members of the Committee on January 12, 2004 in a letter from Dr. James Turk, Executive Director of CAUT. Specifically, the Terms of Reference accepted by the Committee were:

1. to investigate allegations of violations of academic freedom and faculty rights in the Faculty of Medicine at Dalhousie University and in the Department of Medicine at the Capital District Health Authority (Capital Health or CDHA). Dalhousie University and CDHA are affiliated bodies under the terms of an Affiliation Agreement;

[1] During the work of the Committee, Dr. Sackett was Professor Emeritus at McMaster University, Dr. Sharp became Professor Emeritus at the University of New Brunswick, and Dr. Schrank retired from Memorial University of Newfoundland.

2. to determine whether there were breaches of or threats to academic freedom;
3. to determine whether there were breaches of medical research ethics and clinical ethics;
4. to determine whether tenure was inappropriately denied to faculty in clinical departments;
5. to determine how universities can protect the academic freedom and other rights and privileges of university faculty who hold positions at affiliated health care centres; and
6. to make any appropriate recommendations.

Explicit conditions set by the Committee

The Committee accepted these Terms of Reference on a number of explicit conditions, to all of which CAUT agreed:

1. that the Inquiry is the work of the members of the Committee of Inquiry and is absolutely independent of any other person or organization, including the CAUT;
2. that the Committee would prepare an independent report which would be published in its entirety, as delivered by the Committee;
3. that Capital Health, Dalhousie University and CAUT will all receive copies of the independent report upon publication; and
4. that the Committee would determine its own procedures, which are set out below.

Procedures of the Independent Committee of Inquiry

Before undertaking any work, the Committee established a set of procedures for the Inquiry and made those procedures public. The Committee provided a copy of these procedures to every individual it met, prior to having any discussion with that individual. These procedures were:

1. Independent Committee of Inquiry members ("the Committee") will serve without remuneration. However, the expenses of each member of the Committee will be reimbursed.
2. The Committee will seek to review fully and fairly the matters set out in its terms of reference and will prepare a report, which will be published in a timely manner by CAUT in its entirety as delivered to it by the Committee.
3. The Committee has no statutory powers and no authority to compel individuals to participate in its Inquiry. To ensure that it is fully informed with regard to the matters under review, the Committee will rely on the cooperation of everyone concerned. Anyone who chooses to be interviewed by the Committee may be accompanied by an advisor.
4. The Committee will begin by reviewing the documentary record available to it upon its appointment, and will seek further information from individuals in a position to have relevant information by inviting them to meet with it and to submit documents.

5. Persons interviewed by the Committee will be provided with a statement of matters under investigation in advance of the interview. Persons interviewed will be permitted to make a statement to the Committee and to raise issues that they consider relevant, subject to the right of the Committee to decide, having been provided an opportunity for arguments to the contrary, that particular matters are not relevant to its terms of reference.
6. Committee members will take notes during interviews. Interviews will not be recorded except with the express agreement of the person being interviewed.
7. To ensure fairness to persons potentially affected in a materially adverse way by findings in the Committee's report, a fair summary of the information upon which such findings could be based will be provided in confidence to such persons, reasonably in advance of the publication of the Committee's report.
8. At any stage in its Inquiry, the Committee in its discretion may request further information or clarification from individuals who have been interviewed or who have made written submissions, from those mentioned by witnesses or in submissions, or from other persons, by way of either a written statement or an interview with the Committee.

Early in its work, it became apparent to the Committee that it could not rely on the cooperation of all those concerned, and that the participation of all those the Committee wished to interview would not be forthcoming. The Committee therefore chose to modify its procedures and base its work on whatever documentary evidence was available and not to rely on interviews it had conducted (or might be able to conduct in the future) with a limited subset of those concerned. The Committee members destroyed their notes of interviews that had been conducted prior to this decision being taken and did not conduct any additional interviews.

During the course of the Inquiry, the Committee studied thousands of pages of documents dealing with a wide range of matters. Some of these documents make reference to other documents that were not available to the Committee, so it is well known to the Committee that an incomplete set of documents was considered. In particular, a number of civil actions were filed with the Nova Scotia Supreme Court, some of which remain to be decided at the time of final editing of this report.[2] During the course of those civil actions, as Justice Wright noted in his October 2011 ruling on a procedural matter related to one case, voluminous documents had been produced by the parties and extensive discovery examinations had also been held, with more scheduled at the time of the ruling of Justice Wright. It is expected that the Court has available a more complete record than was available to this Inquiry and that the merits of the various allegations by plaintiffs will be fully adjudicated upon by the Court at trial.

Nevertheless, this Committee is satisfied that the findings and recommendations discussed in this report are strongly supported by the evidence available to this Inquiry.

[2] Final editing was conducted in July, 2015 to November, 2015

Brief member biographies

Dr. David L. Sackett, OC, MD (Illinois), ScD (Bern), MSc Epid (Harvard), FRCS (Canada), FRCP (Canada, England, Scotland).

Dave Sackett was the founding chair of the Department of Clinical Epidemiology & Biostatistics at McMaster University, the Founding Director of the Centre for Evidence-Based Medicine at the University of Oxford and the Founding Chair of the Cochrane Collaboration Steering Group. Along the way he practiced and taught in-patient internal medicine for thirty-nine years. At the time of appointment, he was a Professor Emeritus of the McMaster University Faculty of Medicine. He has been involved in about two hundred randomized trials as a study patient, Principle Investigator, consultant, monitor, or member/chair of a Data and Safety Monitoring Board. He is a Member of the Canadian Medical Hall of Fame.

Dr. Bernice Schrank, BA (CUNY), MA, PhD (Wisconsin).

At the time of appointment, Bernice Schrank was Professor of English at Memorial University of Newfoundland. Her areas of academic expertise include modern Irish and American literatures, and she has published extensively in those areas. She was a member of the Memorial University Faculty Association Academic Freedom and Grievance Committee from 1990 to 2001 and served as its Chair from 1996 to 2001. She was also a member of the CAUT Academic Freedom and Tenure Committee from 1988 to 1994, and served as its Chair from 1991 to 1994. She has been involved in the investigation and resolution of disputes at universities across Canada for the past thirty years. Under the auspices of CAUT, she continues to give workshops on grievance management to Faculty Associations across the country. In 1995-96, she was Chief Negotiator for the Memorial University Faculty Association.

Dr. Allan Sharp, BSc (McMaster), MSc, PhD (Waterloo).

At the time of appointment, Allan Sharp was Dean of Science, Professor in the Department of Physics, and Professor of Leadership and Public Policy in Renaissance College, at the University of New Brunswick, Fredericton. He served from 1999 to 2008 as Dean of the Faculty of Science. He served as Chief Negotiator for the first faculty union collective agreement at UNB in 1979 and for all but one of the other collective agreements negotiated prior to his appointment as Dean in 1999. He was President of the faculty union in 1983–84. He was a member of the CAUT Board of Directors from 1980 to 1988, serving as Vice-President, External Affairs from 1984 to 1986, as President in 1986-87 and as Past-President in 1987-88. As President, he wrote the report on restructuring of CAUT that was adopted at CAUT Council in 1987. In 1988 he was the inaugural winner of the Nicole Raymond Award of the Federation of New Brunswick Faculty Associations for outstanding contributions to the profession.

Transparency and disclosure

No member of the Committee has any involvement or relationship with any of the individuals, organizations, or institutions that are a part of this report that would place her or him in a conflict of interest. In particular, none of the members of the Committee has ever had a relationship of any kind with Dalhousie University or CDHA. In the interests of transparency, the members of the Committee disclose in this section any involvement, relationships, or interactions they have had with any of these individuals, organizations, or institutions.

Dr. Sackett had no previous acquaintance with either Dr. Schrank or Dr. Sharp and had no involvement with CAUT prior to his appointment to the Committee. Dr. Schrank was a member and then Chair of the CAUT Academic Freedom and Tenure Committee from 1988 to 1994. She has held no office in CAUT since that time. Dr. Sharp was a member of the CAUT Board of Directors from 1980 to 1988, serving as Vice-President (External Affairs) in 1984 to 1986, President in 1986-87 and Past-President in 1987-88. He has held no office in CAUT since that time.

From 1980 to 1999, Dr. Sharp represented the UNB faculty union as a trustee or alternate trustee of the CAUT Defence Fund, a body independent of CAUT, which has legal authority over the mutual defence fund established on a voluntary basis by a number of Canadian university faculty unions to provide assistance to member unions during strikes or lockouts. Dr. Schrank was a member of CAUT because of her membership in the Memorial faculty union until her retirement. She has maintained retired membership in CAUT from 2015. Dr. Sharp ceased being a member of the UNB faculty union, and hence of CAUT, upon his appointment as Dean in 1999. He has voluntarily maintained an Associate Membership from 1999, and currently holds a Lifetime Retired Membership in CAUT.

Dr. Sharp had met Dr. Schrank socially at CAUT and Defence Fund events, and when he was engaged by the Memorial Faculty Union to make recommendations on appropriate terms and conditions of employment for the professional staff of the Memorial Faculty Union. They had never worked together prior to their appointment to the Committee. Both Dr. Schrank and Dr. Sharp have occasionally been called upon for advice or assistance by CAUT or its member associations since their terms of office in CAUT expired. Dr. Schrank is a regular presenter at grievance administration workshops sponsored by CAUT or its member associations.

Members of the Committee were aware of media reports of the cases of Dr. Horne and Dr. Goodyear prior to their appointment to the Committee. Because of his position at the McMaster University Faculty of Medicine and the McMaster University Medical Centre, Dr. Sackett was somewhat aware of the circumstances surrounding the departure of Dr. Goodyear from McMaster in 1997, although he was in no way involved in those events and had no direct knowledge of them. This slight awareness led Dr. Sackett to form a somewhat negative opinion of Dr. Goodyear. This somewhat negative opinion was disclosed to Dr. Goodyear prior to Dr. Sackett's appointment to the Independent Committee of Inquiry. Dr. Goodyear confirmed in writing that he had no objection to Dr. Sackett serving on the Committee of Inquiry.

Dr. Sackett had no professional relationship (e.g., co-investigatorship, co-authorship, etc.) with any of the individuals who were subjects in this Inquiry, but did know of Dr. Goodyear when the latter was at McMaster University. Dr. Sackett had taught one of the CDHA Vice-Presidents for Research and Academic Affairs when the latter was a medical student and postgraduate at McMaster University. Dr. Sackett was personally acquainted with the Chancellor of Dalhousie University and during the course of the Inquiry on one occasion had an informal conversation with the Chancellor in which he disclosed that he was in Halifax as part of the Inquiry, but there was no discussion of the substance of any of the matters under consideration by the Inquiry. Dr. Sackett did express to the Chancellor an opinion that it would be in everyone's interest to arrive at a fair resolution in a timely manner.

The President of Dalhousie during this Inquiry had served as Vice-President Academic at UNB prior to his appointment as President of Dalhousie. The UNB Vice-President Academic was responsible for overseeing administration of the collective agreement between UNB and the UNB faculty union. During that time, Dr. Sharp was Chief Negotiator for the faculty union, responsible for negotiating resolutions of any disputes that arose between UNB and the faculty union or any of its members. The Vice-President Academic and Dr. Sharp worked together to settle a number of cases, including a very sensitive case that had attracted international attention when a faculty member was suspended by UNB after publishing highly controversial opinions on the subject of date rape. Over these years of working together, Dr. Sharp formed a positive opinion of the Vice-President Academic.

Objections by Dalhousie University

In January 2004, before the Committee had begun its work, the Vice-President Academic and Provost of Dalhousie University expressed "… *grave concerns about the fairness of the process and whether the committee, as presently constituted and structured, can address the issues in a fair and impartial manner.*" The Vice-President Academic and Provost stated "*CAUT's proposed inquiry holds little hope for a fair, impartial and constructive exploration of what you claim to be very serious issues.*"

The Dalhousie Vice-President also asked a number of questions regarding the work of the Committee, including: matters of disclosure; jurisdiction of CAUT; impartiality and independence of the members of the Committee; confidentiality; and protection of privacy. The Dalhousie Vice-President also stated that "*CAUT's failure to provide particulars has created a fertile environment for innuendo, rumour and insinuation*."

Dr. James Turk, Executive Director of CAUT, responded to the Dalhousie Vice-President, "… *It is clear that you were writing for a larger audience so I will treat your letter as a public letter and respond fully and publicly.*" Dr. Turk then answered each of the Vice-President's questions and stated, "… *We have appointed a Committee of Inquiry with impressive credentials and operating under guidelines that ensure fairness and independence.*"

The Committee carefully considered each of the concerns expressed, and the questions asked, by the Dalhousie Vice-President Academic and is satisfied that the terms of reference and

procedures adopted by the Committee provide a sound basis for fairness and independence in the Inquiry.

Scope of the work of the Independent Committee of Inquiry

Three members of the Faculty of Medicine of Dalhousie University, all with jointly-held appointments as Medical Staff of the Capital District Health Authority, requested that the Independent Committee of Inquiry investigate the circumstances that had led them to believe their academic freedom had been violated or threatened.

Dr. Gabrielle Horne:

Dr. Gabrielle Horne was a member of the Active Staff of the Division of Cardiology in the Department of Medicine at CDHA. She was also a member of the Division of Cardiology in the Department of Medicine of Dalhousie University. The principal parties involved in Dr. Horne's case are: the Chief of Medicine at CDHA and Head of Medicine at Dalhousie, positions jointly held by the same individual; the Cardiology Division Head at both CDHA and Dalhousie; the Director of the Heart Function Clinic at CDHA; the VP Academic Affairs of CDHA; the Acting CEO of CDHA in October 2002; the CEO of CDHA succeeding that Acting CEO; and the Interim President and CEO of CDHA succeeding the previously mentioned CDHA CEO.

Other persons who played a role at various times were: the Chair of the CDHA Research Ethics Board; the President of Dalhousie University; the Dalhousie Vice-President Research; the Dalhousie Vice-President Academic; the Dean of the Dalhousie Faculty of Medicine; the Associate Dean for Research and Planning of the Faculty of Medicine at Dalhousie University, who subsequently succeeded the previously mentioned Dean as Dean of Medicine; and the Vice-President Research and Academic Affairs of CDHA.

During the long time studied, legal counsel played a significant role, particularly in producing much of the "*voluminous documentation.*" Dr. Horne's legal counsel at various times were counsel appointed by the Canadian Medical Protective Association in the early stages of the case and later personal counsel retained by Dr. Horne. The CDHA District Medical Advisory Committee and the CDHA Privileges Review Committee were represented by legal counsel. The Director of Risk Management for CDHA acted as legal counsel for the CDHA Administration. Dalhousie University was represented by staff legal counsel.

On October 21, 2002, the CDHA Chief of the Department of Medicine summarily varied Dr. Horne's privileges at CDHA by, among other things, precluding Dr. Horne from "… *participation in those clinical services where team care is the existent model, specifically the congestive heart failure clinic, the adult congenital heart clinic …*" The Chief of Medicine also stated "… *we will cease enrollment into your current research clinical trials effective immediately …*" until certain specified conditions had been met by Dr. Horne. The Chief of Medicine also stated, "*The reason for variance of privilege is concern for the ability of the individual to maintain appropriate professional interaction in a team care model of service delivery, so as to ensure delivery of optimal patient care and integrity of the care team.*" Dr.

Horne considered this action unjust, unwarranted, and a violation of her academic freedom. Dr. Horne denied the allegations regarding her professional interactions.

The variation of Dr. Horne's privileges caused the procedures prescribed in the CDHA Disciplinary Bylaws to be invoked. Those Bylaws proved to be incapable of delivering a binding decision on whether the variation of privileges was warranted within a reasonable time, and the original disputes broadened and intensified over a lengthy period. The maximum time specified in the Disciplinary Bylaws before a case is referred to the Board of CDHA for a hearing is fifty-one days. The Bylaws process did not conclude until the CDHA Board made its ruling in September of 2006, nearly four years — over 1,400 days — after the precipitating event.

Dr. Michael Goodyear:

At the time of the events considered by this Inquiry, Dr. Michael Goodyear was a Medical Oncologist in the Division of Medical Oncology of the Department of Medicine at CDHA, and in the Department of Medicine at Dalhousie. The principal parties involved in Dr. Goodyear's case are: the Chief of Medicine at CDHA and Head of Medicine at Dalhousie, positions jointly held by the same individual; the Chief of the Division of Medical Oncology; the Acting CEO of CDHA in October 2002; the CEO of CDHA succeeding that Acting CEO; the Director of the Nova Scotia Cancer Centre at CDHA and subsequently Vice-President Research and Academic Affairs of CDHA; the President of Dalhousie University; the Dean of the Dalhousie Faculty of Medicine; the Chief of Medicine at CDHA who succeeded the previously mentioned Chief; and the senior officer of the College of Physicians and Surgeons of Nova Scotia.

On October 10, 2002, the CDHA Chief of the Department of Medicine summarily restricted the practice of Dr. Goodyear to ongoing care to those patients for whom he was already responsible. The stated reasons were "… *to reflect significant concerns about: Communication and adherence to practice guidelines; failure to function in a collegial team framework; clinical judgment especially with respect to continuing medical interventions*." On January 9, 2003, the CDHA Chief of the Department of Medicine suspended the privileges of Dr. Goodyear for what was described as "… *flagrant disregard for the conditions set* …" on Dr. Goodyear's privileges on October 10. Dr. Goodyear considered both these actions unjust, unwarranted, and a violation of his academic freedom. Dr. Goodyear denied the allegations that were the basis of the restrictions placed on his oncology practice. Dr. Goodyear also denied that he had breached those restrictions.

As with the case of Dr. Horne, during the long time studied, legal counsel played a significant role, particularly in producing much of the "*voluminous documentation,*" Dr. Goodyear was, at various times, represented by legal counsel appointed by the Canadian Medical Protective Association. CAUT provided counsel to Dr. Goodyear during the settlement negotiations described in Chapter 7 of this report. The CDHA District Medical Advisory Committee and the CDHA Privileges Review Committee were represented by legal counsel. The Director of Risk Management for CDHA acted as legal counsel for the CDHA Administration.

As with Dr. Horne, the CDHA Disciplinary Bylaws were invoked and were, as with Dr. Horne, unable to provide a binding decision within a reasonable time on whether the variation of privileges was warranted. As with Dr. Horne, the original disputes broadened and intensified.

The maximum time specified in the Disciplinary Bylaws before a case is referred to the Board of CDHA for a hearing is fifty-one days. The Bylaws process did not conclude until the CDHA Board made its ruling in January 2009, more than six years — over three thousand days — after the precipitating event.

Dr. Bassam Nassar:

Unlike the cases of Dr. Horne and Dr. Goodyear, which took place within the Department of Medicine at CDHA and Dalhousie, the case of Dr. Bassam Nassar involves the Department of Pathology and Laboratory Medicine at CDHA and the Department of Pathology at Dalhousie. Dr. Nassar was Chief of Clinical Chemistry in those departments. The principal parties involved in Dr. Nassar's case are: the Head of the Department of Pathology and Laboratory Medicine at CDHA and the Department of Pathology at Dalhousie, positions held jointly by the same individual; the CDHA Vice-President Medicine during two different time periods; the Dalhousie Dean of Medicine; the CDHA CEO during two different time periods; and the Dalhousie University President.

Once again, legal counsel played a significant role in producing much of the "*voluminous documentation.*" When Dr. Nassar was dealing with the allegations of harassment made against him, Dr. Nassar's legal counsel was provided by the Canadian Medical Protective Association. Also at that time, the Director of Risk Management for CDHA acted as legal counsel for the CDHA Administration. Later, Dr. Nassar retained personal legal counsel and the CDHA retained external legal counsel.

Dr. Nassar alleges that the Head of the Department of Pathology and Laboratory Medicine and Head of the Dalhousie Department of Pathology abused the authority of his offices to the detriment of Dr. Nassar, and that, in particular, the Department Head created a "*hostile work environment*" for Dr. Nassar, subjected Dr. Nassar to "*malicious prosecution,*" and defamed Dr. Nassar on a number of occasions. When Dr. Nassar sought relief from CDHA and Dalhousie, he became dissatisfied with their response in a number of ways and requested the current investigation.

In the case of Dr. Nassar, the Disciplinary Bylaws were not invoked. All matters were considered under other CDHA and/or Dalhousie policies and procedures, which also proved to be incapable of reaching final and binding resolutions.

The form and objective of this report

This Inquiry had no mandate, nor did the Inquiry have the means, the specialized medical expertise in oncology, cardiology, or clinical chemistry, or the access to confidential patient records, to make definitive judgments about the medical competence of the highly skilled individuals at the centre of this Inquiry. Nothing in this report should be interpreted as a judgment by this Inquiry about such matters.

This Report will not deal with every matter that arose or was in dispute between the various parties. That task is well beyond the capacity of volunteer investigators with other duties to fulfill.

The Committee found that many of the events in dispute derived from, or were enhanced by, a much smaller number of underlying events and issues that brought certain individuals into conflict. The failure to resolve the disputes arising from those conflicts in a fair, final, and binding manner, within a reasonable time frame, caused a great deal of damage. Some of that damage involved spawning a range of other disputes and a cascade of documents on ever-widening matters. These three cases have resulted in thousands of pages of documents, much of it adversarial exchanges between legal counsel for various parties. The Committee has no desire to trigger further such exchanges, which the Committee believes would simply further delay action that could, and should, be taken to ensure that similar events do not happen in the future.

Accordingly, the Report will focus on what the Committee believes to be the foundations of the dispute, the damage done by failure to reach final resolutions of those matters in a timely manner, and the lessons that can be learned from these cases.

During the course of its long deliberations, this Committee performed an extensive analysis of the available documents and developed a detailed commentary on the many events which took place. The Committee concluded that at the heart of these cases are a number of fundamental flaws in the foundational policies and procedures of Capital Health and Dalhousie University, and a failure to appropriately understand and apply the concepts of academic freedom, collegiality, procedural fairness, and natural justice.

This Committee found that the damage created by these unresolved disputes resulted from a collective and systemic failure of policy, process, and academic administrative culture at CDHA/Dalhousie and cannot fairly be attributed to individual errors of commission, omission, or judgment. In situations where an error was identified, that error reasonably could be attributed to inexperience; a lack of sufficient training, support and guidance from others; weaknesses in the policy and procedural framework; undue reliance on an authoritarian, rather than collegial, governance model at CDHA; and remuneration arrangements that place Medical Staff members at great risk. The identified problems are systemic, and systemic solutions are required. Accordingly, the Committee has chosen not to make any materially adverse findings of fault on the part of any individuals.

The Committee believes that the most useful contribution the Inquiry could make would be to identify what the Committee considers to be crucial weaknesses in policy, process, and culture, and make recommendations about how these matters can be addressed to help prevent a repetition of these unfortunate events, either at CDHA/Dalhousie or elsewhere.

The first observation may be the most important of all, namely, that none of the three cases has been definitively resolved, after being ongoing for more than a decade. Some of the unresolved matters considered in the case of Dr. Nassar originated over two decades ago. At the time of final editing of this report, the cases of Dr. Horne and Dr. Nassar both remained before the Supreme Court of Nova Scotia and the reinstatement of Dr. Goodyear that had been ordered

by the CDHA Board had not been fulfilled. For reasons which will be described in Chapter 7, the career of Dr. Goodyear as a medical oncologist at CDHA was terminated.

While there are many differences among the cases, there are some clear similarities. Each of the cases began with some interpersonal disagreements over matters that appear to be within the bounds of what might reasonably be expected to arise from time to time in an academic tertiary-care environment. When such disagreements arise, it is essential to resolve them promptly so that they do not give rise to increased conflict and interfere with a proper work environment. It is widely understood that in such circumstances an array of tools could be applied, including: personal intervention and problem solving by senior administrators; mentors; personal coaches; mediators; counselling; external reviewers; formal arbitration or adjudication; and issue specific education. What sets the three cases considered by this Inquiry apart is the extent to which the available policies and procedures proved incapable of resolving these disputes, and in many ways served to intensify and broaden the disputes, and to bring forth new disputes. The disputes escalated in both scope and intensity and dragged on for an unconscionably long time, during which major damage was inflicted on individuals and the institutions.

This Report will begin with a discussion of those fundamental matters of policy, procedure, and decision-making framework to establish a clear baseline for the discussion of each of the three cases. Those three cases will then be presented as case studies illustrating the ways in which systemic problems with policy and procedure contributed to the problems which arose and the damage that was done. The Report will conclude with a Summary and Recommendations.

To emphasize the collective and systemic nature of the problems which arose, the various individuals involved are identified by the official capacity in which they were acting rather than by name. This is consistent with the case study format of this report. It also suggests that similar problems could arise at other institutions if they have a policy and procedure framework and medical administrative culture similar to that at CDHA/Dalhousie.

In April 2015, the Capital District Health Authority was amalgamated with other health authorities to form the Nova Scotia Health Authority (NSHA). Under the provisions of the legislation establishing NSHA, the bylaws made by the Capital District Health Authority remain in effect and apply to NSHA until such time as they are replaced with new by-laws made by NSHA.

Chapter 2 | Basic Principles

Academic freedom

General principles

Universities, and their individual faculty members, are expected to be at the forefront of the discovery of new knowledge; the synthesis, analysis, interpretation, integration, and application of existing knowledge; and the dissemination of that knowledge through teaching, publication, artistic work, professional practice, and service to the community at large. Academic freedom is widely recognized as essential to meeting these expectations.[3]

One of the most eloquent expressions of the crucial value of academic freedom to universities, and their duty to defend it vigorously, is found in the Statement of Purpose of the University of Toronto:[4]

> *Within the unique university context, the most crucial of all human rights are the rights of freedom of speech, academic freedom, and freedom of research. And we affirm that these rights are meaningless unless they entail the right to raise deeply disturbing questions and provocative challenges to the cherished beliefs of society at large and of the university itself.*
>
> *It is this human right to radical, critical teaching and research with which the University has a duty above all to be concerned; for there is no one else, no other institution and no other office, in our modern liberal democracy, which is the custodian of this most precious and vulnerable right of the liberated human spirit.*

Beyond discovering new facts and concepts in their research, faculty critically analyze the work of others; challenge unwarranted assumptions, popular opinion, prescribed doctrine, prevailing orthodoxy, traditional practices, or established authority and experts; and instill in their students the freedom of a creative and independent mind, able to follow where their insights, judgment, and critical thinking leads.

This work is not easy. Such critiques and challenges are sometimes unpopular and even threatening to both individuals and institutions. Academic freedom provides the essential guarantees that faculty may do their duty as scholars, teachers, and practitioners, free from retribution. It is both a fundamental right of the individual faculty member and an essential component of a dynamic environment in which human knowledge, understanding, and practice are advanced, and a new generation of scholars is nurtured.

If academic freedom is to be an effective right on which faculty can depend, there must be means to give it practical effect and to protect faculty from breaches. First among these is a secure appointment that can be modified or terminated only for good cause, so that a faculty member is not at risk of retribution for exercising his or her academic freedom.

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[3] See for example, Horn, M., *Academic Freedom in Canada*. University of Toronto Press, Toronto, 1999

[4] University of Toronto, *Statement of Institutional Purposes*, October 15, 1992.
Located at:
http://www.governingcouncil.utoronto.ca/Assets/Governing+Council+Digital+Assets/Policies/mission.pdf

In this context, a retributive modification of an appointment would include, among other things, a significant reduction in remuneration, a significant change in duties, expectations, working conditions or hours of work, and a denial of academic advancement or of increases in remuneration that would be a reasonable expectation of the appointment.

Such employment security is an essential requirement because the very people who have been challenged by faculty members exercising their academic freedom may be the administrators who make these employment decisions or the colleagues who make recommendations on employment matters, as happened in all three cases studied in this Inquiry. Those administrators may also be subject to both internal and external pressures. The history of academic freedom is full of cases where faculty members suffered negative consequences because they opposed the prevailing doctrine in their discipline; publicly disagreed with the priorities, practices, and decisions of academic administrators; offended colleagues by criticizing their work; insisted on an independent research path or defended the rights of unpopular colleagues; or acted against the special interests of individuals or organizations who could exert pressure on administrators.[5]

In the event that a faculty member's appointment is modified or terminated, or other disputes arise in the employment relationship, there must be an independent and impartial method of adjudicating a case, based on the twin pillars of procedural fairness and natural justice, and capable of rendering a final and binding decision within a reasonable time.

The normal requirements associated with procedural fairness and natural justice include: the right to know the allegations, and the evidence to be used to support those allegations, in sufficient detail and sufficiently in advance of a hearing to allow the preparation of a full defence; the right to present evidence and the right to challenge the evidence of others; the right to be represented by legal counsel and/or other individuals or organizations of one's choice; the right to a full hearing in a reasonable period of time by an independent and impartial adjudicator or panel of adjudicators; and the right to know the reasons for the decision of the adjudicator or panel.

Finally, there must be some means of addressing the inherent imbalance in resources that commonly exists between a faculty member and the institution in which she or he works. Rarely would faculty members have the personal resources to match those of a university or its affiliated hospital in a protracted dispute. As a first step, and to provide an incentive to the university or hospital to resolve the issue in a timely manner, a faculty member involved in a dispute should continue to receive his or her full remuneration and benefits until the adjudication decision is reached. In addition, the faculty member should have the choice to be represented by, or to receive support from, a formally recognized independent professional organization or union.

In summary, to guarantee the right to academic freedom, the fundamental requirements that must be met are: a clear commitment to academic freedom in official policies; employment security; an independent adjudication procedure ensuring procedural fairness, natural justice, and timely binding decisions; income security during any dispute; and opportunity for representation by an independent professional organization or union.

[5] Horn, *op. cit.*

None of these essential requirements was met in the cases investigated by this Committee.

The Affiliation Agreement

Academic freedom is not mentioned in the Affiliation Agreement between Dalhousie University and the CDHA. The failure to take academic freedom into account means that one of Dalhousie's major institutional obligations is not an integral part of its formal relationship with CDHA.

If Dalhousie did not include academic freedom in the Affiliation Agreement through oversight, Dalhousie's commitment to protecting academic freedom is not as strong as should be the case. Both Dalhousie's self-interest and its ethical obligation to be transparent in its dealings with CDHA demand that academic freedom be a central principle of the relationship. While such silence regarding academic freedom is cause for serious concern, there is a much greater concern if the absence of a statement regarding academic freedom from the Affiliation Agreement were a conscious choice of the parties.

If Dalhousie chose to exclude academic freedom from the relationship with CDHA, it abandoned one of the fundamental rights of an important category of Dalhousie faculty. Were this to be the case, it would be unacceptable on its face and more so when one considers the particular risk the lack of explicit commitment to academic freedom imposes on medical faculty. Compared to teaching and research in other disciplines, medical teaching and research often involves higher stakes. Those high stakes place medical faculty at increased risk of coming under pressure from powerful groups whose interests might be challenged by that research, as the well-known examples of Dr. Nancy Olivieri[6] and Dr. David Healy[7] demonstrate.

If CDHA chose not to be a partner in the protection of academic freedom, it placed its self-interest and the achievement of its stated mission at risk. To prosper, the truly transformative research and teaching that CDHA regards as a major part of its mission requires academic freedom. In addition, without a clearly stated commitment to academic freedom, there are serious practical consequences for the quality of patient care that have a direct impact on CDHA, its patients, and society at large.

Leading physicians base clinical practice and its continual improvement on what is called "*evidence-based medicine.*"[8] The governing concept underpinning evidence-based medicine is that clinical practice must integrate the best available research evidence with clinical expertise and patient values. Accordingly, best clinical practice and accepted standards of care will continue to evolve over time as new knowledge is generated. The recent case of postmenopausal hormone replacement therapy is an excellent example of the way evidence-based medicine

[6] Jon Thompson, Patricia Baird, and Jocelyn Downey. *The Olivieri Report*, James Lorimer Press, Toronto, 2001.
[7] The offer of a leadership position at a hospital affiliated with the University of Toronto, to prominent psychiatrist Dr. David Healy, was withdrawn after he gave a lecture in which he suggested that certain common anti-depressant drugs may be associated with an increased risk of suicide in some patients. Dr. Healy's personal account is given in Chapter 10 of his book D. Healy, *Let Them Eat Prozac*, James Lorimer Press, Toronto, 2006.
[8] See, for example, David L. Sackett *et al.*, *Evidence Based Medicine: What it is and What It Isn't*, BMJ 312, p71, January 13, 1996.

adjusts to new facts and interpretations of research findings. Although hormone replacement therapy had been advocated for decades by experts as offering protection against cardiovascular disease, the Women's Health Initiative Trial recently established[9] that it actually increases the risk of heart attack.

Evidence-based medicine depends on the findings of the very sort of research and critical analysis, free from the constraints of conventional wisdom and the pressures of vested interests, that is encouraged and protected by academic freedom. Therefore, for CDHA to achieve its objectives of acting in the best interests of patients, being a faithful steward of the public trust placed in it to provide the best possible care, and achieving medical research prominence, it must provide an environment in which academic freedom is a core value.

In addition, such an environment increases the ability of CDHA to attract the best medical staff, attract substantial funding for research and clinical trials, and maintain the close connections with leading medical faculty worldwide that such research and clinical trials establish. These are among the chief advantages to CDHA of an affiliation with the Dalhousie Faculty of Medicine, and all are critically dependent on robust support for academic freedom.

There is no conflict between academic freedom and the provision of the best possible medical care. To the contrary, the examples of Dr. Olivieri and Dr. Healy show that a flourishing intellectual environment protected by academic freedom is a direct benefit to patients and society at large by acting to help protect patients from having powerful vested interests supersede the rights of patients to the best possible care. Moreover, academic freedom does not in any way diminish the requirement for medical faculty to exercise due care and diligence, a reasonable standard of practical skill, sound clinical judgment, and high ethical standards in treating patients under their care. Academic freedom is not a defence for negligence, malpractice, incompetence, or unethical behaviour.

As an unfortunate and unacceptable consequence of its exclusion from the Affiliation Agreement, academic freedom had no formal role in the relationship between Dalhousie and CDHA. Thus, the rights of medical faculty were not adequately protected, and the parties lacked an important tool to make their relationship more effective. As a simple example, although the Affiliation Agreement empowers the Liaison Committee to resolve disputes between the parties involving the "*application, interpretation or administration of this agreement,*" these powers would not be automatically invoked in a case involving academic freedom because academic freedom is excluded from the Affiliation Agreement. In the opinion of this Committee, use of such an option by the parties might have contributed to a timely resolution of two of the disputes investigated.

However it occurred, the absence of specific terms in the Affiliation Agreement committing Dalhousie and CDHA to promote and protect academic freedom set the stage for the events that subsequently unfolded, and was an important contributor to the unfortunate disputes that arose and the failure to resolve them expeditiously.

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[9] Sackett DL, Straus SE, Richardson WS, Rosenberg W, Haynes RB: *Evidence-Based Medicine: How to Practise and Teach EBM*, Second Edition. Edinburgh: Harcourt Brace, 2000.].

Appointment terms and academic freedom

The great majority of the members of the Faculty of Medicine jointly hold a Dalhousie academic appointment subject to Dalhousie policies, and an appointment to the CDHA Medical Staff subject to CDHA policies. Moreover, during the period under investigation, it was common for Dalhousie clinical faculty to receive much or all of their income from the Alternate Funding Plan (AFP) or other group practice plans connected to their CDHA appointment, and minimal amounts — even none at all — from Dalhousie itself.

In order to continue unimpeded in their work, faculty members were required to maintain their academic appointment at Dalhousie, their clinical appointment and privileges at CDHA, and their income through the Alternate Funding Plan, each of which is governed by different policies. To guarantee the academic freedom of Dalhousie medical faculty, all three of these sets of policies must meet the standards discussed above. The investigation by this Committee demonstrates that there are serious deficiencies in all three policy domains, thus placing academic freedom in great peril.

The case of Dr. Goodyear, discussed more fully in Chapter 7 of this report, is a clear example of the overall flaws in this system. CDHA took action to suspend Dr. Goodyear's privileges, effectively removing him from clinical practice at CDHA. Under CDHA policies, the only avenue available for Dr. Goodyear to defend himself was under the terms of the Disciplinary Bylaws. Dr. Goodyear's privileges were restricted on October 10, 2002, and subsequently suspended on January 9, 2003. The internal process under the Disciplinary Bylaws was not concluded until the Capital District Health Authority Board issued its report on January 26, 2009. During that entire time, the original suspension of Dr. Goodyear's privileges remained in place, excluding him from clinical practice at CDHA for over six years.

Dalhousie chose to maintain Dr. Goodyear's academic appointment, although unwarranted restrictions were placed on Dr. Goodyear's ability to carry on his academic work.

One year after Dr. Goodyear's clinical privileges were suspended, the Department of Medicine Alternate Funding Plan eliminated that part of Dr. Goodyear's income attributable to clinical work and teaching, reducing his revenue share by 85%, effective December 31, 2003. Dr. Goodyear had no right to appeal this decision under the terms of the Alternate Funding Plan or any other process except "*by way of consultation with the financial committee, and the Executive/Divisional Chiefs Committee if necessary.*" These bodies included the people who had both suspended Dr. Goodyear's privileges and determined the consequent reduction in his revenue share. There was no provision for an independent third party to review the reduction in remuneration and provide a binding judgment. Even the courts declined to do so, on the basis that the Alternate Funding Plan was not a public body and the proper recourse to a dispute was through private contract law. Legal counsel for the AFP took the position that Dr. Goodyear had a contractual obligation to fulfill the clinical and teaching duties specified in his practice profile and the moment he ceased to provide those services he had repudiated his contract and was not entitled to his revenue share for those unperformed duties. Counsel for the AFP held that the AFP had no duty of fairness to Dr. Goodyear and that the sole question to be answered was whether Dr. Goodyear had performed the contractual duties. In the opinion of counsel, the best person to answer that question was the Chief of Medicine, who had direct personal knowledge

that Dr. Goodyear had not performed the contracted duties because the suspension of his privileges prevented him from doing so, a matter of fact that, according to counsel, did not expose the Chief of Medicine to any conflicts of interest. Counsel for the AFP also held that the AFP was entitled to act upon Dr. Goodyear's repudiation of his contract at any time of their choosing and that the AFP had been fair to Dr. Goodyear by not acting for a year after he had repudiated his contract, and by "*gratuitously*" maintaining his revenue share for that one-year period.

The outcome of the actions taken in all three domains was that for over six years Dr. Goodyear suffered a ban on clinical practice at CDHA, restrictions on his appointment as an Assistant Professor in the Dalhousie Faculty of Medicine, and an income only 15% of normal for over five years. These consequences were experienced by Dr. Goodyear despite the fact that none of the concerns raised by CDHA about Dr. Goodyear's performance was proven, and the CDHA Board ultimately determined that "… *there was no basis to vary or suspend the privileges of Dr. Michael* Goodyear" and ordered that "… *Dr. Goodyear be returned to the status he enjoyed on October 9, 2002*." Despite the Board ruling, for reasons discussed in Chapter 7 of this report, Dr. Goodyear was not reinstated and his oncology career at CDHA was terminated. The career and personal life of Dr. Goodyear suffered grievous damage. This unacceptable result was a direct consequence of the appointment and remuneration arrangements in place in the Dalhousie Faculty of Medicine, both directly from Dalhousie and through the affiliation with CDHA and its related AFP. This extensive damage suffered by Dr. Goodyear was also a direct consequence of the inability of the decision-making structures at Dalhousie or CDHA adequately to recognize the growing injustice, and to intervene to put it to an end in a timely manner. Under the Disciplinary Bylaws, the Board should have received the case within fifty-one days of the variation in Dr. Goodyear's privileges. Instead, it was more than six years before the CDHA made its ruling. A number of senior administrators and officials at both Dalhousie and CDHA claimed inability to intervene for various reasons.

The case of Dr. Horne, discussed more fully in Chapter 6 of this report, is another clear example of the overall flaws in this trifurcated relationship among CDHA, Dalhousie University, and the AFP. CDHA took action to vary Dr. Horne's privileges, effectively removing her from clinical practice in the Heart Function Clinic, which also had the effect of preventing her from directly recruiting patients from the Heart Function Clinic for her research, which, according to Dr. Horne's appointment, made up 75% of her duties.

Once again, under CDHA policies, the only avenue available for Dr. Horne to defend herself was under the terms of the Disciplinary Bylaws. Dr. Horne's privileges were varied on October 22, 2002. As was happening in the case of Dr. Goodyear, so too in the case of Dr. Horne. There were extensive delays in reaching a conclusion under the process specified in the Disciplinary Bylaws, which called for the case to be presented to the CDHA Board within fifty-one days. The internal process under the Disciplinary Bylaws was not concluded until the Board issued its report on September 8, 2006, nearly four years after the variation of privileges. The Board found that there was insufficient reason to vary Dr. Horne's privileges and ordered that her status revert to what it had been on October 21, 2002. Throughout this long time, the variation of Dr. Horne's privileges remained in place, and her research program in heart failure was effectively shut down.

Dalhousie also chose to maintain Dr. Horne's academic appointment, but rescinded her Clinical Scholar Award, which provided funding to the Department of Medicine to protect approximately 75% of her time for research. As a result of intervention by the Dalhousie University Senate, that action was, in part, reversed. Nevertheless, Dr. Horne spent a great deal of time that should have been focused on research defending herself during what can only be described as an expanding and ever widening investigation going far beyond the issues originally raised as the basis for the variation of her privileges.

Following the variation in Dr. Horne's privileges, the Department of Medicine AFP reduced Dr. Horne's salary in absolute terms, and relative to her colleagues in the Division of Cardiology, on two different occasions. As in the case of Dr. Goodyear discussed above, Dr. Horne did not have an appropriate mechanism to appeal the salary decision.

The effect of the actions taken in all three domains was that for nearly four years Dr. Horne was unable to carry out clinical work in the Heart Function Clinic, she was unable to recruit patients directly into her research studies from the Heart Function Clinic, she could not continue with her original research plan, and she was deprived of a portion of her income. As in the case of Dr. Goodyear, Dr. Horne experienced these consequences despite the facts that none of the allegations raised by CDHA against her was ever proven and the CDHA Board ordered her status restored.

The career and the personal life of Dr. Horne have suffered extensive damage, and a promising research program ceased. In addition, the patients already enrolled in her studies have not seen their participation and sacrifice lead to valid and useful medical knowledge, a situation that violates research ethics. This unacceptable result is a direct consequence of the appointment, discipline, and salary arrangements in place in the Dalhousie Faculty of Medicine, both directly from Dalhousie and through the affiliation with CDHA and its related AFP. It is also a tragedy for the good name and reputation of Dalhousie University. A Statement of Claim filed by Dr. Horne in the Supreme Court of Nova Scotia in November 2006 claiming damages against CDHA, the Department of Medicine, the Chief of the Cardiology Division, and the interim CEO at the time of the Board ruling remained before the Court at the time of final editing of this report.

The case of Dr. Nassar also demonstrates the flaws in this system. Unlike Drs. Goodyear and Horne, no action was taken under the Disciplinary Bylaws against Dr. Nassar, and this Committee has seen no document indicating that Dr. Nassar's income was negatively impacted. However, Dalhousie and CDHA failed to resolve a number of interconnected disputes between Dr. Nassar and the Chief of the Department of Pathology and Laboratory Medicine, originally involving the Department Chief's private business activities and moving on to other matters related to the exercise of his authority as Department Chief. Those unresolved disputes extended over a period beginning in the early 1990s, and remain unresolved at the time of final editing of this report. These ongoing disputes led Dr. Nassar to file a complaint of "*hostile work environment*" against his Department Chief in early 2001. Subsequent to this event, Dr. Nassar's Department Chief recommended that Dr. Nassar's Continuing Appointment with Periodic Review (CAPR) appointment at Dalhousie not be renewed, which, if implemented, also would have threatened Dr. Nassar's CDHA appointment. Only the intervention of the Dalhousie President to extend Dr. Nassar's Dalhousie University CAPR appointment, despite that negative

recommendation that had been partially supported by the Dean of Medicine, prevented Dr. Nassar's career being terminated under questionable circumstances. The career and the personal life of Dr. Nassar have also suffered extensive damage. A Statement of Claim filed in the Supreme Court of Nova Scotia by Dr. Nassar in March 2004, and revised in June 2008, claiming damages against CDHA and Dr. Nassar's Department Chief, remained before the Court at the time of final editing of this report.

There were also serious defects in the CDHA Medical Staff Disciplinary Bylaws in place at the time[10] the privileges of Dr. Goodyear and Dr. Horne were varied. Under those Bylaws, the disciplinary action imposed by the Department Chief was to be first considered by the District Medical Advisory Committee (DMAC) within twenty-one days and subsequently by the Privileges Review Committee (PRC) within a further twenty days. Once the PRC made a report and recommendations to the Board, the Board of CDHA had then to hold a formal hearing to determine whether or not to uphold the variation of privileges. While the Board hearing had to be based upon both procedural fairness and natural justice, the Disciplinary Bylaws specified that neither the PRC nor the DMAC are required to provide procedural fairness or natural justice in their hearings. The effect was that neither Dr. Horne nor Dr. Goodyear had an appropriate opportunity to question the evidence presented against them, carry out cross-examination of witnesses, or provide evidence in their own defence, until the CDHA Board hearings took place. In the case of Dr. Horne, procedural fairness and natural justice were denied her for almost four years. Dr. Goodyear was denied procedural fairness and natural justice for nearly six years. This miscarriage of justice is a direct result of serious flaws in the Bylaws and other statutory documents defining the relationship of faculty members in the Dalhousie University Faculty of Medicine with the University, CDHA, and the AFP.

Under the terms of joint appointments, the Dalhousie University Faculty of Medicine defines academic and related administrative responsibilities, and CDHA defines medical care and related administrative responsibilities. The parties jointly determine the proportion of time allocated to clinical care, academic responsibilities, and administration.

Clearly, persons holding these joint appointments are subject to three sets of policies and three different reporting relationships (Dalhousie, CDHA, AFP). In the absence of an agreement protecting the right of academic freedom in both CDHA and Dalhousie appointments, there is a risk that one set of policies protects certain actions and the other does not. This risk is amplified by the absence of an explicit provision for reaching a fair and final resolution of conflicts, such as by arbitration.

When an appointment is terminated by either Dalhousie or CDHA, or the category of the appointment is changed, normally the related appointment with the other partner is also terminated subject to the policies of each party. Lack of congruence between the documents governing the relationship between CDHA and the Dalhousie Faculty of Medicine introduces the risk that an appointment could be terminated or modified in one domain under policies that do not protect academic freedom even if academic freedom were well protected in the other domain. The effect is that the faculty member does not truly enjoy the protection of academic freedom in either domain. Add to this the fact that the remuneration of clinical staff is controlled by a third

[10] These Bylaws are referred to as the "*Former Bylaws."* They were replaced by the "*New Bylaws*" in 2007.

domain, the group practice plans or Alternate Funding Plan, and it is clear that academic freedom does not enjoy the required protection. The cases considered by this Inquiry exposed all of these flaws.

Dalhousie appointments and assessments

The Faculty of Medicine at Dalhousie recognizes four different types of appointments:[11]:

> *a)* ***Probationary periodic review-track****: Normally an initial appointment of clinical staff is of this type. It is normally for three years, is in the career stream, and may lead to a reappointment to a periodic review-track appointment, but there is no undertaking to make a subsequent appointment.*
>
> *b)* ***Periodic review-track appointments****: Normally made after a successful review of a probationary appointment. It is normally for three years, is in the career stream, and will lead to consideration for a continuing appointment with periodic review.*
>
> *c)* ***Continuing appointment with periodic review (CAPR)****: Normally a continuing appointment subject to review every five years. If a continuation of the appointment is not granted, the clinical member has a right to a limited term appointment, normally for a term of up to two years, to allow the member to be reconsidered for a continuation of CAPR.*
>
> *d)* ***Limited term appointment****: Normally made for a period not exceeding three years, is not a career stream appointment, and will not lead to consideration for reappointment. There is no undertaking that a subsequent appointment will be made.*

In all cases the terms and conditions of an appointment are provided in writing to the appointee and include a mutually agreed-upon outline of responsibilities in clinical care, teaching, research, and administration. Faculty members are to be assessed in relation to the terms and conditions set out.

Dalhousie policies provide that the assessment for a probationary periodic review-track appointment shall also be based on evidence that:

> *a) The terms have been reasonably and responsibly fulfilled;*
>
> *b) The quality of the teaching, clinical practice and clinical skills, research, and professional clinical activity has been satisfactory;*
>
> *c) The member has demonstrated a commitment to academic and clinical vitality and a willingness to play an effective part in the work of the Department;*
>
> *d) Decisions are based on the overall performance but no clinical member may be reappointed if performance in any characteristic is less than satisfactory;*
>
> *e) The program, clinical, and budgetary considerations of the Department and Faculty have been satisfied.*

[11] Policy statement *Faculty of Medicine, Dalhousie University: Appointment Process for Clinical Faculty*, approved by Senate, January 26, 1998.

Dalhousie policies provide that the assessment for a periodic review-track appointment shall also be based on evidence that:

> *a) The terms and conditions of the previous appointment have been reasonably and responsibly fulfilled;*
>
> *b) The quality of the teaching, clinical practice and clinical skills, research, and professional clinical activity has been satisfactory;*
>
> *c) The member has demonstrated a satisfactory ability and willingness to work with colleagues so that the academic unit concerned functions effectively;*
>
> *d) The member must possess personal integrity;*
>
> *e) The program, clinical, and budgetary considerations of the Department and Faculty have been satisfied.*
>
> *f) Decisions are based on the overall performance but no clinical member may be reappointed if performance in any characteristic is less than satisfactory;*
>
> *g) There must be satisfactory evidence that the clinical member has demonstrated a commitment to academic and clinical vitality, and a willingness to play an effective part in the work of the Department; and*
>
> *f) The clinical member has attained and is likely to maintain a high degree of academic and clinical proficiency.*

Dalhousie policies specify that the assessment for a Continuing Appointment with Periodic Review (CAPR) will include:

> *a) teaching effectiveness;*
>
> *b) research and professional clinical service;*
>
> *c) ability and willingness to work with colleagues so that the academic units concerned function effectively;*
>
> *d) and personal integrity.*

Decisions are to be based on an overall assessment of performance. However, no clinical member can be awarded a CAPR, or a continuation of a CAPR, if the performance in any characteristic is less than satisfactory. Dr. Nassar's Department Chief recommended that Dr. Nassar's CAPR appointment not be continued because of alleged deficiencies in "*collegiality*" and personal integrity.

Clearly, these types of appointments do not provide the security of employment that is essential to the protection of academic freedom. The standard protection for academic freedom is tenure, which guarantees that an appointment can be terminated only for just and sufficient cause. Prior to being granted tenure, it is standard to have a probationary appointment for a substantial period, typically of the order of six years, during which appointees are given an opportunity to demonstrate that they meet the criteria for tenure. Clinical faculty at Dalhousie University had tenure-stream appointments until tenure was taken away and replaced with CAPR

appointments during the late 1990s. By contrast, at Queens University clinical faculty have an active Clinical Teachers Association and have the protection of tenured appointments.

The Dalhousie appointments most similar to pre-tenure probationary appointments are the probationary periodic review-track and the periodic review-track appointments, each of which is normally three years. One of the criteria that must be met to complete successfully either of these appointments is that "*the program, clinical, and budgetary considerations of the Department and Faculty* have *been satisfied.*" This is a very broad and poorly defined criterion. What is the nature of the "*considerations*" and who has the power to determine what those considerations are or if they have been satisfied? Could a program consideration be, for example, collaborative research with other faculty in the Department? If a faculty member preferred not to collaborate, as (s)he has the right to do, would that be seen as a failure to satisfy a Department or Faculty "*consideration*"? Or would it be seen as evidence of unwillingness to work with colleagues so that the academic unit functioned effectively? These issues are more than just examples of potential difficulties; they actually arose in the case of Dr. Horne.

Another criterion that is equally vague and potentially dangerous to academic freedom involves assessing "*commitment to academic and clinical vitality*." How exactly does someone demonstrate a "*commitment to academic and clinical vitality and a willingness to play an effective* part *in the work of the Department*"? For example, a faculty member who believes that the Department is in need of major reform might express his or her commitment to academic and clinical vitality through criticism of the leadership of the Department and/or its traditional approaches. Would such criticism be seen by those being criticized as playing an effective role in the work of the Department? This vague wording in relation to acceptable behaviour is particularly a problem in view of the lack of a clear statement of the right to academic freedom, which should make clear that criticism of one's colleagues, the Department Chief, or the University as a whole is acceptable. These examples of potential difficulty became real in the cases of Dr. Horne, Dr. Goodyear, and Dr. Nassar.

Yet another vague criterion that threatens academic freedom is the requirement that "*the member has demonstrated a satisfactory ability and willingness to work with colleagues so that the academic unit concerned functions effectively.*" Who judges that the academic unit is working "*effectively,*" and what does "*effectively*" mean in this context? This Committee saw some clear examples of how this criterion could be problematic when faculty exercised their academic freedom. One Department was subject to considerable turmoil as the result of one member criticizing the personal integrity of the unit Chief, which academic freedom gives him the right to do. This was a part of the experience of Dr. Nassar. Another unit experienced difficulties when a faculty member declined to involve certain colleagues in a research project, a situation resented by some of those colleagues. This was part of Dr. Horne's experience. In still another case, some colleagues were offended when a faculty member returned from conferences determined to integrate what he had learned there into daily practice, and to update treatment protocols based on such evidence. This was part of Dr. Goodyear's experience.

Both the Dalhousie and the CDHA appointments are either for a specific term or are Continuing Appointments with Periodic Review (CAPR). Neither type of appointment provides adequate protection for academic freedom.

The Alternate Funding Plan determines the majority of the remuneration to be paid to most of the clinical faculty, with usually only a small (or no) contribution from Dalhousie. It is possible under the terms of the AFP for the Department Chief to determine the revenue share paid to each faculty member, and the only appeal is to bodies of which that same Department Chief is a member. Putting such power into the hands of a single individual is an exceptional threat to academic freedom because it could substantially curtail the income of a faculty member, who would then have no effective recourse to appeal. This actually happened in the case of Dr. Goodyear.

Dalhousie University has a duty to defend the academic freedom of its faculty members and to protect the ethical conduct of their research. In each of the cases considered by this Committee, the policies and practices of Dalhousie proved inadequate to meet that duty effectively.

Collegiality

Introduction

The words "*collegiality*" and "*collegial*" occur repeatedly in documents originating from all three cases under investigation by this Committee. Collegiality has such importance that there was a recommendation from Dr. Nassar's Department Chief that Dr. Nassar should lose his appointment at Dalhousie University because "*in my opinion, Dr. Nassar fails to meet the required CAPR standards in the area of collegiality and personal integrity.*" Dr. Goodyear's Department Chief gave as one of her reasons for varying the privileges of Dr. Goodyear "*failure to function in a collegial team framework.*" One reason given by Dr. Horne's Department Chief for varying her privileges was "*concern for the ability of the individual to maintain appropriate professional interaction in a team care model of service delivery."*

There is no apparent consistency in the understanding of these terms, other than a general sense that collegiality is viewed as an important attribute of faculty members and active medical staff. There appears to have been no general agreement in practice about its meaning, other than that it relates to professional interactions with other faculty members leading to effective functioning of the department. Unfortunately, the combination of the undefined "*collegiality*" with the equally undefined "*effective functioning*" allowed both "*collegiality*" and "*effective functioning*" to be applied to Drs. Horne, Goodyear, and Nassar in broad, unspecific, but negative ways that related to perceptions of personality rather than to professional competence.

Indeed, it would appear that "*collegiality*" was commonly misunderstood as a personal characteristic, rather than a professional one. A weakness of the CDHA/Dalhousie environment is the vague and flexible way in which the term "*collegiality*" appears to be used.

The definition of "*collegiality*" adopted unanimously by the Dalhousie Faculty of Medicine on January 28, 2004 states:

> *Collegiality is broadly defined as the ability to function professionally within the academic community, and involves the demonstrated willingness to work with*

> *colleagues in contributing to the academic mission and governance of the department, the Faculty of Medicine, and Dalhousie University. As such, it is evaluated within the context of professional activities in the areas of teaching, research and administration and, where applicable, clinical service.*

This definition of "*collegiality*" is helpful in its focus on the professional meanings of "collegiality." Unfortunately, it was not in place when many of the formative events described in the cases of Drs. Horne, Goodyear, and Nassar unfolded.

As an example, in the case of Dr. Nassar, the CAPR guidelines used by the Department of Pathology Chief set out a University criterion and a Faculty requirement for collegiality. The University requirement states: "*The faculty member must have demonstrated a willingness to work with colleagues so that the academic unit functions effectively."* The Faculty requirement states: "*The faculty member must have demonstrated a commitment to academic and clinical vitality and a willingness to play an effective part in the work of the department.*" In his recommendation to the Dean of Medicine that Dr. Nassar's CAPR appointment not be renewed, Dr. Nassar's Department Chief gave a lengthy description of a number of incidents that, in his opinion, indicated that Dr. Nassar did not meet these criteria. In response, Dr. Nassar argued that many of those incidents related to attempts by Dr. Nassar to change practices within the Department, and by the Department Chief personally, changes that Dr. Nassar saw as being essential to the effective functioning of the Department and its academic and clinical vitality. Dr. Nassar also gave numerous examples of his willingness to play an effective part in the clinical mandate, research, and teaching of the Department.

As a second example, Dr. Goodyear regularly engaged his colleagues in collegial discussion of a wide range of issues and participated very actively in the work of the tumour site groups. When colleagues were asked for opinions about Dr. Goodyear, one colleague reported no problem working beside him, another explicitly complimented his collegiality, and a third described the personal support he provided during a career transition. Such comments provide clear evidence of functioning in a collegial fashion. It appears that the concern about Dr. Goodyear not being collegial was based on several of Dr. Goodyear's attitudes and actions. Dr. Goodyear did not always accept the advice of his colleagues. Moreover, Dr. Goodyear sought means to implement treatments he believed to be in the best interests of his patients so that the slow pace of discussions about treatment standards did not dictate what treatments could be offered to those patients. These differing approaches to treating patients offended some of Dr. Goodyear's colleagues. A proper understanding of "*collegial*" in an academic clinical setting does not require Dr. Goodyear always to accept the advice of colleagues, nor to abandon his opinions about the proper treatment of patients because his colleagues disagreed with him.

As a third example, Dr. Horne had extensive research collaborations, and worked effectively with a number of individuals both within her own department and others, notably the School of Biomedical Engineering, in which she held a cross-appointment. Many colleagues wrote letters attesting to her collegiality. What she did not do was invite certain of her colleagues to participate in her research programs, for which she was criticized, but which was entirely her right. She also experienced interpersonal communication difficulties with certain of her colleagues, notably the Director of the Heart Function Clinic and to a lesser extent the Director of the Adult Congenital Heart Disease Clinic, difficulties that were characterized as

unprofessional and a threat to the functioning of the HFC and safety of its patients. There had been no proper investigation of these allegations, but the label of "*uncollegial*" was applied to Dr. Horne by her Department Chief and her Division Chief with serious consequences to Dr. Horne, including a threat to her promotion and to her continuing appointment.

Basic principles of collegiality

There is an extensive literature on collegiality, much of which is contradictory. As Linda Hutcheon has discussed,[12] at least some of this confusion arises because different languages provide roots with different meanings. Hutcheon gives four examples that relate to authority, consultation, and daily relationships taken from different cultures: the Latin "*collegium*" and Russian "*kollégia,*" meaning an advisory committee whose consultation by decision makers was mandatory; the German "*collegialismus,*" meaning a voluntary association formed by contract in which supreme authority rests with the whole body of the members; and the French "*collégialité*" which has been translated as "*colleagueship.*" With so many different meanings and nuances at play, there is a great risk that collegiality has become a word whose meaning may well differ between the writer and the reader, and between formal and vernacular speech. The resulting potential for major misunderstandings is dangerous when collegiality is used as a criterion for determining employment status of individuals.

Serious efforts have been made by both the Canadian Association of University Teachers (CAUT) and by the American Association of University Professors (AAUP) to provide guidance about the meaning and uses of the term "*collegiality*" in the University context. Indeed, CAUT has approved a *Policy Statement on Collegiality*[13] which states:

> *Collegiality refers to the participation of academic staff in academic governance structures. Collegiality does not mean congeniality or civility.*
>
> *To be collegial, academic governance must:*
>
> *(a) allow for the expression of a diversity of views and opinions,*
>
> *(b) protect participants so that no individual is given inappropriate advantage (for example, due to power differentials) with respect to decisions, and*
>
> *(c) ensure inclusiveness so that all who should be participating are provided the opportunity to do so.*
>
> *Collegial governance depends on participants being given and delivering their share of the service workload.*

This definition explicitly emphasizes the characteristics of good academic governance, encouraging a range of opinions in an inclusive discussion leading to decisions free from the influence of inappropriate power differentials among the participants. The emphasis is on

[12] Hutcheon, Linda, *Saving Collegiality*, Profession 2006 (MLA), p60–64
[13] CAUT Policies: *Policy Statement on Collegiality*, (Approved November 2005, and with editorial revisions, March 2010). Retrieved from https://www.caut.ca/about-us/caut-policy/lists/caut-policy-statements/policy-statement-on-collegiality

governance and its structures, not on personal behaviour. At a personal level, it is the willingness and ability to become actively engaged in making and implementing the necessary decisions that is valued.

However, there is a great deal of "*colleagueship*" implicit in this definition, which should also be explicitly recognized. The safer it is to engage fully and state one's opinions honestly, the stronger will be the collegial approach. A robust commitment by all participants to protection of academic freedom, sharing of critical information, and valuing the inherent worth and dignity of others will enhance both engagement and the quality of debate rather than chilling it. To encourage properly the expression of a diversity of views and opinions, to protect participants, and to ensure inclusiveness by making it safe to participate fully, a commitment to reasoned and respectful discussion founded on a basic level of civility and mutual respect is essential. A further commitment to constructive cooperation in the service of the common good is desirable. Individual behaviour which has the effect of inhibiting honest, frank, and open discussion weakens the collegial approach. As Hutcheon states, successful collegiality

> *... means happily living with, indeed actively appreciating, difference: difference of opinion, of character, of background, of scholarly interest, of political position. It is what inhabitants of diverse multicultural societies must learn to live with daily ... ideally with civility and respect, minimally with tolerance and acceptance.*

Therefore, properly understood, "*collegiality*" is a collective value to which each participant contributes by engaging with others. Collegiality is not an individual characteristic, but arises from interaction and engagement among the participants.

Unfortunately, collegiality has sometimes been misunderstood, and misused, as a vaguely subjective personal characteristic that is to be judged as a criterion for reappointment, tenure, or continued appointment. The inherently collective nature of collegiality makes it impossible to define objectively this characteristic at the personal level. How is it possible objectively to assign packets of blame to individuals for the collective failure of a dysfunctional Department or one that fails to rise above "groupthink," and musty orthodoxy? There is a real danger that such personalization of collegiality can lead to exclusion of those who are different from the existing norm by reason of gender, race, ethnicity, age, political belief, sexual orientation, academic values, personality, or any of a number of other irrelevant characteristics. Collegiality must not be allowed to become discrimination by stealth. Similarly, personalization of collegiality can become a weapon against those who "don't fit in," "don't show sufficient support to the Chief," are "too aggressive," "uppity," "disagreeable," "disloyal," "demanding," "over-assertive," "inflexible," "tedious," "abrasive," "pushy," "a problem child," "a troublemaker," "gadfly," "malcontent," "unappreciative," "toxic," or other negative descriptor of choice.

The AAUP has also adopted a statement[14] "*On* Collegiality *as a Criterion for Faculty Evaluation.*" It recognizes the potential threat to academic freedom from invoking collegiality as a personal criterion, separate from the usual criteria of teaching, scholarly work, and academic service, for academic status decisions:

[14] AAUP Policy Statement *On Collegiality as a Criterion for Faculty Evaluation*, adopted November 1999.

> *... collegiality may be confused with the expectation that a faculty member display "enthusiasm" or "dedication," evince "a constructive attitude" that will "foster harmony," or display an excessive deference to administrative or faculty decisions where these may require reasoned discussion. Such expectations are flatly contrary to elementary principles of academic freedom, which protect a faculty member's right to dissent from the judgments of colleagues and administrators. A distinct criterion of collegiality also holds the potential of chilling faculty debate and discussion. Criticism and opposition do not necessarily conflict with collegiality. Gadflies, critics of institutional practices or collegial norms, even the occasional malcontent, have all been known to play an invaluable and constructive role in the life of academic departments and institutions. They have sometimes proved collegial in the deepest and truest sense.*
>
> *... collegiality is not a distinct capacity to be assessed independently of the traditional triumvirate of teaching, scholarship, and service. It is rather a quality whose value is expressed in the successful execution of these three functions. Evaluation in these three areas will encompass the contributions that the virtue of collegiality may pertinently add to a faculty member's career. ... Institutions of higher education should instead focus on developing clear definitions of teaching, scholarship, and service, in which the virtues of collegiality are reflected. Certainly an absence of collegiality ought not, by itself, constitute a basis for non-reappointment, denial of tenure, or dismissal for cause.*

The AAUP policy statement also states:

> *Professional misconduct or malfeasance should constitute an independently relevant matter for faculty evaluation. So, too, should efforts to obstruct the ability of colleagues to carry out their normal functions, to engage in personal attacks, or to violate ethical standards. The elevation of collegiality into a separate and discrete standard is not only inconsistent with the long-term vigor and health of academic institutions and dangerous to academic freedom, it is also unnecessary.*

The AAUP policy statement makes clear that professional misconduct and malfeasance are relevant matters for faculty evaluation that can, and should, be separately evaluated. There is an important distinction between professional misconduct and the effect that such misconduct has on the collective collegiality of the Department. Employers and employees alike have a legitimate interest in correcting professional misconduct, in part because of the important impact it can have on collegiality and the ability of others to do their jobs effectively. When misconduct is allowed to continue, the result can be a poisoned environment characterized by anger, resentment, distrust, anxiety, and a desire to withdraw and/or seek alternative employment. However, the proper context for dealing with such misconduct is through codes of ethics and disciplinary procedures, not through the academic assessment process. The accepted standard is that disciplinary action should be taken only for just and sufficient cause, which must be demonstrated by the accuser through a fair process, and the penalty applied must be appropriate for the offence. Allegations of serious misconduct such as direct or implied threats of retribution, bullying, intimidation, discrimination, and harassment should be dealt with promptly through a fair disciplinary process.

Differences: academic and clinical posts

Lack of an appropriate collegial environment in an academic setting can be inconvenient, ineffective, and even uncomfortable for people who work in that environment, but it does not have the same potentially dangerous quality that pertains to a clinical environment in which there is shared care.

Effective communication among members of the clinical team providing team care, or cross-covering at nights and on weekends, is vital for the well-being of the patients. In a clinical team environment it is essential that members communicate effectively, negotiate solutions to differences that arise, and strive for consensus and consistency. In such circumstances, lack of an appropriate collegial environment presents a risk to quality of care and can cause actual harm to patients. Team leaders have a particular role in encouraging and, if necessary, enforcing an appropriate collegial environment.

However, not all clinical environments require that level of teamwork. Exceptions would be: solo-practitioners who provide total care; "peripheral" physicians who neither assume nor require ongoing responsibilities, such as diagnostic imagers and pathologists; or physicians who have a time-limited role, such as surgeons who provide a high level of technical skill to teams responsible for providing the pre- and postoperative care.

Even in the best of collegial environments it may be necessary on occasion to correct inappropriate behaviour or ineffective communications on the part of an individual. Such events are properly viewed as not meeting reasonable expectations for interpersonal behaviour, not as a lack of "*collegiality.*"

Hospital privileges and fairness

Hospital Boards have a general responsibility to maintain appropriate standards of patient care. One of the mechanisms by which they do so is to exercise control over who may practice in the hospital and on what terms.

In general, no physician may admit patients or provide any service to a patient in a hospital without being authorized to do so through the granting of privileges by the hospital Board. In hospitals such as Capital Health that are also centres for teaching and research, no physician may be involved in teaching or conduct research in the hospital unless (s)he holds an appointment that includes those privileges. In short, no one is able to carry out any of the normal duties of an academic physician unless he/she has appropriate privileges and authorization by the hospital Board.

In the case of Dr. Horne, the District Medical Advisory Committee defined[15] "privileges" of a physician at Capital Health as "*The 'privileges' of a member of the Medical Staff in the category of active staff encompass the duties and responsibilities of a specialist physician*

[15] Report and Recommendations of DMAC of CDHA in the Matter of the Variation of Privileges of Dr. Susan Gabrielle Horne, p52, February 21, 2003

working in a tertiary environment as an attending or active staff physician with the right to admit and discharge patients, the right to diagnose and treat disease, the right to perform certain technical, medical or surgical procedures of a diagnostic or therapeutic nature and to exercise overall responsibility and direction for the care of patients…" DMAC made no reference to research, which made up approximately 70% of Dr. Horne's duties.

Hospital bylaws, such as those at Capital Health discussed in Chapter 3 of this report, provide detailed procedures by which requests for privileges are vetted, reviewed, and granted. Typically the hospital Board will delegate certain review and recommendation functions regarding privileges to various individuals and committees. At Capital Health those functions were delegated to clinical Department Chiefs and Vice-Presidents, and to committees such as the District Medical Advisory Committee and the Privileges Review Committee. In most cases, privileges are granted for a specific period and are subject to review before a renewal is granted.

It is also common that academic physicians provide secondary and tertiary care for patients and derive substantial proportions of their income, directly or indirectly, from the fee for service attached to the care of those patients, or through group practice plans such as the Alternate Funding Plan at the CDHA Department of Medicine. Therefore, privileges are necessary in order for clinical faculty to teach, to do research, to provide care for patients, and, in most cases, to earn a living.

For academic physicians like those considered in this Inquiry, the privileges they hold are vital. Variation of privileges can have a serious impact on the physician's research and teaching activities, as well as on the nature of the patients for whom (s)he is authorized to care. Revoking or suspending privileges is a career-threatening action. Varying or revoking privileges must be reported to the provincial Medical College, which in turn may result in limits on the license to practice medicine in that province or the suspension of that license. If a physician attempts to move to another jurisdiction, his/her current jurisdiction is required to report any limitations imposed on his/her ability to practice, including any variation or suspension of privileges.

Therefore, once physicians have been granted privileges, it is critical that they not have those privileges varied or suspended except for just and sufficient cause and in accordance with a fair process. A high standard of protection of the rights of the individual physician must be maintained. Part of that high standard is the requirement that the principles of natural justice and procedural fairness apply to all processes used to vary or suspend privileges.

When the hospital Board, or any of its designated agents, intends to make a decision that will affect the privileges of a physician, that individual must be informed of the reasons and be provided a meaningful opportunity to respond. The hospital Board, and its designated agents, must also conduct a fair process at all stages, including at the stage where a Department Chief takes the initial action. Where the governing bylaws do not stipulate a fair process, it is to be implied. The hospital Board and all of its agents must also exercise due diligence, and have a duty to determine, examine, and weigh all of the facts before making a decision. They are not entitled simply to accept a recommendation made to them at a previous stage in the proceedings.

It is to be expected that most issues that might lead to a variation or suspension of privileges will be examined during the periodic reviews of privileges. Most hospital bylaws also

include a means by which a review of privileges can be conducted outside the normal periodic review process. Most hospital bylaws also provide for some form of summary procedure to be used in an emergency; for example, when there is imminent threat of harm to a patient or patients, and a response is required that cannot wait for regular review or even a special review. Hospitals have a responsibility to act immediately to protect patients from harm, and they require the means to do so when appropriate. However, the emergency does not remove the requirement that the process be fair, and in particular does not remove the requirement that the principles of natural justice and procedural fairness apply.

As discussed in Chapter 3 of this report, the bylaws of Capital Health include regular reviews of privileges, a process for special reviews at other times, and provisions for an emergency review. To maintain an appropriate level of trust and confidence, special and emergency reviews are reserved for special circumstances.

Accordingly, it is expected that special reviews would be rarely used, and that summary or emergency procedures would be exceptional. In particular, it is not appropriate to deal with issues of long standing through special or emergency provisions if they reasonably could have been dealt with during a normal review. A mid-term variation of privileges carries substantial consequences, as discussed by Dykman.[16] "… *A mid-term suspension or revocation can be devastating for a physician: it will undermine the physician in the eyes of his or her peers, affect the confidence of patients, and in most circumstances, bring the physician's practice to a halt. It may result in loss of income. An alteration, suspension or revocation may have more significant consequences than a non-renewal …*"

Dispute resolution

Acts of provincial legislatures establishing the legal framework for collective bargaining require that every collective agreement contain a provision for the final and binding settlement, by arbitration or otherwise, of all differences between the parties concerning the interpretation, application, administration, or alleged violation of the collective agreement, including any question as to whether a matter is arbitrable. This provision for resolution of disputes is considered so important that it is usually deemed to be a part of every collective agreement even if no other provision in the collective agreement specifies what those procedures are.

It is common for the parties to agree to make every reasonable effort to settle all grievances in a prompt, amicable, just, and equitable manner. Wherever possible, informal attempts at resolving the dispute, such as negotiation or mediation, are typically encouraged. If informal means are not successful, there is usually a provision for a formal hearing before an independent (usually external) adjudicator, or panel of adjudicators, with all of the protections of natural justice and procedural fairness. The adjudicator or panel is empowered to make a final and binding ruling to resolve the matter. It is also common to provide that the parties agree not to practice any discrimination, harassment, or coercion against anyone who chooses to use, or not use, these procedures.

[16] Dykman; *Canadian Health Law Practice Manu*al, Butterworth, September 2002

The formal process usually has defined time limits that may be waived only by mutual agreement. In unionized settings, it is usual for representatives of the union and/or other advisors to be present at all meetings arising from the grievance.

Formal dispute resolution processes that will result in a final and binding decision using fair procedures in a timely manner are an essential component of the policies and procedures in any complex organization. Dalhousie University faculty, other than clinical faculty, are unionized and disputes are governed by the collective agreement, which contains provisions similar to those described above. However, none of Drs. Goodyear, Horne, or Nassar was included in the faculty bargaining unit at Dalhousie. The medical staff at CDHA are not unionized because Section 2(2)(b) of the Nova Scotia *Trade Union Act* forbids unionization of clinical faculty who hold a provincial licence to practice medicine.

There appeared to be no dispute resolution procedures at CDHA other than the seriously flawed Disciplinary Bylaws, or, in any event, such procedures as might exist other than the Disciplinary Bylaws were not deployed in any of the cases considered by this Committee. The result was that disputes dragged on without resolution for inordinate periods of time. In some cases an unresolved dispute actually became the basis or cause for new disputes, as occurred in the case of Dr. Nassar.

It is of crucial importance that dispute resolution procedures such as described above be defined, formally approved using collegial processes, and enshrined in published policies which are known to all.

Chapter 3 | Foundational Documents

Introduction

It is clear from the thousands of pages of documents examined by this Inquiry that fundamental changes are required in order to ensure that the events examined by this Inquiry cannot happen again. These changes should have the intent of ensuring that the Capital Health community is, and remains, healthy in the broadest sense.

In particular, all three cases considered by this Committee dragged on for unconscionably lengthy periods of time. There was no demonstrated mechanism for reaching a full and final settlement of the issues involved in a timely manner, except the mediation that did so in the case of Dr. Horne. Unfortunately even that "… *full and final settlement* …" reached on June 6, 2003, in a mediation involving all of the people most directly involved in the matter, was not implemented by CDHA and was allowed to wither and die over the succeeding months. In all of the cases examined by the Committee, a lengthy list of senior administrators holding a wide range of responsible positions seemed unable or unwilling to require that the issues be resolved. As the damage to all parties accumulated over the years, none of the senior administrators succeeded in ending the damage in a timely manner.

This Committee concluded that the damaging events that unfolded could not be explained simply as errors of commission, or even errors of omission, on the part of so many individuals. What happened was a systemic failure, not a collection of individual failures. Ultimately, in the opinion of this Committee, it was the seriously flawed bylaws, policies, procedures, foundational documents such as the Affiliation Agreement, and academic culture at Capital Health that must bear the burden of blame. Accordingly, it is important to examine the foundational documents and the ways in which they proved to be deficient in the three cases considered by this Inquiry.

The Capital District Health Authority (CDHA) is governed and administered in accordance with the Medical Staff Bylaws Part A: General, the Medical Staff Bylaws (Disciplinary) and various regulations. The relationship between CDHA and Dalhousie University is defined by the Affiliation Agreement between the parties. Among them, these foundational documents describe the roles, committees and processes that are relevant to the cases considered by this Inquiry and the administrative, legal, and procedural context in which the events under study in this Inquiry unfolded.

This chapter describes the requirements of the General Bylaws and the Affiliation Agreement and provides commentary concerning how the various provisions were applied, and the problems that arose, during the matters under investigation by this Inquiry. These provisions played a role in all three cases considered. Chapter 4 considers the role of the Medical Staff Bylaws (Disciplinary) in the granting and variation of privileges to practice medicine at CDHA and provides commentary on those specific matters that were at the core of the cases of Drs. Horne and Goodyear.

This Inquiry finds these foundational documents seriously lacking in provisions that would ensure procedural fairness, appropriate and timely consultation among the parties, and transparency. It is unacceptable that matters of critical importance to the mission of Dalhousie

University, notably academic freedom, are not even addressed in the Affiliation Agreement, let alone protected in a manner consistent with standard practice at Canadian universities. Crucial decisions about the employment status of Dalhousie University faculty members are left in the hands of affiliation partner Capital Health without the basic safeguards needed to protect the faculty members from injustice of a type that would not be tolerated in any other realm of Dalhousie University, or indeed in any other Canadian university.

Dalhousie was not demonstrably effective in protecting the academic freedom of its faculty members working within Capital Health, and ensuring transparency, procedural fairness, and full rights to natural justice when disputes arose between officers of Capital Health and some of those faculty members. The opinion of this Committee is that Dalhousie could have done more in the face of the apparent injustices suffered by Drs. Nassar, Horne, and Goodyear. This Committee has seen no evidence that Dalhousie made effective use of provisions in the Affiliation Agreement that might have put an end to obvious injustices, such as the lengthy delays in adjudicating the disputes. Dalhousie apparently made only limited attempts to use its good offices to encourage its partner, Capital Health, to take appropriate steps to end the continuing injustice and limit the damage to individual faulty members and Dalhousie's own good name and reputation. When the privileges of Dr. Horne were first varied, the Dalhousie VP Research promptly expressed concerns about the impact the variation of privileges would have on the academic rights and freedoms of Dr. Horne, and asked for assurances that those rights would be fully protected. Unfortunately, senior officials at Dalhousie explained on a number of occasions that they lacked the jurisdiction or legal authority to intervene appropriately as the disputes stretched over lengthy periods and the damage accumulated. It was not until the threat of censure by CAUT, and the related pressure from the Dalhousie University Senate, that Dalhousie officials took visible public action.

Missions and mandates

The CDHA General Bylaws apply to the Medical Staff at Capital Health, who are defined as "… *physicians licensed to practice pursuant to the Nova Scotia Medical Act who have privileges granted by the Board pursuant to the Medical Staff (Disciplinary) Bylaws* …" The Bylaws are drafted pursuant to Section 24 of the *Health Authorities Act*. They set out the governance, organizational structure, responsibilities, and privileges of the Medical Staff.

Capital Health consists of three separate legal entities: (1) Queen Elizabeth II Health Sciences Centre; (2) Nova Scotia Hospital; and (3) Capital District Health Authority. Under the *Health Authorities Act* the same persons are members of the Board of Directors of each of these entities and together govern Capital Health's facilities and programs and are called the Board. Capital Health provides tertiary and quaternary health services throughout Nova Scotia and Atlantic Canada and is the largest integrated academic health district in Atlantic Canada.

These specialized medical programs and facilities mean that what happens at Capital Health is not solely a local affair but certainly has regional and provincial implications, and in some cases, national and even international implications. The cases of Drs. Horne and Goodyear have attracted international attention, and have reflected badly on both Capital Health and Dalhousie.

The stated purpose of the Bylaws includes providing for: (a) the administrative structure for the governance of Medical Staff affairs involving treatment, teaching, and research; (b) the high quality of medical care for patients (within limits of available resources); (c) the teaching and research support to the mandate of Capital Health; (d) the description of duties, responsibilities, and privileges of the Medical Staff; (e) the means of effective and efficient communications between Medical Staff and other health care professionals, executive, and administrative staff within Capital Health, the Board, and Dalhousie; and (f) Medical Staff input into policy, planning and budget decisions.

The stated mandate of Capital Health is the provision of high-quality health care services, which includes clinical care, teaching, research, and advocacy, in the pursuit of healthy people in healthy communities. Capital Health states that the values that guide its decisions and behaviour are collaboration, accountability, respect, and excellence. The stated aim of the Dalhousie Faculty of Medicine is an equal commitment to exemplary patient care, education of students, promoting and sustaining the discovery and advancement of knowledge through scholarly research, and through education and community work, service to society in the Maritimes, Canada, and worldwide. These statements clearly show that the missions and aims of Capital Health and Dalhousie are mutually consistent.

To fulfill these mandates, Capital Health and the Dalhousie University Faculties of Medicine, Dentistry and Graduate Studies entered into an Affiliation Agreement. The stated purpose of the Affiliation Agreement is to provide a foundation upon which Dalhousie and Capital Health will collaborate in order to strive for excellence in clinical care, medical education, and medical research, and to accomplish these tasks in a manner consistent with their respective complementary missions, their statutory powers and duties, and their continuing obligations to others who are not parties to the Affiliation Agreement.

As discussed below, a serious problem is that the Affiliation Agreement between Capital Health and Dalhousie is deficient in a number of important ways. In particular, the Affiliation Agreement provides no protection for academic freedom. Moreover, various provisions allow for confusion regarding decision-making, particularly during disciplinary processes.

Alternate Funding Plans

There is another type of organization that is not explicitly mentioned in the Affiliation Agreement, but plays a critical role in every aspect of the activities at both Dalhousie and Capital Health. The Department of Medicine "*Alternate Funding Plan*" (AFP) explicitly provided almost all of the total remuneration of both Dr. Goodyear and Dr. Horne. Dr. Nassar obtained most of his remuneration from University Avenue Laboratory Medicine Associates (UALMA), a group-practice partnership offering pathology services to CDHA and academic and research services to Dalhousie. Neither Dalhousie nor Capital Health controls the remuneration of those people on whom each relies to meet its institutional objectives and, so, the independent actions of an unaffiliated organization (such as the Department of Medicine AFP, or UALMA) can have a significant impact on the ability of Dalhousie and Capital Health to meet their mandates. In itself, this situation is unacceptable. Failure to address specifically the relationship between Dalhousie, Capital Health, and the various AFPs and Group Practice Plans compounds the

difficulties embedded in the complex relationship between Dalhousie University and Capital District Health Authority.

As a particular example of those difficulties, the AFP reduced Dr. Goodyear's "*revenue share*" to 15% of what it had been before the suspension of his privileges, despite the fact that the charges on which he had been suspended had never been adjudicated, let alone proven, and were ultimately found by the CDHA Board to be insufficient to justify the variation of Dr. Goodyear's privileges. The decision to reduce Dr. Goodyear's income caused Dr. Goodyear to be without 85% of his income for over five years while his case ground on through the Capital Health decision-making process, causing a grave injustice to him. The Inquiry has seen no record of attempts by Capital Health or Dalhousie to intervene with the AFP and prevent this injustice. In fact, the Chief of the CDHA Department of Medicine first suspended Dr. Goodyear's privileges, later made the decision as Head of the relevant AFP to reduce Dr. Goodyear's revenue share, and then was a member of the bodies to which any appeal of the revenue share decision needed to be made. This obvious conflict of interest arose, in part, because no recognition of the critical role of the AFP was included in the Affiliation Agreement.

Relevant definitions

Some of the relevant definitions used throughout are described and grouped together below for easier reference. They include:

CDHA CEO is the Chief Executive Officer of Capital Health and is appointed by the CDHA Board and reports to the Board. The CEO appoints the VP Medicine, VP Academic Affairs, Department Chiefs and Division Chiefs, and assigns their administrative duties. The CEO is consulted by the Board on appointments to the District Medical Advisory Committee (DMAC, see below), and is an *ex officio* member of DMAC. In all cases in this report, the term "CDHA CEO" refers to the office itself and is not specific to a particular individual. Several different people held this position at times relevant to this Inquiry.

Medical Staff means physicians licensed to practice pursuant to the Nova Scotia *Medical Act* who have privileges granted by the CDHA Board pursuant to the Medical Staff (Disciplinary) Bylaws, or who provide services to Capital Health under contract either as an employee or as an independent contractor. Medical Staff with privileges at CDHA are subject to the CDHA Bylaws. Drs. Nassar, Horne, and Goodyear all held positions as Medical Staff. The granting and significance of hospital privileges is discussed in Chapter 4.

Physician means a person who is registered in the Medical Register and holds a license to practice, under the terms of the *Medical Act*. Drs. Goodyear, Horne, and Nassar are all physicians.

Attending Physician means a Medical Staff member who has the overall responsibility for a patient's care. During the case of Dr. Horne, disputes arose about who was considered the "*Attending Physician*" for certain patients, or groups of patients, and about the powers of that "*Attending Physician*." In particular, there was a dispute about whether the consent of the Attending Physician was required for a patient to be

enrolled in a research study, and, if so, who that Attending Physician was. In one of Dr. Horne's research studies, one of her colleagues insisted that the Attending Physician must be a member of the Heart Function Clinic, whereas Dr. Horne considered the Attending Physician to be the electrophysiologist who had implanted the pacemaker whose effectiveness was being studied in her research.

Academic appointment means an appointment made by Dalhousie's Board of Governors to one of the Faculties on terms set out in a letter of appointment from Dalhousie.

Faculty Member means a person who has an academic appointment.

CDHA appointment means an appointment to the clinical positions of Medical Staff or Affiliated Medical Staff with privileges granted by the CDHA on terms set out in a letter of appointment from CDHA.

Joint appointment means membership in the Capital Health Medical Staff or Affiliated Medical Staff pursuant to an appointment or contract with Capital Health granted in conjunction with a corresponding Dalhousie academic appointment under the terms of the Affiliation Agreement

District means the Capital Health District established pursuant to the *Health Authorities Act*.

District Department means a clinical organizational unit established pursuant to Subsection 8.1 of the Bylaws. It is structured on a district-wide basis and consists of Medical Staff members with related fields of practice. Dr. Goodyear and Dr. Horne were members of the Department of Medicine. Dr. Nassar was a member of the Department of Pathology and Laboratory Medicine.

District Department Chief means a person appointed by the CEO to be a senior medical administrator of a Department. The Chief is accountable to the VP Medicine in all cases considered during this Inquiry. Two Chiefs played principal roles in the events considered by this Inquiry, the Chief of the Department of Medicine in the case of Drs. Horne and Goodyear, and the Chief of the Department of Pathology and Laboratory Medicine in the case of Dr. Nassar.

University Department means an academic organizational unit within the Dalhousie Faculty of Medicine comprising faculty members involved in related academic disciplines. Drs. Horne, Goodyear, and Nassar were members of their respective University Departments.

Dean means the Dean of Dalhousie's Faculty of Medicine.

University Department Head is appointed by Dalhousie University to be the senior medical education and research administrator in a University Department. With the approval of the CDHA Board, the Head has designated clinical education responsibilities pursuant to the Affiliation Agreement. Under the terms of the Affiliation Agreement, the Chief and the Head are normally the same person, and they were in the cases considered by this Inquiry.

District Chief of Staff (VP Medicine) is appointed by the CEO to be the senior medical administrator for the District and reports to the CDHA Board through the CEO.

District Division means a subsection or portion of a District Department. Dr. Goodyear was a member of the Division of Medical Oncology, Dr. Horne was a member of the Division of Cardiology, and Dr. Nassar was Chief of the Division of Clinical Chemistry.

District Division Chief is appointed by the CEO to be the senior medical administrator of a District Division, and is accountable to the District Department Chief. The relevant Division Chiefs in the case of Drs. Horne and Goodyear were, respectively, the Chief of the Division of Cardiology and the Chief of the Division of Medical Oncology, both of whom reported to the Chief of the Department of Medicine. Dr. Nassar was the Chief of Clinical Chemistry and reported to the Chief of the Department of Pathology and Laboratory Medicine.

District Medical Advisory Committee (DMAC) is established pursuant to Section 7 of these Bylaws, and has a structure, roles, and responsibilities described in a separate section below.

District Medical Staff Association (DMSA) is established pursuant to Section 9 of these Bylaws, and has a structure, roles, and responsibilities described in a separate section below.

CDHA Policy is guidance and directives approved by the appropriate administrative authority respecting the operation of a health care facility or program.

CDHA Rules and Regulations are the Capital Health Bylaws and the rules and regulations drafted pursuant to those Bylaws, Capital Health policies and procedures, and Capital Health department policies and procedures, with respect to the management of the Medical Staff activities of Capital Health. These are established by CDHA.

Dalhousie Rules and Regulations means applicable Dalhousie, Faculty, and Faculty Department regulations, policies, procedures, and guidelines. These are established by Dalhousie. There appears to be no mechanism to ensure that the policies, rules, and regulations of CDHA and Dalhousie are consistent and not in conflict with each other, other than the requirement that the Chief of a CDHA Department and the Head of the corresponding Dalhousie Department normally be the same person.

Academic freedom is missing from foundational documents

Academic freedom is a very important element missing from these foundational documents. As discussed in Chapter 2 of this report, academic freedom provides the essential guarantees that faculty may do their duty as scholars, teachers, practitioners, and public commentators or advocates, free from retribution. It is both a fundamental right of the individual faculty member and an essential component of a dynamic environment in which human knowledge, understanding, and practice are advanced, a new generation of scholars and clinicians is nurtured, and social progress is stimulated. Academic freedom is therefore essential

for attaining exemplary patient care, high quality education, discovery and advancement of knowledge, and service to the community and society at large.

The critical importance of academic freedom should be stressed in these foundational documents as one of the interests that Dalhousie and CDHA wish to see enshrined as a prerequisite for meeting their stated mission and objectives. Academic freedom is such a core value that it should be recognized in the CDHA Bylaws and the Affiliation Agreement should include a separate section devoted to a definition of academic freedom and the means required for its protection in the joint activities to be carried out by Dalhousie and Capital Health under the terms of the Affiliation Agreement. That section should be consistent with the academic freedom requirements described in detail in Chapter 2 of this report.

In the cases this Inquiry investigated, a common theme was serious misunderstanding of, or disregard for, the basic tenets of academic freedom on the part of some officials at Capital Health. As discussed in later chapters of this report:

Dr. Nassar had the right to criticize the behaviour of his Department Head, CDHA officials, and colleagues without fear of retribution;

Dr. Horne had the freedom to choose her research topics and collaborators without direction or pressure from her Department or Division Chief or her colleagues in Cardiology, or retribution when she refused those directions; and

Dr. Goodyear had the right to treat patients in accordance with his professional understanding of the best available clinical evidence and the properly informed wishes of his patients, whether or not his immediate colleagues agreed with these choices, provided Dr. Goodyear's care met a reasonable standard within the discipline as a whole. Dr. Goodyear also had the right to advocate new treatment protocols, and to be critical of, and to advocate changes to, standard treatment protocols based on new research evidence, without retribution from his colleagues or Department or Division Chiefs.

Had these rights been properly understood and respected by Capital Health officials, including Department and Division Chiefs, much of the great damage that ensued in these cases could have been avoided. Had senior academic administrators of Dalhousie, including the President, Vice-Presidents and Deans of Medicine, had the means to insist, in a timely manner, that their Capital Health colleagues respect these rights, that damage could have been greatly curtailed. Had proper procedural safeguards been in place to ensure procedural fairness and the full rights of natural justice, the damage could also have been minimized and contained.

Importance of privileges

No Medical Staff member is authorized to admit (or provide any service to) a patient, or to teach or to conduct research in a health care facility operated by the CDHA Board, unless he or she holds an appointment which includes the privileges to do so, or has been otherwise authorized by the Board to do so. In short, Medical Staff are not able to carry out any of the

normal duties of an academic physician unless they have appropriate privileges or authorization from the Board.

At the core of the case involving Dr. Horne was the variation of her privileges by the Chief of the Department of Medicine. At the core of the case involving Dr. Goodyear was the variation of his privileges, and subsequently the suspension of his privileges, by the same Chief of the Department of Medicine. One event in the case involving Dr. Nassar included a threat to Dr. Nassar's CDHA privileges when the Chief of the Department of Pathology and Laboratory Medicine recommended that Dr. Nassar's CAPR appointment at Dalhousie not be renewed.

Medical staff categories

Dr. Goodyear, Dr. Horne, and Dr. Nassar all held appointments as Active Medical Staff members. Such members may admit and treat patients in accordance with the privileges they have been granted on recommendation of the Department Chief. They may also teach and conduct research as *directed by the Department Head*. They also participate in the on-call services of Capital Health and are expected to share in the administrative work of their Departments. They are members of, and may hold office in, the District Medical Staff Association (DMSA) described below and pay dues to that body. It must be understood that the direction of the Department Head must not conflict with the academic freedom of the members of the Medical Staff.

Associate Staff have the same rights and responsibilities as Active Staff except that their contract is for a period up to two years. Capital Health has no obligation to renew that appointment, and Associate Staff have no rights to require a review or hearing or to otherwise appeal to the Provincial Appeals Board.

Dr. Goodyear's first appointment at CDHA was in the *locum tenens* category. *Locum tenens* staff are appointed to relieve members of the Medical Staff who are on vacation or extended leave. They have the same rights and responsibilities as the Associate Staff except that their contracts are for periods between thirty days and one year and can be extended for a further one-year period.

Dr. Goodyear was originally appointed to a *locum tenens* position for three months. This was renewed for four months, then again for six months, again for twelve months and finally for another six months. The extensions meant that Dr. Goodyear held a *locum tenens* appointment for more than the maximum two-year period.

Upper limits for what are designed as temporary appointments are commonly used to ensure that decisions about the need for ongoing appointments are made and to prevent what can become an exploitive short-term appointment. Time limits are also designed to reduce the risk of the employer accumulating liabilities without consciously deciding to do so.

During Dr. Goodyear's *locum tenens* appointments, Dr. Goodyear's Division Chief expressed some concerns about Dr. Goodyear's performance, which prompted the CDHA CEO to question one of the reappointments in December 1999. When it was proposed to reappoint Dr.

Goodyear again in December 2000, the Medical Oncology Chief was advised against doing so and was advised that, in the event he chose to appoint Dr. Goodyear contrary to this advice, he should include terms in an Appendix to the appointment letter that expressed those concerns. That Appendix, and attempts by the Medical Oncology Division Chief to enforce its contents, was a central event in the case of Dr. Goodyear.

CDHA appointments and Dalhousie appointments

Capital Health alone makes the appointment to the clinical positions of Medical Staff and Affiliated Medical Staff. Both Medical Staff and Affiliated Medical Staff are subject to the Capital Health Bylaws and are granted privileges in accordance with those Bylaws. The appointment letters usually specify that remuneration comes from the Alternate Funding Plan or similar Group Practice Plan, discussed above. The AFP, the appointment letters, and these definitions all explicitly include provisions for the Medical Staff to be independent contractors and not employees of either Dalhousie or Capital Health. In addition, the *Trade Union Act* precludes physicians licensed in Nova Scotia from being members of a union. Normally, Medical Staff or Affiliated Medical Staff of CDHA are required to hold an academic appointment at Dalhousie.

Dalhousie University alone makes the academic appointment, and does so on terms which are explicit in a letter of appointment issued by Dalhousie and signed by the President of Dalhousie. The appointment letter specifies the Faculty and Faculty Department. One of the terms in the appointment letters of Drs. Horne and Goodyear is that Dalhousie provides no salary for the Dalhousie duties Dr. Horne and Dr. Goodyear undertake. As discussed above, and in Chapter 7 of this report, this term had far-reaching implications for Dr. Goodyear. Even when Dalhousie University funds were used to support a significant part of Dr. Horne's duties when she was awarded a Research Scholar Award, those funds were transferred to another agency and were not paid directly to Dr. Horne as Dalhousie remuneration. In addition, clinical faculty at Dalhousie are excluded from the union representing other Dalhousie University faculty members.

Any person holding an academic appointment is a Faculty Member of Dalhousie. There is nothing in the Bylaw or Affiliation Agreement definitions that requires a Faculty Member to hold an appointment in Capital Health. However, normally, Capital Health Medical Staff must hold a Dalhousie appointment.

Joint appointments require both an appointment at Dalhousie and one at Capital Health. The Capital Health appointment has place of precedence in the definition. Joint appointments are subject to the rules, regulations, and policies of both parties, but there is nothing to ensure that those policies are consistent and not in conflict.

Dalhousie regulations and policies are specific to Dalhousie. Capital Health has no direct role in determining or implementing these policies. There is no agreement that these Dalhousie policies will be discussed with Capital Health or that there will be any mechanism to ensure that there is no conflict between Dalhousie policies and Capital Health policies on similar matters. As an important example, there is no guarantee that a Dalhousie policy on academic freedom would

be consistent with an academic freedom policy at Capital Health. In fact, it appears that Capital Health did not have a policy statement on academic freedom.

An Attending Physician must be a member of Capital Health's Medical Staff. The question of who is the Attending Physician plays a part in some of the issues involving Drs. Horne and Goodyear. A valid medical license is required to be a member of the CDHA Medical Staff. Nothing in these definitions requires someone holding an academic appointment to have a valid license to practice medicine unless it is specified as one of the terms in the letter of appointment.

The Capital Health Department includes only Medical Staff members with related fields of practice, and the Faculty Department includes only faculty members involved in related academic disciplines. These two different departments are established differently and could, in principle, have different members even though they may have the same name, except that "*normally*" people would hold joint appointments. Members of the Capital Health Department are appointed by Capital Health and are subject to Capital Health Bylaws and the related rules and regulations. Faculty Department members are appointed by Dalhousie and are subject to Dalhousie regulations and policies.

Departmental organization

After consultation with DMAC, the CDHA Board may establish Departments and Divisions and assign Medical Staff to them. Medical Staff are expected to act in accordance with the Rules and Regulations and the policies of their Department and Division. At various times, all three of the Medical Staff at the core of this Inquiry were accused of not abiding by policies of their Department or Division. An issue that arose in several instances was whether such a policy had been formally approved or whether what was described as a policy could more accurately be called a common practice.

In the opinion of this Committee, there should be a specific requirement that Department or Division policies be written and formally approved by the Department and/or Division in accordance with relevant CDHA policies, and that these policies may not conflict with the academic freedom of the Medical Staff. These policies should be available online and also provided to all new appointees in hard copy at the time of their appointment. In this regard, a Division may not enact a policy that conflicts with the academic freedom to choose one's research topic and research partners. This was a central issue in the case of Dr. Horne.

District Chief of Staff (VP Medicine)

The VP Medicine is appointed by the CDHA CEO following consultation with the DMAC, and is responsible to the CDHA Board through the CEO. The VP Medicine is responsible for the effective functioning of the Medical Staff, and for the implementation of Medical Staff affairs policies established by the Board. Some of the particular duties of the VP Medicine of relevance to this Inquiry are: (1) monitoring the effectiveness and performance of the Chiefs; (2) quality assurance, and ensuring regular evaluation of the performance of the Medical Staff; (3) ensuring that members of the Medical Staff comply with Bylaws, Rules, and Regulations and policies

established by DMAC and the Board; and (4) reporting to the CEO on the activities of the Medical Staff. The VP Medicine is a member of DMAC, its Executive Committee, and is an *ex officio* member of all DMAC subcommittees.

The VP Medicine has responsibility for monitoring the effectiveness and performance of the Chiefs. This Inquiry has no knowledge of such monitoring of the Chiefs at the centre of the cases investigated. The VP Medicine played an active role in attempting to resolve some of the disputes involving Dr. Nassar and the Chief of the Department of Pathology and Laboratory Medicine. The VP Medicine considered her role on DMAC, which was examining the variation of privileges of Drs. Horne and Goodyear, to preclude her involvement in other ways in those cases. In the opinion of this Committee, this perceived conflict had the unfortunate effect of removing the VP Medicine from playing what might have been an effective role in questioning the effectiveness and the appropriateness of the disciplinary process as it dragged on over an inordinately long time for both Dr. Horne and Dr. Goodyear.

District Department Chiefs and Division Chiefs

Each CDHA Department has a Chief appointed by the CDHA CEO, with written appointment terms, normally for a renewable five-year term. The appointment or renewal is based on the positive recommendation of a survey and search committee. The Chief must be a member of the Active Medical Staff and will normally hold an academic appointment and a concurrent appointment as the University Department Head for the relevant Department. The appointment of the Chief can be terminated pursuant to the terms of his or her appointment. Perhaps a more open and democratic process of selection might enhance the overall performance of CDHA in dealing with situations like those demonstrated in the three cases that are at the heart of this Inquiry.

The Chief is responsible for the medical administration and functioning of the CDHA Department. The Chief has authority and responsibility for clinical care of patients. Medical issues take priority over research and teaching issues if any conflict arises. Although prioritizing in this manner is certainly reasonable, it must be carefully monitored to ensure that patient safety is invoked only in *bona fide* cases, and not used as an excuse to override other matters. For example, patient recruitment to one of Dr. Horne's research projects was halted because it was alleged that the particular research protocol presented a danger to patients. This allegation was acted upon despite the fact that the protocol had been subject to rigorous peer and ethical review and had all the required approvals by the Research Ethics Board. When that research protocol was subsequently reviewed by a special meeting of the Division, no safety concerns were identified.

The Chief is responsible to the VP Medicine. Logically, the VP Medicine would be an advisor to the Chief. This Committee is unaware of any advice or mentoring by the VP Medicine to the Chief of Medicine related to the cases of Drs. Horne and Goodyear. The VP Medicine did work with the Chief of Pathology and Laboratory Medicine in some attempts to resolve longstanding issues involving that Chief and Dr. Nassar.

The Chief advises DMAC on the quality of care and treatment provided to patients, and on the fulfillment of teaching and research responsibilities within the Department. The Chief participates in development of Capital Health's overall objectives, planning, budgeting, resource allocation, and resource utilization, and makes recommendations regarding the medical personnel needs of the Department.

The Chief would have made a recommendation about the need for an additional full-time permanent Medical Oncologist, the position for which Dr. Goodyear was the successful candidate, and would have recommended the credentials and skills required for that position. Clearly Dr. Goodyear was judged to have met those criteria or he would not have been appointed.

The Chief is responsible for the organization and implementation of the clinical activities, establishes a process for continuing professional development, and ensures the development of programs to maintain and enforce professional standards. The Chief also meets regularly with Medical Staff and reviews the performance of Medical Staff annually for the purpose of making recommendations for reappointments or contract renewals. The Chief holds considerable power over individual Medical Staff by being able to recommend against reappointments. The same individual is typically Head of the corresponding Dalhousie Department and can also recommend that a CAPR appointment at Dalhousie not be renewed. The Head of the Dalhousie Department of Pathology did recommend that Dr. Nassar's CAPR appointment at Dalhousie not be renewed. Had Dr. Nassar's Dalhousie appointment not been renewed, his CDHA appointment would also normally have been terminated according to provisions of the Affiliation Agreement.

The Chief ensures consultation on, and compliance with, Capital Health and departmental objectives, policies, and rules and regulations. The Chief submits minutes of regular departmental meetings to the VP Medicine and may delegate appropriate responsibility to Division Chiefs.

Division Chiefs are responsible to the Department Chief for all of the same matters as discussed for the Department Chief, in particular making recommendations for reappointments. The Division Chief holds regular meetings of the Division and advises Medical Staff regarding Capital Health and Division policies and rules and regulations. The Division Chief submits minutes of regular Divisional meetings to the Department Chief and liaises with the University Department Head (normally the same person as the Department Chief) respecting academic activities within the Division.

District Medical Advisory Committee (DMAC)

DMAC is a committee of the CDHA Board advising it on matters concerning the provision of quality patient care, teaching and research, the major items in the Capital Health mandate. DMAC consists of the Capital Health CEO (*ex officio*), the VP Medicine, the VP Academic Affairs, the President of the DMSA, one designated member of the DMSA other than the President, and members reflecting representation of the departments, programs and geographical locations, selected by the Board after consultation with the CEO, the VP Medicine, the VP

Academic Affairs and the President of DMSA. Except for the two members of the DMSA, all members of DMAC are appointed directly or indirectly by the Board.

The DMAC Chair is appointed by the Board on recommendation of the voting members of DMAC. The President of DMSA, the VP Medicine, and the VP Academic Affairs are not eligible to be Chair. The Chair of DMAC is normally appointed by the Minister of Health to be an *ex officio* member of the Board. The Chair of DMAC is accountable to the Board through the VP Medicine. DMAC is required to meet at least ten times per year, and the Chair may call special meetings on at least forty-eight hours notice. DMAC had adequate opportunity to consider the matters which are the subject of this Inquiry.

DMAC has broad powers regarding the performance and conduct of members of the Medical Staff. Among other matters, these include ethical conduct and professional practice; supervision, quality, organization, and delivery of patient care, teaching, and research; recommending to the Board Rules, Regulations, and Policies that apply to the Medical Staff; and making recommendations to the Privileges Review Committee concerning appointments, discipline, and privileges of the Medical Staff.

DMAC both makes recommendations about rules, regulations, and policies and also makes recommendations in cases where a member of the Medical Staff is accused of breaching these same rules, regulations, and policies. In the opinion of this Committee, it is inappropriate for the same body to have responsibility for establishing the policies and then for interpreting those rules and judging those who are alleged to have breached those policies. In addition, some DMAC members may also have prior involvement in disciplinary matters. For example, the approval of the Capital Health CEO is required before any action by a Department Chief to vary privileges takes effect; the VP Medicine may have had prior involvement in attempting to enforce compliance with the rules, regulations, and policies; and DMSA, two members of which are members of DMAC, may be consulted by members of the Medical Staff who are experiencing difficulties, as was the case with Drs. Horne, Goodyear, and Nassar. In the opinion of this Committee, these apparent conflicts are unacceptable and the role and/or composition of the DMAC must be reformed.

District Medical Staff Association (DMSA)

The purpose of the DMSA is to represent the interests of the Medical Staff to the Executive Management Team, the DMAC, and the Board. All medical staff members are required to be members of, and pay dues to, the DMSA. The President of DMSA is a member of DMAC, and, at the pleasure of the Minister of Health, is a member of the Board. The President of DMSA communicates to the Board through the CEO, the VP Medicine, and other Board representatives. In addition to general representation of the Medical Staff, DMSA and its President may speak for individual members of the Medical Staff.

In principle, DMSA has most of the powers that are required to act as a representative body protecting the rights of the Medical Staff as a whole, and of individual members of the Medical Staff who have a grievance with the Administration. However, an important constraint is that all CDHA physicians are members of DMSA, including those who hold Administration positions.

Consequently, DMSA could be in the position of representing both the member of the Medical Staff with the grievance and the Administrator, such as a Department Chief, against whom the grievance is filed. Through its mandatory fee structure it also has, in principle, the required economic power to support individuals during those grievances. Although DMSA took certain steps in support of both Dr. Horne and Dr. Goodyear, it did not succeed in preventing the lengthy delays in the disciplinary process that did so much damage to Dr. Horne and Dr. Goodyear. DMSA also did not succeed in requiring a final and binding resolution of the concerns raised by Dr. Nassar.

Aside from some limited legal assistance from the Canadian Medical Protective Association for some aspects of their cases, Drs. Horne, Goodyear, and Nassar had to pay most of their legal expenses, while CDHA made extensive use of both in-house counsel and external lawyers. A body such as the DMSA with the authority to represent the individual members and the financial resources to provide a level playing field is an essential requirement if academic freedom is to be properly protected and the rights of individuals to fair and timely resolution of disputes is to be enforced.

The DMSA carried out a peer review, by four of Nova Scotia's most respected physicians, of the allegations against Dr. Horne. That peer review found that none of the allegations against Dr. Horne was justified and urged that CDHA reinstate Dr. Horne. One of the unusual events in the case of Dr. Goodyear was when the DMSA, under legal threat from lawyers acting on behalf of CDHA, destroyed all materials they had collected during an investigation of the concerns raised by Dr. Goodyear's Division Chief and his Department Chief about the care provided to patients by Dr. Goodyear. It is inappropriate and unacceptable that a body specifically given the power to speak on behalf of individual members of the Medical Staff should be subject to such legal actions by CDHA. There needs to be a clear recognition that members of the Medical Staff may disclose to DMSA confidential information, legitimately in their possession, that is required by DMSA in the course of fulfilling their legal responsibilities.

Leave of absence

Members of the Medical Staff have the right to apply for leaves, on certain terms. For a leave of more than twelve consecutive weeks, a member of the Medical Staff applies in writing to the Chief stating the duration and purpose of the proposed leave. The leave will not exceed twelve months, but with reasonable notice the member may apply to the Chief for an extension for up to an additional year. If leave exceeds two years, a member must submit a new application for appointment to the Medical Staff. During the leave, the member remains a member of the Medical Staff but is excused from clinical, teaching, research, and committee responsibilities. Upon return, he or she resumes his or her former status and is required to file a report of his or her leave activities to the Chief, including proof of good standing in any other jurisdictions in which he or she practiced during the leave. Even during a leave, reappointment applications must be submitted at the regular time.

It appears that a leave of absence with pay could have been a less damaging alternative to a variation of privileges in the case of Dr. Goodyear. For example, such a leave could have allowed for time to do an impartial external review of Dr. Goodyear's practice, as he had

suggested. That could have provided the information needed by the Chief of Medicine to investigate properly and assess the situation without the stigma attached to Dr. Goodyear of having his privileges varied. Similarly, a leave could have been approved for Dr. Horne. This is not to suggest that leaves should be imposed on members of the Medical Staff as covert discipline. An imposed leave could also attach stigma to the individual, although likely less than would a variation of privileges. However, rather than the imposition of a variation of privileges, there were actually more creative possibilities available in dealing with the issues raised in the cases of Drs. Goodyear and Horne, possibilities that might have included a mutually agreed upon period of leave in order to allow time to reach a resolution to the concerns raised about each of their practices.

Rules and regulations

The Bylaws provide that, subject to approval by the CDHA Board, the Medical Staff may make rules and regulations with respect to medical activities, patient care, teaching and research, and the conduct of Medical Staff. The Bylaws take precedence if there are conflicts with rules and regulations. CDHA has an extensive set of rules and regulations. There should be a clear statement that the rules and regulations must not conflict with the academic freedom of the members of the Medical Staff.

Bylaw amendments

The Board may recommend amendments to the Minister of Health, subject to Section 24 of the *Health Authorities Act* after consultation with DMAC and DMSA. DMAC and DMSA may also recommend amendments to the Board if they are passed by a two-thirds majority at a meeting and appropriate notice has been given. In the case of DMAC, notice of motion must have been given at an earlier meeting, and, in the case of DMSA, a notice of motion must have been given in writing at least thirty days prior to the meeting.

Scope of the Affiliation Agreement

The Affiliation Agreement states that it is to be interpreted in the light of the intention that it address the affiliation between Dalhousie and Capital Health in relation to the integration of the Faculty of Medicine's programs and research activities within Capital Health. In other words, this Affiliation Agreement is to be interpreted to include issues related to the integration of the programs and research of the Faculties within Capital Health (and by inference, to no wider purpose).

The Affiliation Agreement also states that, notwithstanding any other provision in the agreement, in the event of any conflict between medical care, education, and research in the application, interpretation, or administration of the Agreement, the parties agree that medical care of the individual patient shall take precedence and have priority over education and research.

It may seem obvious that individual patient medical care takes priority over any other considerations, such as teaching and research. Left unaddressed are crucial matters such as who decides when the medical care of the individual patient is inappropriate? How is that decision made? What procedures are in place to protect all the parties? What is the time frame for examining concerns about patient safety? Also left unaddressed is the crucial role of academic freedom in teaching and research, and the understanding that patient care does not obviate academic freedom.

The commitment to patient safety nevertheless needs to include some concern for individual doctors accused of putting patients at risk. For example, both Dr. Horne and Dr. Goodyear had disagreements with certain of their colleagues concerning practices that those colleagues alleged were potentially harmful to patients. In both cases, after a substantial time had passed, those concerns by colleagues were judged to be unfounded. However, Dr. Horne's research program had been shut down for a sufficiently long period that irreparable damage was done to that program, and Dr. Goodyear's Medical Oncology career at CDHA had been ended. While in no way wishing to diminish the responsibility that CDHA has to the health and well-being of individual patients, it is important to understand that "*patient safety*" can, as happened in the cases of Drs. Goodyear and Horne, however unintentionally, become the means by which intellectual conformity and professional penalties can be imposed on colleagues whose only fault is that they disagree with other colleagues.

Clinical care — delineation of responsibilities

The Affiliation Agreement cedes to Capital Health exclusive authority over patient care, treatment, and safety, and Dalhousie both recognizes this statutory power of Capital Health, and agrees to support Capital Health in its efforts to achieve and maintain high-quality care. It was this sole responsibility that the CDHA Chief of Medicine claimed to be exercising when the privileges of both Dr. Horne and Dr. Goodyear were varied amid allegations that their conduct exposed, or was reasonably likely to expose, patients to harm or injury. There appears to have been no consultation with Dalhousie, other than in the trivial sense that the CDHA Chief of Medicine was also Head of the Dalhousie Department of Medicine. The result was the unacceptable situation in which two Dalhousie faculty members had career-threatening actions taken against them with no input from Dalhousie, no notice to Dalhousie, and no reasons given to Dalhousie after the fact. CDHA also claimed sole responsibility for the process under the Discipline Bylaws, which stretched on for four years in the case of Dr. Horne and six years in the case of Dr. Goodyear.

Interestingly, there is a specific provision dealing with what Capital Health may do in the event of a similar situation arising with respect to one of Dalhousie's "*clinical learners*" (a person enrolled in any of Dalhousie's undergraduate or graduate programs). In that case, although Capital Health asserts the right to act based on its "*sole opinion*," Capital Health is obliged to give Dalhousie written notice and reasons for such action. It is surprising that Capital Health is required to give notice and reasons to Dalhousie for actions taken against, say, a first-year medical student, and has no such obligations for actions against Dalhousie faculty members such as Drs. Horne and Goodyear.

The Affiliation Agreement appears to require that Dalhousie support Capital Health in the event that Capital Health determines that a concern exists with regard to a doctor's treatment of a patient. Although this Inquiry has seen no record of actual support, it has also seen little to indicate that Dalhousie took appropriate formal steps to protect either Dr. Horne or Dr. Goodyear from the damage that was inflicted upon them as events unfolded. This Inquiry has also seen no formal record that Dalhousie requested reasons from Capital Health for its actions against Dr. Horne or Dr. Goodyear, even though they would have been entitled to such reasons if Drs. Horne and Goodyear had been medical students. This is also an unacceptable situation.

The sole rights of Capital Health set out in these provisions of the Affiliation Agreement appear to be very broad. Capital Health's opinion is the only one that matters. Other than being informed of the intervention and the reasons, when the action is taken against a "*clinical learner*," Dalhousie appears to have no rights. Furthermore, there appears to be no appeal process other than the provisions of the Medical Staff Bylaws. This is a very strong power for Capital Health to hold, and such strong powers require a greater degree of transparency, accountability, and responsibility than is expressed in the Affiliation Agreement. As a minimum, Dalhousie should be advised, together with reasons, and have the opportunity to express its concerns in a timely manner.

The Affiliation Agreement requires Capital Health to ensure that the Attending Physician is responsible for medical care and for integration of this care with Dalhousie's research and teaching programs. This section seems to identify the right of the Attending Physician to make clinical decisions. Capital Health must therefore know who the Attending Physician is. The issue of who the Attending Physician is and what powers (s)he may exercise, particularly what powers (s)he has in identifying subjects to be enrolled in research projects, arose in several places in this Inquiry.

Dr. Horne was instructed not to list certain specialists as Attending Physician in her research projects, and was specifically barred from being an Attending Physician in the Heart Function Clinic when her privileges were varied in October, 2002. After the mediated settlement was reached, Dr. Horne's reintegration into the Heart Function Clinic faltered, in part, over questions related to when she would resume the responsibilities of Attending Physician in the Heart Function Clinic and over appointment of a clinical mentor from among the Attending Physicians in the Heart Function Clinic.

At various times, Dr. Goodyear's autonomy as a medical oncologist was diminished and his privileges were curtailed. On several occasions, he was subject to the supervision and judgment of others, his explanations to patients regarding their treatment required the presence of other doctors, and he was eventually denied independent access to his patients.

This section also requires that the integration of medical care with Dalhousie's clinical education and research activities is to be in accordance with the Capital Health rules and regulations and this Affiliation Agreement. This requirement that medical care be integrated with clinical education and research provides another example of why this agreement must contain provisions such as academic freedom that are critical to the research and education activities of Dalhousie.

Dalhousie has a responsibility under the Affiliation Agreement to tell clinical learners to comply with the rules and regulations of both Dalhousie and Capital Health, which presumably means they are told what those rules and regulations are. They are also required to know who the Attending Physician is and to follow directions and instructions from that individual. Such a rule is intended to eliminate any confusion about the identity of the Attending Physician. The standard for clinical learners is reasonable skill, and appropriate ethical and professional behaviour. There is no indication of who is to judge these standards and what the standards mean in practice.

Clinical learners who are not physicians are, according to the Affiliation Agreement, dealt with according to Dalhousie regulations and policies as a question of academic discipline. Dalhousie is required to take academic disciplinary action against any clinical learner who is a physician who fails to meet the Dalhousie-imposed obligations described in the previous paragraph, or who Capital Health has restricted. In addition, Capital Health "*reserves the right to take such action as it deems appropriate*" under its governing statute and its own rules and regulations. Dalhousie must apply academic discipline to clinical learners who have been restricted by Capital Health, even though such restrictions are solely at the discretion of Capital Health.

It is interesting that the Affiliation Agreement specifies how clinical learners are to be disciplined in a range of circumstances, and describes the respective roles of Dalhousie and Capital Health. By contrast, the Affiliation Agreement is silent about any actions by Dalhousie in the case of faculty members who have had restrictions imposed by Capital Health for disciplinary reasons. If the Affiliation Agreement can be so specific in the case of clinical learners, there does not appear to be a reason why it ought not to be specific in the case of faculty members.

Capital Health and Dalhousie are both required to "*cooperate and participate fully and promptly*" in each other's procedures "*when requested to do so."* A request from either party triggers a requirement for the other party, but there is no right for either party to participate in the other's procedures if they are not asked. In particular, under the provision described above, Capital Health can do "*as it deems appropriate*" without any right for Dalhousie to be involved, even though the action taken by Capital Health might prevent a Dalhousie "*clinical learner who is a physician*" from completing a program or doing research. A similar problem arises from the silence of the agreement regarding faculty members. Finally, the Affiliation Agreement does not specify how the required communication between Dalhousie and Capital Health is to take place, nor what time limits apply for various actions. These are major shortcomings of the Affiliation Agreement.

Clinical education

This Affiliation Agreement gives Dalhousie University exclusive responsibility for programs and for selecting the learners, but all instruction, supervision, and evaluation must be done by people who hold appointments in both Dalhousie and Capital Health. This has the important implication that Capital Health can prevent anyone from carrying out the normal teaching and research duties of university faculty by refusing, restricting, or terminating an

appointment at Capital Health or the privileges on which the appointment is based. As an example, the variation of the privileges of Dr. Horne became a major obstacle to her ability to conduct her normal research duties, despite the facts that Dr. Horne held an appointment as a Clinical Scholar with 75% of her duties specified as research and that funding for that Clinical Scholar position came from Dalhousie. Similarly, when Dr. Goodyear's privileges were varied, restrictions were imposed on certain of his academic activities that had nothing to do with his clinical duties.

The Affiliation Agreement specifies that Capital Health is to support Dalhousie in achieving and maintaining excellent research. This support was lacking in the case of Dr. Horne, despite a number of attempts by the CDHA VP Research and Academic Affairs to enlist the cooperation of others at Capital Health in finding effective ways for patients to be enrolled in Dr. Horne's research program. By contrast, Dalhousie appears to have placed restrictions on Dr. Goodyear's purely academic activities in parallel with the clinical restrictions imposed by Capital Health.

Collaboration takes place in a framework defined by the parties' rules, regulations, policies, and accreditation requirements. However, there is no provision to ensure that there is no conflict between the respective rules, regulations, and policies of the parties. The agreement to cooperate could be construed to require Capital Health and Dalhousie to work together to remove any such conflicts that arise, but no formal mechanism exists by which this desirable end might be achieved, except for the Liaison Committee discussed below.

What is clear is that the parties went to considerable effort to achieve clarity with regard to jurisdictions. However, these jurisdictions are complex, potentially contradictory, and certainly confusing in the implementation phase. Yet it would appear that considerably more discretion to enforce rules and alter responsibilities rests with Capital Health. It seems fair to say that the Affiliation Agreement does not take the form or practice of a true partnership of equals.

Joint appointees schedule activities and evaluate the clinical learners. Capital Health ensures that those joint appointees provide adequate and appropriate supervision. The Attending Physician is ultimately responsible for the care of patients. Here again is a strong indication that there must be no confusion about who the Attending Physician is.

Residents as employees

The Affiliation Agreement recognizes that Residents, unlike faculty members, are employees of Capital Health and entitled to all of the protections of collective bargaining. The terms and conditions of Residents are governed by a collective agreement, which is supreme over anything in the Affiliation Agreement.

The Collective Agreement for Residents[17] contains extensive grievance and arbitration procedures which provide for final and binding resolution of all disputes. It also provides that disciplinary action may only be taken for just cause and that the onus of proving just cause lies with the Employer. Should a Resident be suspended, the Employer must provide the reason for the suspension within ten days. In subsequent grievance procedures, including arbitration, Capital Health is limited to such written reasons. It may not add additional complaints or change the reasons it originally stated for its action. It must prove that those stated reasons provided just cause for its actions. Such provisions are commonly found in collective agreements, including those of many university faculty.

In the cases of Drs. Horne and Goodyear, during the lengthy process leading to the reports of DMAC, PRC, and the Board, Capital Health made further allegations after the original variations of privileges. Those additional allegations were unfair to Drs. Horne and Goodyear. Ironically, had Drs. Horne, Goodyear, and Nassar been covered by a collective agreement such as that for Residents at Capital Health, they would have experienced a much more rapid resolution of their respective disputes. The fact that they were faculty members in the Faculty of Medicine and private contractors of Capital Health left them vulnerable, with very negative impacts on their careers.

Program reviews

The parties to the Affiliation Agreement agree to participate in each other's program reviews and to inform each other of all accreditation decisions that might affect activities of the other party. By analogy, it should likewise be possible for each party to participate in reviews of individuals and to inform the other party of any decisions that could affect the other party's clinical education and research activities. Dalhousie clearly had an important interest in the reviews of Dr. Horne and Dr. Goodyear, and the decisions taken by Capital Health in both cases had an effect on the research and teaching programs of Dalhousie. Unfortunately, Dalhousie had no role in matters being processed using the Capital Health Disciplinary Bylaws. Indeed, PRC, through their legal counsel, specifically objected to the role played by Dalhousie in the mediated resolution of Dr. Horne's dispute and refused to include Dalhousie in any proposed agreement of Dr. Horne's case.

Research

Each party to the Affiliation Agreement asserts ownership of research activities. They agree to support each other in striving to maintain excellence, to coordinate efforts and maximize use of research funds, to cooperate and participate in each other's review and accountability processes, to seek comment on progress and general resource implications, and in planning and initiation of new research.

[17] The Collective Agreement Between Professional Association of Residents in the Maritime Provinces and Capital District Medical Authority (and others), April 12, 2013 http://www.cdha.nshealth.ca/system/files/sites/834/documents/professional-association-residents-maritime-provinces.pdf

It appears that these provisions provide both responsibilities and opportunities in addressing a case such as the languishing of Dr. Horne's research, since while it languished it was not achieving the excellence each party sought. The CDHA VP Research and Academic Affairs and the Dalhousie University VP Research both made attempts to restart or to otherwise protect Dr. Horne's research but did not appear to receive the level of support from Capital Health that was necessary for success.

The parties agree that no research is permitted without prior approval by either or both parties, and that all research shall comply with the Tri-Council policies. The details of the ethical review process are established in a separate document, the inter-institutional *Agreement on the Ethical Approval of Human Research Protocols* between Dalhousie, Capital Health, and others. There was a great deal of confusion about what approval had been granted for Dr. Horne's research, what were appropriate procedures for obtaining approval, and the precise meaning of the Tri-Council policies regarding confidentiality. Dr. Horne's research protocols had all the required approvals by the Research Ethics Board but, despite those approvals, there were allegations made that the research was unsafe and had not been approved appropriately by the Division of Cardiology.

The right to publish research is maintained, subject to a maximum delay of 12 months, and clinical learners have some protection regarding confidentiality agreements. The agreement is silent on confidentiality agreements for faculty, such as the agreement which caused such problems in the high-profile case of Dr. Nancy Olivieri at the University of Toronto. Confidentiality agreements were a source of concern in the case of Dr. Horne, and the Affiliation Agreement should contain provisions on faculty confidentiality agreements consistent with the recommendations of *The Olivieri Report*.

The parties also agreed to mutual acknowledgement in publications, presentations, or news releases based in whole or in part on work supported by the other partner. The word "*supported*" was defined to include the use of facilities, patients, health information, programs, laboratories faculty members, clinical learners, medical staff, and affiliated medical staff. This definition of "*supported*" research is broad. Nevertheless, Capital Health objected to Dr. Goodyear including his affiliation with Capital Health on presentations he proposed to make after his privileges were suspended.

Selection, Dean of Medicine, Capital Health CEO

Under the terms of the Affiliation Agreement, search committees for these positions must have a member appointed by the other party. For Dalhousie Dean of Medicine, the Capital Health CEO nominates a member subject to approval by the Dalhousie President. For Capital Health CEO, the Dalhousie Dean of Medicine nominates a member subject to approval by the Chair of Capital Health's Board. Note that in this provision the Capital Health CEO and the Dalhousie Dean of Medicine have analogous roles, while the Dalhousie President and the Chair of the Capital Health Board have analogous roles. There are other places where the analogies are different. This difference could lead to confusion.

An important example of confusion about authority at Capital Health occurred when the Capital Health CEO participated in the mediation to resolve Dr. Horne's case and signed the negotiated "*Minutes of Settlement*" on behalf of Capital Health. Later, the Privileges Review Committee of Capital Health took the position that the CEO had no authority to reach such a settlement and repudiated the agreement. When Dr. Horne sought to enforce the agreement in the Supreme Court of Nova Scotia, the Court ruled in favour of the PRC position.

Authorities for joint appointments

The Affiliation Agreement specifies that employment status of individuals is governed by the applicable rules of the respective bodies. For example, appointment and reappointment of Department Chiefs, Medical Staff, and Affiliated Medical Staff are under the authority of Capital Health, whereas appointment, reappointment, promotion, and tenure of Dalhousie Faculty Members and Department Heads are under the authority of Dalhousie. For joint appointments, this provision means that each party carries out its own process according to its own rules. Collective agreements are recognized where they exist. However, the reality is not as simple. The reappointments and promotions of both Dr. Horne and Dr. Goodyear were influenced by the actions of Capital Health to restrict their privileges. By definition, Dr. Goodyear could not meet the terms of his practice profile because he was forbidden to do the clinical work designated. Dr. Horne could not meet the research requirements of her practice profile because the loss of her privileges in the HFC impeded the recruitment of suitable patients into her research program. By extension, neither Dr. Horne nor Dr. Goodyear could meet the requirements for reappointment and promotion at either Capital Health or Dalhousie.

Joint appointment of Faculty Department Head/Capital Health Department Chief

Normally, the CDHA Department Chief and the Dalhousie Department Head will be the same person, and that was the case throughout all the matters considered by this Inquiry. The stated purpose for this arrangement is to ensure integration and accountability for the clinical care and the academic activities. The Chief of the CDHA Department of Medicine was also the Head of the Dalhousie Department of Medicine and the Chief Administrative Officer of the CDHA Department of Medicine Alternate Funding Plan, which provided remuneration for Drs. Horne and Goodyear. Those three positions each had its specific responsibilities and policy framework. In one of the most unusual events in the case of Dr. Goodyear, at one stage this single individual was represented in court proceedings by three different legal counsel, one for each of the three roles simultaneously held. Even the judge in that case found this situation confusing.

These three interconnected sets of responsibilities potentially place the person holding those three positions in a clear conflict. The situation Dr. Goodyear found himself in provides a good example of that conflict. Dr. Goodyear's privileges were suspended by the Chief of the CDHA Department of Medicine. That suspension of privileges made it impossible for Dr. Goodyear to meet the clinical requirements for his CDHA appointment, which led to Dr. Goodyear's remuneration being reduced to 15% of its previous level by the Chief of the CDHA

Department of Medicine AFP. The only appeal to this action was to bodies which included the Chief of Medicine who had both suspended Dr. Goodyear's privileges and determined the consequent reduction in his revenue share. In the opinion of this Committee, the same person playing a role in all three stages of this matter is a clear conflict. In addition, the Dalhousie Department of Medicine Head recommended that Dr. Goodyear's Dalhousie CAPR appointment not be renewed on the basis that he had failed to meet the clinical requirements of his position, which he clearly could not meet because the hospital privileges he required to conduct those activities had been suspended by the same person who was making the recommendation against renewal. All of these events unfolded despite the fact that the CDHA Board ultimately found that there was insufficient cause to vary Dr. Goodyear's privileges and ordered that he be restored to his former privileges. This tightly connected sequence of actions might conceivably meet some definition of integration because a single individual made all relevant decisions, but by doing so set up clear conflicts of interest that would seem to negate any potential advantage.

However, the position of counsel for the CDHA Department of Medicine AFP was that as soon as Dr. Goodyear failed to provide the services specified in his practice profile, he had repudiated his contract with the AFP and had no right to continue to receive the associated revenue share. Counsel for the AFP held that the sole question to be answered was whether Dr. Goodyear had performed the contractual duties and that there could be no conflict in the Chief of Medicine using that factual information, of which she had direct personal knowledge, and enforcing the terms of the contract in her role as Chief of the AFP.

The implications of this position by the AFP counsel are profound for the great majority of CDHA members of the Medical Staff who are simultaneously a member of a group practice plan like the Department of Medicine AFP. Under this interpretation, the Department Chief could suspend the privileges of a member of the Medical Staff, immediately reduce the revenue share of that member on the basis that they were not meeting his or her contractual obligations, and then assert that there were no grounds for appeal because the member had repudiated his or her contract with the AFP by not performing the contracted duties. And all of this could happen, as it did in the case of Dr. Goodyear, without the allegations that led to the suspension of privileges even being heard by an appropriate body, let alone being proven. There can be few more bald threats to academic freedom than that provided by this situation.

There are several crucial features set out in the Affiliation Agreement where duties, responsibilities, and reporting relationships are complex and/or confusing.

The Head reports to the Dean whereas the Chief reports to an array of Vice-Presidents. The Head reports regarding Faculty academic responsibilities, whereas the Chief reports regarding clinical and non-Faculty academic responsibilities. It is unclear what non-Faculty academic responsibilities include, or exclude.

The Head *liaises* with the Vice-Presidents regarding academic matters that relate to clinical services, whereas the Chief *reports* to those same VPs regarding clinical matters. The distinction between liaising and reporting on some issues is never clarified and these presumably different activities may be in possible conflict. For example, the Head *liaises* with the VPs regarding teaching and research that relates to clinical matters, but the Chief *reports* to those same VPs regarding the clinical matters themselves. The meaning of "*liaising*" and "*reporting*" in these

contexts is amorphous, vague, and speculative; indeed these terms are never defined. Without specific requirements for written reports, approvals, and timelines, it is unclear what each of these Heads is supposed to do and when.

There are other terms that are potentially confusing. The Head develops the academic budget and the human resource strategy to meet the *academic mandate*, whereas the Chief develops the clinical budget and the human resource strategy to meet the *clinical needs*. How distinctions are made in these budgets and human resource strategies between "*clinical needs*" and the "*academic mandate*" is not clear, when most of the people are jointly appointed and carry out both clinical and academic functions. The Agreement is silent on what (and who) are listed on which budgets, and the source of the remuneration of a joint appointment. Neither Dr. Horne nor Dr. Goodyear received remuneration directly from Dalhousie and Dr. Goodyear was explicitly told in his Dalhousie appointment letters that there was no salary paid for his Dalhousie duties. For both Drs. Horne and Goodyear the remuneration came from yet a third Chief, that of the Alternate Funding Plan. Given the powers associated with the purse strings, it would appear that control over the employment situation of Drs. Horne and Goodyear rested neither with Dalhousie nor with Capital Health but with the third Chief, the Chief of the Alternate Funding Plan. Even so, Capital Health holds great power because Capital Health determines who has privileges, which is a prerequisite for both a Dalhousie appointment and membership in the Alternate Funding Plan.

The Head develops and implements assessments of Department academic activities, and the individual academic activities of faculty members, whereas the Chief does so for clinical, educational, research, and administrative activities within Capital Health. The Chief also considers outcomes, whereas the Head does not. At least the educational and research activities within Capital Health are also individual academic activities of faculty members and the sum of these individual activities makes up a significant portion of the academic activities of the Department. This degree of overlap implies a certain level of inherent confusion about what is to be assessed, by whom, and when. Undoubtedly one could maintain that an argument for a single person holding both positions as Capital Health Chief and Dalhousie Head is to remove this ambiguity. However, such reassurance must be balanced by concerns about the inevitable potential conflicts of interests, which seems not to have been on the radar of either party when the Affiliation Agreement was written.

The Head may be directed by the Dean, whereas the Chief may be directed by the CEO of Capital Health. There is an interesting anomaly in this document in that the Chief does not report to the CEO and yet is directed by the CEO.

The Affiliation Agreement provides for a joint job description for the position of Chief/Head, but Capital Health and Dalhousie provide separate letters of appointment. Either party may decide to terminate. The notice period is remarkably short. This provision appears to say that Dalhousie would receive three months' notice of the intention of Capital Health to terminate an appointment as Chief. If a termination is being considered, there is no requirement for consultation or input from the other party, and there is no agreement on what constitutes sufficient reason for termination, or even that reasons must be given by the party that decides to terminate. There is no mention of any appeal, or of a mechanism to resolve a dispute if the other party disagrees with the decision to terminate, although presumably the Joint Liaison Committee

(discussed below) could be invoked. Despite the multiple possibilities for confusion and crossed wires, the termination situation for Chief/Head is somewhat better than the termination situation for a faculty member in that notice of termination is required in the case of the Chief/Head. No notice is required should one party decide to terminate a faculty member.

Joint appointment of Medical Staff

Normally, according to the Affiliation Agreement, members of the Capital Health Medical Staff must hold a Dalhousie appointment. If Capital Health exempts someone from this requirement, the Liaison Committee determines supervision and related arrangements for clinical learners, and that exempted individual may still report to and act on behalf of Capital Health. Drs. Nassar, Horne, and Goodyear all held joint appointments.

According to the Affiliation Agreement, academic responsibilities are defined by the Faculty and are subject to Dalhousie policies, whereas medical care responsibilities are defined by Capital Health and subject to Capital Health policies. Each party issues a separate appointment letter or contract detailing the terms and conditions of the appointment and the scope of the responsibilities as medical staff (Capital Health) and as a faculty member (Dalhousie). The Faculty and Capital Health jointly determine the proportion of time allocated for clinical, academic, and administration duties.

The record of the fraction of time allocated for clinical, academic, and administrative duties for Drs. Horne and Goodyear is the "*Practice Profile*" that was proposed by the Capital Health Department Chief and the Capital Health Division Chief, and agreed to by Drs. Horne and Goodyear. There is no formal record of the joint determination of these matters with Dalhousie. It seems that Dalhousie relied upon the fact that the Capital Health Department Chief was also the Dalhousie Department Head, and used the Capital Health Practice Profile as the record of duties assigned to Dalhousie faculty members.

The Affiliation Agreement does not mention how salaries of joint appointments are arrived at, reviewed, or accounted for. In particular, it makes no mention of the Alternate Funding Plan (or other group practice plans such as UALMA), which actually provided the remuneration to Drs. Horne, Goodyear, and Nassar. There is no provision to ensure consistency or to resolve conflicts between Capital Health and Dalhousie. Again, it appears that Dalhousie relied upon the joint appointment status of the Capital Health Department Chief as the Dalhousie Department Head to ensure consistency and avoid conflicts. As has been discussed several times, there is a serious flaw in this arrangement. There may be times when the interests of Dalhousie and those of Capital Health do not coincide, or are in conflict, placing the Chief/Head in a conflict of interest position. Such a situation arose in the case of Dr. Horne when the Chief varied the privileges of Dr. Horne, thereby having a major negative impact on Dr. Horne's research program in which Dalhousie had a major stake.

Both the Chief and the Head conduct an annual review of the roles, responsibilities, and performance of each joint appointment and disclose the results to the CEO and the Dean. There is no indication of when these reviews occur, what the criteria are for matters under review, what process is used for the review, who participates in the review, whether individuals under

consideration can provide input to the review, whether the reviews include input from both parties, or the time frame within which the results are disclosed to the other party. There is also no indication of what happens in the event that the person under review, or one of the parties, is not satisfied with the results of the reviews.

Capital Health and the Dalhousie Faculty of Medicine jointly review Capital Health's physician resource and recruitment plans where they impact on Faculty programs (including clinical learners).

When an appointment is terminated by either CDHA or Dalhousie, or the category of appointment is changed, normally the related appointment is terminated or changed subject to the policies of each party. The Dean or CEO taking action notifies the other in writing and provides advance notice of his/her intentions "*if circumstances permit*." It is not clear what circumstances would not permit advance notification of the other party. It might be better if this provision stated that the other party would be notified in advance, "unless an emergency arises requiring immediate action to protect the welfare of patients, staff or members of the public." We have seen no formal notification of Dalhousie by Capital Health of the stated intent to terminate Dr. Goodyear, or of the suspension of his privileges, or of the variation of Dr. Horne's privileges. Again, there is no provision for consultation between the parties, and no provision for objections to a proposed termination to be lodged by the other party.

Mutual consultation

The Affiliation Agreement requires that Capital Health take into account that its organization, medical care, and accreditation have an impact on Dalhousie's programs. In turn, Capital Health agrees to "*timely*" consultation regarding department restructuring, clinical care procedures impacting education and research, accreditation, and proposed amendments to rules and regulations that might affect the Affiliation Agreement. As previously discussed, there should also be timely consultation if Capital Health proposes to take actions that would change the employment status of a joint appointee, or when a joint appointee is to be assessed.

This provision appears to require explicit consultation of Dalhousie when planned changes in clinical care procedures might impact on research. Excluding Dr. Horne from the Heart Function Clinic appears to constitute a change in clinical care procedures and it undeniably had an impact on Dr. Horne's research. It appears that the agreement required consultation with Dalhousie. This Inquiry saw no evidence that such consultation took place, except in the trivial sense that the Dalhousie Department of Medicine Head was the person who varied Dr. Horne's privileges acting in the capacity of Capital Health Department Chief. Does the exclusion of Dr. Horne from the Clinic, which was the source of many of her research patients, require consultation, and did it occur? This Inquiry believes consultation was required, and has seen no document demonstrating that consultation took place. Indeed, after Dr. Horne's privileges were altered, the Dalhousie VP Research expressed concerns about the potential impact on Dr. Horne's research and was told that such matters could not be considered until after the clinical matters involved in the variation of Dr. Horne's privileges were addressed. After the fact, the VP Research and Academic Affairs of CDHA and the VP Research at Dalhousie worked together to try to mitigate the damage and restart recruitment into Dr. Horne's research projects. Had

appropriate consultation with Dalhousie occurred in advance, the impact on Dr. Horne's research could have been discussed and mitigated before damage was done.

Whereas the Affiliation Agreement repeatedly enjoins consultation between the parties, meaningful consultation in relation to any of the matters this Inquiry examined is rarely in evidence. Surely, the parties need to reconsider in more specific and operational terms what processes are entailed by the term "*consultation*." The Affiliation Agreement should contain explicit statements of when consultation will occur, who will be consulted, what procedures will be used for consultation, what constitutes timely consultation, how the consultation will be documented, and what happens when the parties do not agree.

It appears that the Affiliation Agreement rests on the flawed premise that there is automatic "*consultation*" because of the joint role of Capital Health Department Chiefs and Dalhousie Department Heads. While this informal consultation may work adequately in many cases in the normal course of events, it is potentially seriously flawed when unusual events occur, or when the parties have fundamentally different interests. It is precisely at these moments of difficulty that robust procedural safeguards and a written record are essential. The lack of such procedural safeguards directly contributed to the escalation of the problems in the cases examined in this Inquiry. It is also important that the meaning of "*timely*" consultation be defined. Dalhousie agrees to "*timely*" consultation with Capital Health when program changes might impact on clinical care at Capital Health or when proposing amendments to rules and regulations that might affect this agreement. Does Capital Health have a parallel requirement for timely consultation with Dalhousie when changes in clinical care might impact on research at Dalhousie?

Use of facilities/financial arrangements

Capital Health agrees to give joint appointments access to its facilities and services, patients, and clinical and patient records subject to resource availability, patient consent, and this Affiliation Agreement. Joint appointments doing teaching and research at Capital Health are subject to the *Health Authorities Act*, the *Hospital Act*, and Capital Health's rules and regulations. Purchasers own equipment but must make all arrangements concerning that equipment in advance of purchase. Again, there is no indication of financial arrangements concerning salary of joint appointments. It is interesting that this section places emphasis on certain arrangements requiring mutual agreement, in writing, and in advance. The specificity and clarity of the arrangements envisioned here with regard to mutual agreement allow the inference that, in other sections of the Affiliation Agreement in which "*mutual agreement*" is invoked, such advance written agreement is not required.

Joint Liaison Committee

The Affiliation Agreement provides for a Joint Liaison Committee and specifies its membership, role, and responsibilities. The Liaison Committee has equal numbers from each party. The Dean of Medicine appoints one Dalhousie Department Head to serve with the Dean, the VP Academic, and one of the Deans of Dentistry or Graduate Studies. The CEO appoints one Capital Health Department Chief to serve with the CEO, one Capital Health VP, and the Chair of the District Medical Advisory Committee.

The provision that the Committee may add to or reduce its membership from time to time is both unwise and unnecessary. The Affiliation Agreement first specifies the composition of the Committee, and then gives the power to the Committee itself to exclude any of these appointees as it sees fit. The Committee could reasonably have the power to increase its numbers from time to time, if, for example, it considers it useful to have a broader range of expertise available while considering a certain issue. However, the Committee should not have the power to remove any members who are specified in the Affiliation Agreement. If the parties wish to change the composition of the Liaison Committee, they should formally amend the Affiliation Agreement.

The Liaison Committee meets as required, but at least once a year. Meetings are closed. The Chair alternates between Dalhousie and Capital Health representatives. The Chair convenes the meetings and ensures that minutes are kept. The phrase *"... as the Committee deems appropriate.*" referring to the keeping of minutes requires explanation. The Affiliation Agreement should be clear that there must be minutes for Liaison Committee meetings to provide an official record, and specify who is to record and maintain the minutes. The amount of detail to be included in the minutes could well be determined by the Committee provided there is a written record of at least what topics were discussed and what decisions were taken.

Meetings of the Liaison Committee can be initiated in four different ways.

- A meeting may be called by the Chair on his/her own initiative;
- A meeting may be called by the Chair on request by any two members of the Liaison Committee;
- Capital Health may request a meeting if Capital Health chooses to exempt an appointment from the normal requirement of a joint appointment with Dalhousie;
- Dalhousie may request a meeting if Dalhousie chooses not to terminate the Dalhousie appointment of someone whose Capital Health appointment has been terminated.

The Liaison Committee approves the programs covered by the Affiliation Agreement and resolves any disputes arising from the Affiliation Agreement. The Liaison Committee also deals with situations arising when one party wishes to exempt an individual from the normal requirement that he or she hold a joint appointment. Liaison Committee recommendations are required to include appropriate mechanisms to ensure that a member of the CDHA Medical Staff with no Dalhousie appointment does not engage in teaching or research with academic learners, and that a faculty member with no Capital Health appointment has restricted access to Capital Health facilities, patients, and health information or programs. That is, the effect of not having a joint appointment is to restrict seriously the ability of that person to carry on functions with the party that terminated their appointment.

In addition to the matters specified in the Affiliation Agreement, the Liaison Committee also has the power to "*consider matters of mutual interest*" and "*make recommendations to appropriate authorities as deemed appropriate*." The Committee may also "*address other issues as the parties may agree*."

The Liaison Committee may establish a subcommittee to make recommendations to it in cases involving a termination of one of the two joint appointments, and may consult with anyone it wishes. If the Liaison Committee cannot resolve a dispute, the Dean and CEO will appoint an

arbitrator mutually agreeable to Dalhousie and Capital Health. If they cannot agree, a single arbitrator will be appointed in accordance with the *Arbitration Act*, and will render a binding decision within thirty days. This is a standard arbitration procedure.

Taken together, it appears that the powers and procedures of the Liaison Committee might have been used to arrive at final and binding resolutions of any issues the parties chose to address. It would seem they even had an inferred responsibility to do so in cases involving variation of appointments by Capital Health.

Indeed, given these powers and procedures, it appears that Dalhousie might have caused the Liaison Committee to consider the cases of Drs. Horne or Goodyear in a number of ways. It might have called a meeting for that purpose when one of its appointees held the Chair, or by having any two of its appointees request a meeting. In the case of Dr. Goodyear, Dalhousie might have triggered a meeting by stating its intention not to terminate Dr. Goodyear's academic appointment in parallel with the intention of Capital Health to terminate his clinical appointment. At any meeting of the Liaison Committee, Dalhousie might have insisted on discussing the cases of Drs. Horne, Goodyear, and Nassar as matters that were of mutual interest. In the event that the Liaison Committee could not resolve the differences, Dalhousie might have used the arbitration process to arrive at a final and binding resolution of the dispute. This Inquiry has seen no evidence that Dalhousie sought to use the powers of the Liaison Committee to attempt to resolve any of the long disputes that were considered in this Inquiry.

In particular, Dalhousie should have raised with the Liaison Committee the rejection by Capital Health of the mediated settlement of Dr. Horne's case. Dalhousie was a signatory to this settlement, reached in good faith, and should have been as concerned by the repudiation of that settlement by Capital Health as was Dr. Horne. This repudiation goes to the core of the Affiliation Agreement between Dalhousie and Capital Health because, among other things, it deals with the question of who is empowered to act on behalf of Capital Health in dealings with its partner Dalhousie.

The Capital Health CEO signed the mediated "*Minutes of Settlement*" in Dr. Horne's case. It is clear that all parties to that mediated settlement intended that settlement to be final and binding, and, by inference, purported to have the authority to make the settlement final and binding. When the settlement came to the attention of the PRC, it was asserted that the CDHA CEO had no authority to bind Capital Health to a settlement of a privileges matter, and that under the Bylaws only the Board could do so, after receiving recommendations from PRC. Justice Hall of the Nova Scotia Supreme Court ruled that the CDHA CEO had neither actual nor ostensible authority to settle the privileges dispute with Dr. Horne.

By signing the "*Minutes of Settlement*," the CDHA CEO purported to have authority to act on behalf of Capital Health in an agreement with Dalhousie and Dr. Horne. In signing the agreement together with the CDHA CEO, Dalhousie believed it had reached a full and final settlement with its partner Capital Health of a matter in which Dalhousie had a core interest. That settlement was repudiated by Capital Health, in part on the basis that the CDHA CEO did not have appropriate authority. It is an exceedingly important matter of principle when an agreement is reached in good faith with a partner, who then repudiates that agreement because the person

who purported to represent the partner lacked the authority to do so. Surely, this act of repudiation should have been an urgent matter for consideration by the Liaison Committee.

In accordance with the important principle involved, Dalhousie might have insisted that the matter be resolved by the Liaison Committee, and, failing that resolution, might have used their right to submit the matter to binding arbitration. Dalhousie might even have insisted that Capital Health and Dalhousie had already agreed that the external mediator should be that arbitrator because the mediation agreement specified that the mediator was seized of the matter in case of a subsequent dispute over implementation of the agreed-upon settlement. This Committee has seen no documents indicating that Dalhousie did any of these things.

Under the terms of the Affiliation Agreement, the arbitrator is required to make a ruling within thirty days. Whatever the ruling of the arbitrator regarding the validity of the "*Minutes of Settlement*," all parties would have benefited from timely clarity in this matter. Instead, the status of the "*Minutes of Settlement*" was in dispute for a period of about twenty months from June of 2003 until Justice Hall's ruling on February 23, 2005.

Confidentiality

Section 19(C) of the *Freedom of Information and Protection of Privacy Act* states that Dalhousie may refuse to disclose any information that has been provided to it in confidence, either explicitly or implicitly, for purposes of evaluating a research project; or evaluating the suitability of someone for appointment, promotion, or tenure as a faculty member; for admission to an academic program; or for receipt of an award.

Section 19(D) states that Capital Health may refuse to disclose any report, statement, memorandum, recommendation, document, or information that is used in the course of, or arising out of, any study, research, or program carried on by or for Capital Health or any of its committees for the purpose of education or improvement in medical care or practice. It appears that these sections provide a right to refuse to disclose certain information, but does not impose an obligation not to do so.

Section 71.1 of the *Hospitals Act* states that patient records are confidential and shall not be disclosed to any person or agency without the consent of the patient.

Invoking their responsibilities under these statutes, CDHA and Dalhousie agree to a very broad confidentiality provision. This includes "*all reports, statements, memoranda, recommendations, documents or information*" respecting "*patient care, clinical learner performance, peer review, research, and all other matters of a personal and confidential nature*." In particular, it appears that "*statements*" and "*information*" could include oral descriptions of events that occurred, and it is not clear who determines what "*other matters*" are personal and confidential. This clause could be read to suggest that the parties will also keep confidential matters secret from each other, although it is not clear if this was the intention of the parties. If that were the intention, there is a further problem with Capital Health Chiefs and Dalhousie Department Heads being the same person.

There was a disagreement between the parties regarding the meaning of the confidentiality clause included in the mediated "*Minutes of Settlement*" of the Horne case. That disagreement resulted in multiple exchanges among counsel for the parties over a lengthy period. Ultimately it was agreed that the "*Minutes of Settlement*" were confidential in the sense that any other documents in Dr. Horne's official personnel file were confidential, and that the "*Minutes of Settlement*" could be disclosed to the CDHA Board. The need for confidentiality ought to be weighed in relation to the need for accountability.

Intellectual property

The Affiliation Agreement specifies that the rights and obligations of Capital Health and Dalhousie with respect to the protection, marketing, and licensing of intellectual property arising from collaborative research or collaborative development of educational materials shall be the subject of separate agreement(s) among Capital Health, Dalhousie, and, where appropriate, the authors, creators, or inventors of such work or property.

At one point Dr. Horne expressed concerns about the possibility that some of her intellectual property may have been misused by others, to her disadvantage. There are no provisions in the Affiliation Agreement for dealing with this situation.

Additional provisions

There are a number of other detailed provisions in the Affiliation Agreement. If either party breaches the agreement or is negligent in performing its obligations set out in the agreement, the other party is held harmless against all claims. The parties each agree to carry appropriate liability insurance, which policies will be shared with the other partner and are confidential.

The Affiliation Agreement came into effect October 1, 2002, and ended on September 30, 2007, renewable by mutual written consent of the parties. Either party can terminate the agreement by giving twelve months written notice. There appears to be no explicit provision for modification of the agreement, other than to give notice and terminate this agreement and (presumably) replace it with a modified version.

Only an express waiver in writing is acceptable. It is interesting in this context that Capital Health insisted that there was an inferred complete waiver of the timelines in the Disciplinary Bylaws in relation to the case of Drs. Goodyear and Horne, waivers that extended for several years. Whereas it is true that both Dr. Goodyear and Dr. Horne agreed to waive deadlines, it is equally clear that neither anticipated that this waiver would become open-ended and allow the Disciplinary Bylaws process to drag on for such an extended period. The waiver of timelines should indeed be expressed and not inferred, and the agreed-upon waiver should be in writing with copies to the parties.

The Affiliation Agreement remains binding on the parties' respective heirs, etc., is severable, and is subject to Nova Scotia law. Note that all those who sign this Affiliation Agreement warrant that they have appropriate authority to do so, and that one of the signatories

is the (then) interim President and CEO of Capital Health. If the CEO could warrant that he had authority to sign a wide-ranging Affiliation Agreement with Dalhousie, it is striking that the same officer was considered not to have the authority to sign a mediated settlement of the dispute involving the variation of the privileges of a single physician (Dr. Horne).

General commentary on the Affiliation Agreement

There are, clearly, serious deficiencies in the Affiliation Agreement. These deficiencies start with the basic concept on which the Affiliation Agreement is based and continue with the detailed provisions.

The Affiliation Agreement begins with the fundamentally flawed premise that Dalhousie is solely responsible for the academic appointments of faculty and the selection of students, interns, and residents who together comprise the Dalhousie Faculty of Medicine, whereas Capital Health is solely responsible for the clinical appointments and the privileges required to practice medicine in the Capital Health facilities. However, Dalhousie clinical faculty cannot do their job without access to the Capital Health facilities and patients, and Capital Health cannot provide the tertiary medical care that is their mandate without the participation of the Dalhousie faculty, residents, interns, and students. The premise that each organization acts on its own within a certain sphere and that an affiliation agreement can bridge the inherent contradictions in this model is tenuous at best and was shown to be badly flawed in the cases under investigation.

The legal framework on which this premise is based is the separate legal identities of Dalhousie and Capital Health. In particular, Capital Health derives its powers as a Health Authority under the Nova Scotia *Health Authorities Act*, and Dalhousie operates under other Nova Scotia statutes. This legal framework has been used to embed the nearly complete separation of powers that has proven to be dysfunctional in the current cases under review. In turn, the separation of powers has resulted in an imbalanced power structure between Dalhousie and Capital Health, which has contributed significantly to the difficulties which arose. It is in the interests of all parties to find a model that is soundly based and more effective than the current model at managing the power relationship.

Chervenak and McCullough[18] have identified ways in which the power relationship between medical schools and teaching hospitals can be responsibly managed. Their analysis begins with an examination of the sources of potential abuse of power and identifies a cooperative model based on transparency to overcome these potential abuses.

Potential abuse occurs when one party is a single source of an essential product or service that is required by another party, or when one party is the only user of a particular product or service provided by another party. Such disparities of power are not intrinsically unethical or dysfunctional, but may become so if the disparity of power leads to exploitation of one party by the other, or a breakdown in the effectiveness of the relationships between the parties.

[18] Chervenak, Frank A, and McCullough, Laurence B, *Academic Medicine* 80, 690–693, 2005

The relationships between medical schools and teaching hospitals are fraught with the risks of both these potential abuses, and must be managed so as to prevent unethical or dysfunctional outcomes. That management requires a high degree of transparency between the parties and an active joint commitment to meeting the overall objectives of the partnership. Under such a relationship, Capital Health would have a responsibility for transparency with Dalhousie, giving an adequate account of its current and potential actions and decisions, and the reasons for them. It would also have a responsibility jointly to meet the overall objectives of the partnership with Dalhousie rather than insisting on its sole authority in certain matters. Neither of these important components of an effective partnership was apparent in the cases considered by this Inquiry, or in the Affiliation Agreement.

A specific CDHA/Dalhousie example of the potential abuses that must be managed is the following. On the one hand, to achieve its goals of clinical education, training, and research, Dalhousie must place its students, interns, residents, and faculty researchers in a teaching hospital. CDHA is the dominant provider of those facilities, which are essential to Dalhousie achieving its goals as a leading medical school. On the other hand, Dalhousie is the dominant source of medical students, interns, residents, and clinical researchers, without whom Capital Health would be unable to achieve its clinical and research goals as a leading tertiary care hospital. Neither party can prosper without the active participation and cooperation of the other. Their relationship must be managed in recognition of these realities.

Chervenak and McCullough argue that medical schools and teaching hospitals need to form a close partnership in which both parties are fully committed to playing a role in meeting the overall objectives of the partnership. In particular, both parties must be forthcoming about the real costs and revenues, and be prepared to share those costs and revenues in a transparent and principled way, consistent with their shared commitments. The relationship must provide for means of gathering information about these costs and revenues and sharing them in the pursuit of excellence in clinical care, research, and education. In order to ensure that this close partnership happens, Chervenak and McCullough advocate adopting a co-fiduciary responsibility by the parties, by analogy to the long-recognized fiduciary responsibility of physicians in relating to their patients.

The fiduciary responsibility of physicians in relation to their patients is well grounded in medical ethics. It begins with a recognition that patients place confidence, trust, and reliance on the doctor whose aid or advice is sought. Accordingly, doctors are required to behave in a manner that justifies that reliance on them by the patient, and in particular are required to act in the best interests of the patient. Such responsibility requires the doctor to exhibit loyalty to the patient and to refuse to put his or her personal interests, including personal profit, before the duty to the patient.

Because the doctor has information and access to the means of treatment that patients do not normally have on their own, there is an inherent imbalance of power in the relationship. However, patients are empowered by the transparency of informed consent, a process in which a doctor is ethically obliged to provide information on which the patient can rely in making a decision about what treatment, if any, he or she wishes to receive. Informed consent means that a doctor provides information about what is known, or not known, about a patient's condition, what reasonable alternatives for treatment exist, and what benefits or risks may attach to any

treatment, including no treatment. The transparency of informed consent and the duty of the doctor to act in the patient's best interest do not remove the power differential between patient and doctor, but do legitimize it by protecting the patient from possible exploitation arising from it.

In light of the analysis of Chervenak and McCullough, consider the case of Capital Health and Dalhousie. Capital Health has power over Dalhousie because it operates the teaching hospital and controls hospital privileges. Dalhousie's Faculty of Medicine is forced to rely upon the decisions of Capital Health in order to carry out its mandate. On the other hand, Dalhousie has power over Capital Health because it provides the medical students, interns, residents, and clinical researchers. Capital Health is forced to rely upon the decisions of Dalhousie University to carry out its mandate. Similarly, the Alternate Funding Plans have power over Dalhousie and Capital Health because the Faculty of Medicine and Capital Health both rely upon those plans to provide the great majority of the remuneration of the faculty members and clinicians that they need to carry out their mandates. These power imbalances are inherent in the present administrative arrangements as set out in the Affiliation Agreement, and in the case of the AFPs, not set out in any agreement of which this Committee is aware. In the long run, these power imbalances created a flawed set of relationships. Despite the language of reciprocity and consultation in the Affiliation Agreement, the fact of a series of power imbalances undermines the stated need for reciprocity.

By analogy to the physician-patient relationship, Capital Health and Dalhousie both place confidence, trust, and reliance on the other whose assistance or advice is sought. Each is required to behave in a manner which justifies that reliance on them by the other, and in particular each is required to act in the best interests of the other rather than acting solely in their self-interest. Accordingly, each party must exhibit loyalty to the other and to refuse to put its own interests before the duty to the other.

Because of the co-fiduciary responsibility Dalhousie and Capital Health have to the patients, they each have an ethical imperative to base their relationship with each other on that co-fiduciary responsibility. The Affiliation Agreement fails to meet this duty, because it establishes an organizational culture that is not based on mutual commitment to meeting those co-fiduciary responsibilities. Patient care, medical education, and medical research are all imperiled by this organizational culture, as the events under investigation in this Inquiry amply demonstrate.

What is required is a fundamental rethinking of the relationship between Dalhousie and Capital Health. A renewed relationship should be based from the beginning on the solid medical ethical ground of co-fiduciary responsibility for excellence in patient care, medical education, and research. From that sound foundation, leaders at Dalhousie and Capital Health should enshrine an organizational culture of co-fiduciary responsibility both in writing and in practice, and become models for the reform and improvement of the power relationships between Dalhousie and Capital Health to the benefit of the patients, students, interns, residents, faculty, staff, and the public at large.

The Affiliation Agreement should begin with an explicit recognition of the co-fiduciary responsibility of Dalhousie and Capital Health to the patients that they jointly serve. It should

recognize the important role that medical education and research play in promoting the best possible evidence-based care for patients, making education and research synergistic, rather than competitive, with patient care. It should recognize the critical role played by academic freedom in medical education, research, and even administration. It should make explicit commitments to openness and transparency in all joint activities. It should provide explicit terms for sharing revenue and costs between Dalhousie and Capital Health instead of abrogating many of the cost issues to third parties such as the AFPs. It should include explicit means for reaching final and binding resolutions of any disputes that arise over actions, or the inaction, of either or both parties.

Based on the co-fiduciary responsibilities, all of these matters become obligatory for the parties, not merely matters that are in their respective enlightened self-interests. The enlightened self-interest of the parties should have led them to resolve all of the matters under investigation by this Inquiry much sooner than they were in practice. This is a clear demonstration that enlightened self-interest in an insufficient inducement.

Ethics and ethical relationships

The question of medical and research ethics arose several times in the cases considered by this Inquiry. One of the specific terms of reference of the Inquiry is to determine if there were breaches of professional ethics. The professional conduct of the Medical Staff is governed by the Code of Ethics of the College of Physicians and Surgeons of Nova Scotia.

This code "… *is based on the fundamental ethical principles of medicine, especially compassion, beneficence, non-maleficence, respect for persons and justice. It interprets these principles with respect to the responsibilities of physicians to individual patients, family and significant others, colleagues, other health professionals and society …*" The code is not exhaustive and is interpreted and applied in particular situations. It is recognized that " … *physicians may experience conflict between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of patients, proxy decision makers, other health professionals, employers or other involved parties ….*"

The Code of Ethics specifies the following general responsibilities of Medical Staff:

- Consider first the well-being of the patient.
- Recognize your limitations and the competence of others and where indicated, recommend that additional options and services be sought.
- Provide whatever appropriate assistance you can to any person with an urgent need for medical care.
- Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.
- Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.

- Recommend only those diagnostic and therapeutic procedures that you consider to be beneficial to your patient or to others.
- Respect the right of a competent patient to accept or reject any medical care recommended.
- Respect your patient's reasonable request for a second opinion from a physician of the patient's choice.
- Ensure that any research in which you participate is evaluated both scientifically and ethically, is approved by a responsible committee, and is sufficiently planned and supervised that research subjects are unlikely to suffer disproportionate harm.
- Inform the potential research subject, or proxy, about the purpose of the study, its source of funding, the nature and relative probability of harms and benefits, and the nature of your participation.
- Before proceeding with the study, obtain the informed consent of the subject, or proxy, and advise prospective subjects that they have the right to decline or withdraw from the study at any time, without prejudice to their ongoing care.
- Use health care resources prudently.
- Refuse to participate in or support practices that violate basic human rights.
- Recognize a responsibility to give the generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate.
- Teach and be taught.
- Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.
- Be willing to participate in peer review of other physicians and to undergo review by your peers.
- Enter into associations only if you can maintain your professional integrity.
- Do not keep secret from colleagues the diagnostic or therapeutic agents and procedures that you employ.
- Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services.
- Seek help from colleagues and appropriately qualified professionals for personal problems that adversely affect your service to patients, society, and the profession.

Ethics in the case of Dr. Goodyear

All Medical Staff, and all physicians licensed to practice medicine in Nova Scotia, are expected to show respect for justice. The lengthy delays faced by Dr. Goodyear in the adjudication of his case were a clear denial of justice. In the opinion of this Committee,

physicians involved in that lengthy process had an ethical obligation to show respect for justice by helping to prevent the lengthy delays experienced by Dr. Goodyear. Those delays were a denial of justice.

From Dr. Goodyear's perspective, his ethics required him to provide possibly beneficial treatments to patients if they asked for them, because patients, not doctors, should decide if they want to undergo a particular treatment or not. The Code of Ethics contains several items related to this issue, and sets out certain standards that Dr. Goodyear had to meet in following this approach.

The Code of Ethics specifies that a physician must respect the right of a competent patient to accept or reject any medical care *recommended*. Some of Dr. Goodyear's colleagues believed Dr. Goodyear was required to offer only treatment that he could recommend, and that he could recommend only those treatments that his colleagues considered beneficial. These matters require significant judgment, and expert medical testimony before the CDHA Board was that it was not unusual for physicians to have different opinions about appropriate care in complex cases. What one individual patient considers beneficial may differ greatly from the view of another patient, and both may differ from what the physician might consider beneficial. What a physician considers beneficial to one patient in particular circumstances may be different from what that same physician considers beneficial to a different patient in different circumstances. Different physicians may also make different determinations in the same cases, as did some of the external reviewers of Dr. Goodyear's cases.

The physician must provide sufficient information to allow the patient to make an informed choice about treatment, and must do so in such a way that the patient can understand that information. In doing so, there are certain ethical standards in the Code of Ethics that (s)he must meet. It is generally accepted that informed choice requires that the physician inform the patient of the potential benefits and risks of any course of action. There is less agreement on whether physicians also must tell patients what their recommendation is or what the commonly held informed medical opinion is. There is a provision in the Code of Ethics that physicians must give the "*generally held opinions of the profession*" when interpreting scientific knowledge to the public, and a responsibility to indicate when they are presenting an opinion that is contrary to the generally held opinion of the profession.

There is also a provision that health care resources be used prudently. This becomes an issue when very costly treatments are recommended, as occurred in some of the cases in dispute in Dr. Goodyear's practice. It might be argued that there is a potential conflict between the right of the patient to make the final decision about treatment when the treatment is costly and considered to be of insufficient benefit. As always, these are questions of judgment on which qualified and well informed individuals may differ.

In the particular case of Dr. Goodyear, there was an attempt to set aside this issue of judgment. The Division Chief was responsible for administering the Division within its approved budget. He told Dr. Goodyear to stop making case by case requests for approval of drugs which had not been approved for a particular purpose instead of making a general case and convincing his colleagues that the treatment Dr. Goodyear preferred should be included. Dr. Goodyear tried to initiate a more general discussion with his colleagues about the benefits of alternate

treatments, and, at the same time, continued to believe that the patient should be able to receive the potential benefit whether or not Dr. Goodyear's colleagues agreed with the treatment he proposed. Dr. Goodyear argued that the data collected about the cost of the treatments would more accurately reflect what the budget for treatment should be.

There are also issues relating to the behaviour of others in Dr. Goodyear's case. One provision of the ethical guidelines is that physicians should "*teach and be taught*." It is clear that some found Dr. Goodyear's constant interest in teaching what he had found in the literature or at the most recent conference to be difficult for them personally. However, it is clear that Dr. Goodyear not only had the right to make this information available to others and to argue for his position even if others found it difficult, and it could also be argued that he had an ethical responsibility to do so, and that his colleagues had a responsibility to consider the issues he introduced for discussion.

Physicians have a responsibility to report any unprofessional conduct by colleagues to appropriate authority. This Committee has seen no evidence that any of Dr. Goodyear's colleagues did so until they were asked by the Division Chief to provide examples of cases in which they had concerns about the patient care provided by Dr. Goodyear. If they considered his conduct unprofessional or unsafe, they had a responsibility to report it immediately. The fact that they did not do so until faced with a request from their Division Chief was a significant factor in the Board ruling in Dr. Goodyear's case.

In conclusion, it is clear that there was a difference of opinion between Dr. Goodyear and some of his colleagues, in particular his Division Chief. Differences of opinion are to be expected in a tertiary academic medicine setting. The question to be asked in such circumstances is whether Dr. Goodyear's behaviour was in accordance with the requirements of the Code of Ethics. This Committee saw no evidence that Dr. Goodyear's behaviour fell short of his ethical responsibilities.

A related issue is the behaviour of the Division Chief and the Department Chief. Both are required to see that justice is done. After allegations were made about the patient care provided by Dr. Goodyear, no adequate procedure to assess fairly and promptly those allegations took place. It appears possible that this oversight could have resulted from inadequate recognition of personal limitations and/or a failure to consult the expertise of others and/or a lack of advice, assistance, and mentoring from more experienced colleagues. The CDHA Board ruled that there was no evidence of malice toward Dr. Goodyear by anyone involved.

Ethics in the case of Dr. Horne

There were also substantial delays in the adjudication of Dr. Horne's case, which were a clear denial of justice. In the opinion of this Committee, physicians involved in that lengthy process had an ethical obligation to show respect for justice by helping to prevent the lengthy delays experienced by Dr. Horne. Those delays were a denial of justice.

Much of the research in which Dr. Horne was engaged was partially funded by an external granting agency and therefore had undergone thorough scientific peer review. It also had all the

required approvals by the Research Ethics Board. Those approvals included arrangements that Dr. Horne take appropriate steps to meet the requirement that subjects were unlikely to suffer disproportionate harm. Those approvals also required that all subjects be provided with appropriate information about the purpose of the study, the funding source, the nature of Dr. Horne's role, and the nature and relative probability of harms and benefits. Furthermore, there were requirements that informed consent be obtained, and that it be made clear to subjects that their participation, or refusal to participate, would not prejudice their ongoing care. All of these steps are in accordance with the ethical requirements for research.

One aspect of Dr. Horne's research protocol was a letter to the potential patient's attending physician asking that Dr. Horne be informed if there were any alterations in beta blocker treatment. It was suggested by some that this letter presented a risk to patients because the wording might be construed to suggest that treatment with beta blockers should not be altered. Setting aside the fact that this letter had been approved by the Research Ethics Board, it would clearly be unethical for the attending physician not to provide the best care for patients because those patients were involved in a research study. The first standard is to consider the patient, and as Capital Health's various Bylaws set out, the quality of patient care always trumps research or teaching.

Summary

This examination of the foundational documents governing the complex relationship between Dalhousie University and CDHA testifies to serious deficiencies and important lacunae in the foundational documents. The effects of these deficiencies were apparent in the three cases considered by this Committee. Recommendations for correcting these problems are provided in Chapter 9.

Chapter 4 | Variation of Medical Staff Privileges

Introduction

Concerning variation, suspension, revocation, or nonrenewal of privileges, Medical Staff are subject to the Medical Staff (Disciplinary) Bylaws and Section 23 of the *Health Authorities Act*. That Section empowers the Minister of Health to make the Medical Staff (Disciplinary) Bylaws, and to establish a Provincial Appeals Board to make final decisions in cases of dispute about granting, variation or suspension of privileges, and the discipline of members of the Medical Staff. Drs. Horne, Goodyear, and Nassar were subject to these Bylaws. The Disciplinary Bylaws were not applied in the case of Dr. Nassar but were central to the cases of Drs. Horne and Goodyear.

Many of the events that are the subject of this Inquiry are related to the summary variation of the privileges of Dr. Goodyear and Dr. Horne by the Department of Medicine Chief on October 10, 2002, and October 21, 2002, respectively. Dr. Goodyear's privileges were subsequently suspended on January 9, 2003.

According to the Department of Medicine Chief, these actions were taken pursuant to Section 8 of the Medical Staff (Disciplinary) Bylaws then in force, entitled *Revocation, Suspension, Variation of Medical Staff Privileges — Suspension*. The submission to DMAC on behalf of Capital Health in Dr. Horne's case states that "… *measures taken by the Department Head in varying Dr. Horne's privileges, were the least intrusive available, prudent and appropriate.*"

In addition to Section 8 invoked by Department of Medicine Chief, there are two further ways in which the Medical Staff (Disciplinary) Bylaws then in force make provision for revocation, suspension, or variation of Medical Staff privileges. Section 9, entitled *Revocation, Suspension, Variation of Medical Staff Privileges — Special Review,* provides for a Special Review of privileges, and Section 10, entitled *Revocation, Suspension, Variation of Medical Staff Privileges — Automatic Suspension*, provides for automatic suspension of privileges under certain conditions.

This Chapter examines the provisions of the Medical Staff (Disciplinary) Bylaws as they relate to the variation of privileges and provides a commentary on the Bylaws themselves and the manner in which they were applied in the cases of Dr. Horne and Dr. Goodyear. This commentary concerns the Bylaws in effect on the date that the privileges of Dr. Goodyear and Dr. Horne were varied in October 2002. During the course of the cases of both Dr. Horne and Dr. Goodyear, a new set of Bylaws came into effect in 2007. These *"New Bylaws"* or *"2007 Bylaws"* differ in some important respects from the *"Former Bylaws*,*"* as will be discussed later in this Chapter.

Major participants in variation of privileges cases

A member of the Medical Staff is a physician who is registered in the Medical Register and holds a license to practice medicine. Each member of the Medical Staff must hold hospital privileges granted by the CDHA Board. In the cases considered in this Inquiry, Dr. Horne and

Dr. Goodyear were members of the Medical Staff and held appropriate privileges. The Chief of the CDHA Department of Medicine was the person who acted to vary the privileges of Drs. Horne and Goodyear, and subsequently to suspend the privileges of Dr. Goodyear. These actions by the Chief of the Department of Medicine were approved by the Acting CEO of Capital Health in October 2002.

There are also two CDHA committees that played major roles in considering the variation of privileges under the Bylaws, the District Medical Advisory Committee (DMAC) and the Privileges Review Committee (PRC). DMAC is an advisory committee of the Board concerned with patient care, teaching and research.

District Medical Advisory Committee

The District Medical Advisory Committee (DMAC) is established pursuant to Section 4 of the Bylaws. This Section specifies that:

> *4.1 The District MAC is hereby established for the purpose of these Bylaws and shall have such composition as the District Health Authority determines in the District Health Authority's Medical Staff (General) Bylaws.*

The Medical Staff (General) Bylaws specify the composition and role of the District MAC in Section 7. The purpose of the DMAC is set out in Section 7.1 as follows:

> *7.1 The District MAC is a committee of the Board established to advise the Board on matters concerning the provision of quality patient care, teaching and research as prescribed by the mandate of Capital Health.*

The composition of DMAC is specified by Section 7.2 and the provisions for a Chair of DMAC by Sections 7.3 and 7.4:

> *7.2 The District MAC shall consist of the following:*
>
> > *7.2.1 members reflecting representation of the leadership of the departments … as determined by the Board after consultation with the CEO, District Chief of Staff (VP Medicine), VP Academic Affairs and President of the District Medical Staff Association;*
> >
> > *7.2.2 designated member of the District Medical Staff Association and the President of the District Medical Staff Association;*
> >
> > *7.2.3 the District Chief of Staff (VP Medicine) and VP Academic Affairs;*
> >
> > *7.2.4 The CEO ex officio and other non-voting representatives from Capital Health administration.*
>
> *7.3 The Chair of the District MAC shall be appointed by the Board on the recommendation of the District MAC …*
>
> > *7.3.1 the voting members of the District MAC shall elect from among their number by majority vote, a member for recommendation to the Board to be the Chair of the District MAC.*

7.3.2 the President of the District Medical Staff Association, the District Chief of Staff (VP Medicine), and the VP Academic are not eligible to be Chair of the District MAC.

7.4 At the pleasure of the Minister of Health, the Chair of the District MAC shall be an ex-officio member of the Board.

7.4.1 The Chair of the District MAC shall be accountable to the Board through the District Chief of Staff (VP Medicine).

The Board appoints the members of DMAC after consultation with senior administrators and the President of DMSA. It is intended that this committee reflect medical leadership of the District. A number of people are members of DMAC by virtue of the position they hold. The Chair is recommended to the Board by the Committee, reports to the Board through the VP Medicine and is normally appointed by the Minister of Health to the Board.

The responsibilities of DMAC are specified by Section 7.8:

7.8 District MAC shall:

7.8.1 be responsible for the ethical conduct and professional practice of the members of the District Medical Staff;

7.8.2 be responsible for the supervision, quality, organization and delivery of all services provided by the Medical Staff including patient care, teaching and research;

7.8.3 consider, coordinate and recommend to the Board the Rules and Regulations and policies as they apply to the Medical Staff as a whole or to individual departments, divisions, or sections;

7.8.4 make recommendations to Capital Health's Privileges Review Committee concerning appointments, reappointments, discipline and privileges of the Medical Staff;

7.8.5 consider and take appropriate action on all matters and recommendations forwarded by standing and ad hoc committees or subcommittees;

7.8.6 consider and make recommendations on such matters as may be referred to it by the Board;

7.8.7 advise the Board of such committees as it considers necessary for the proper governance of the District MAC and shall set their terms of reference and appoint the members and chairs of such committees.

DMAC has specific responsibility for the ethical conduct and professional practice of all members of the Medical Staff, and for all the services provided by the Medical Staff. It recommends to the Board rules, regulations, and policies regarding the Medical Staff as a whole, and individual units. It makes recommendations to the Privileges Review Committee (PRC) regarding appointments, reappointments, privileges, and discipline of the Medical Staff.

Privileges Review Committee

The Privileges Review Committee (PRC) is established pursuant to Section 2 of the Bylaws. This Section specifies that:

> *2.1 for the purposes of these Bylaws, the PRC shall have the composition as described in the DHA's corporate Bylaws.*
>
> *2.2 In presenting oral submissions to the PRC, a physician may be accompanied by legal counsel if the physician so wishes.*

Section 11.7 of the corporate Bylaws of Capital Health specifies the composition of the PRC as:

> *11.7.1 Membership*
>
> > *11.7.1.1 a chairperson appointed by the Board who is a Director but not a member of the Executive Committee;*
> >
> > *11.7.1.2 one Director who is not a member of the Executive Committee;*
> >
> > *11.7.1.3 one member who is appointed by the Board and may or may not be a Director.*
>
> *11.7.2 The Privileges Review Committee may add such ex officio members as it sees fit.*

The **Privileges Review Committee (PRC)** is appointed by the Board of Capital Health. Two of the three members are required to be Directors (i.e. they are Members of the CDHA Board), and the third may be. The Chair must be a Director.

Sections 11.7.3 and 11.7.4 specify certain procedures and duties of the PRC.

> *11.7.3 Any members of the Privileges Review Committee who are present during a Board meeting where information is presented or discussed which has the potential of becoming a source of review by the Committee shall absent themselves during the Board's discussion of such matters.*
>
> *11.7.4 The Privileges Review Committee shall perform such duties as described in the Medical Staff Bylaws and may be required to perform such other duties as the Board may prescribe.*

Members of the PRC should have no *a priori* knowledge from Board discussions of the matters they review. They perform duties set out in the Medical Staff Bylaws.

Sections 8, 11, 13 of the Medical Staff (Disciplinary) Bylaws

Section 8.1 specifies who can vary the privileges of a member of the Medical Staff, and for what reasons.

> *8.1 The CEO, … the District Chief of Staff, or the District Department Chief (but not their delegates) may suspend or vary the privileges of any member of the Medical Staff at any time where the member has been found to have engaged in conduct which*
>
> > *8.1.1 exposes or is reasonably likely to expose, patients, Medical Staff, employees or the public to harm or injury … or*
> >
> > *8.1.2 is adversely impacting or is reasonably likely to adversely impact the delivery of patient care at any hospital site in the District.*

The Chief of the Department of Medicine may suspend or vary privileges of a member of the Medical Staff at any time provided (s)he "*found*" that a member's conduct "… *exposes or is reasonably likely to expose* …" relevant people to "… *harm or injury* …," or that the member's conduct "… *is adversely impacting or is reasonably likely to adversely impact the delivery of patient care* …" The Chief of the Department of Medicine cannot delegate this authority and is personally required to make a finding regarding the member's conduct before the member's privileges can be varied.

Although the Bylaws are silent in this regard, it is well established that making a finding requires that the person making the decision has first diligently examined the evidence, including any response of the member to that evidence. Therefore the member must know the evidence in sufficient detail, and with sufficient notice, to prepare a full response.

The Chief of the Department of Medicine may vary privileges only if the Chief finds, after due consideration, that the evidence establishes that the conduct exposes people to actual harm or injury, or adversely impacts the delivery of patient care, or is reasonably likely to do either or both of these.

Section 8.2 specifies what a person who has varied a member's privileges must do.

> *8.2 The person who has suspended the member pursuant to subsection 8.1 shall*
>
> > *8.2.1 advise the District MAC and the member concerned within 24 hours of such action*
> >
> > *8.2.2 at the time of advising the member of the suspension pursuant to clause 8.2.1, shall inform the member of his or her right to*
> >
> > > *8.2.2.1 make a written submission to the District MAC, and*

8.2.2.2 request the consent of the District MAC to make oral submissions within 10 days of the suspension.

The Chief of the Department of Medicine must advise DMAC and the affected member of the action taken within twenty-four hours, and must inform the member of his or her rights regarding submissions to DMAC. If the member chooses to exercise his or her rights, the member must make a written submission to DMAC and/or a request for oral submissions within ten days of the suspension.

Sections 8.3 and 8.4 specify certain powers of the CEO.

8.3 If anyone, other than the CEO, suspends or varies privileges pursuant to subsection 8.1, that person shall obtain the approval of the CEO or the CEO's designate within 1 working day from the suspension or variation and if such approval is not obtained, such suspension or variation of privileges shall lapse.

8.4 Notwithstanding subsection 8.1, the CEO may temporarily reinstate, with or without conditions, privileges of a member of the Medical Staff, pending the outcome of the action being taken under Section 8 if, in the opinion of the CEO, after consultation with the District Chief of Staff, the circumstances warrant it.

The CEO has unconditional authority to overrule a variation of privileges by the Chief of the Department of Medicine. The CEO may also temporarily reinstate privileges, with or without conditions, pending the outcome of the disciplinary proceedings. The CEO must consult with the District Chief of Staff (at CDHA, the VP Medicine), before temporarily reinstating privileges, but otherwise is able to do so if, in the CEO's opinion, the circumstances warrant it. These powers of the CDHA CEO were not invoked in the cases of Drs. Horne and Goodyear. Had they been, in the opinion of this Committee, a great deal of the damage to these two doctors might have been avoided or mitigated.

Section 8.5 specifies the responsibilities and time frame for the District Medical Advisory Committee.

8.5 The District MAC shall conduct any investigations it deems necessary and submit its recommendation and any submissions that the District MAC received pursuant to clause 8.2.2 to

8.5.1 the CEO

8.5.2 the District Chief of Staff

8.5.3 the member, and

8.5.4 the PRC

within 10 days of receiving and/or hearing the member's written and/or oral submissions pursuant to clause 8.2.2, or within 10 days of the member waiving the right to make such submissions; and

> *8.5.5 if the District MAC has not received a member's written and/or oral submissions pursuant to clause 8.2.2 or a written notification that the member has waived the member's right to make such submissions within the 10 days referred to in clause 8.2.2, then it shall be deemed that the member has waived his or her right to make such submissions.*

DMAC "… *shall conduct any investigations it deems necessary and submit its recommendation … within 10 days* …" The time starts from the submission of the member, the member's waiver of his/her right to make a submission, or the member's failure to meet the time limits of Subsection 8.2.2.

DMAC is required to investigate and to make recommendations within ten days. Although the Bylaws are silent in this regard, it is broadly understood that in such situations a body like DMAC must exercise reasonable diligence in determining what investigation is necessary and making its recommendations, with due regard for the time limits.

Reasonable diligence requires DMAC to give due consideration to the submission of the member and to investigate the evidence on which the variation of privileges was based. It also requires that DMAC determine whether the evidence before it establishes that the conduct exposes patients, staff, or members of the public to actual harm or injury, or adversely impacts the delivery of patient care, or is reasonably likely to do either or both of these. Reasonable diligence also requires that DMAC consider whether appropriate procedures were used by the Chief of the Department of Medicine in reaching the findings used to justify the variation of privileges, and by the CEO in approving the variation of privileges.

The requirement to investigate includes a requirement that DMAC determine whether the conduct alleged to expose people to harm does in fact do so. One mechanism available to DMAC is to commission an unbiased and independent external review to determine if the cases alleged to represent harm, or reasonably likely to result in harm, represent a departure from the usually accepted standard for clinical practice in the profession as a whole.

There appears to be no limit to what DMAC may recommend. In that case, it could, therefore, recommend measures other than variation of privileges to resolve the issues before it. Such measures might include, for example, negotiating a leave with the member and/or conducting a review by appropriately qualified investigators.

The timelines specified in the Bylaws appear to be problematic in two ways. In a case such as Dr. Goodyear's, establishing a proper unbiased and independent external expert review to consider the case would clearly take more than the allotted ten days foreseen in the Bylaws. In recognition of this reality, Dr. Goodyear and CDHA mutually agreed to waive those time limits. That created a second problem. Once the mutual agreement had been reached there was no way to withdraw or alter that agreement, nor was there a provision that such extensions themselves have some upper limit. As a result, as the time taken by the process rapidly expanded, there was no preestablished means to limit the damage. It is difficult to accept a premise that waiver of a ten-day time limit could lead properly to an extension of the deadline for several years. In the opinion of this Committee, this unacceptable lengthy extension of the deadline required corrective action on the part of CDHA, which was not forthcoming.

Section 8.6 specifies a ten-day time limit for a recommendation by PRC.

> *8.6 The PRC shall make a recommendation pursuant to section 8.11 within 10 days of receiving the submission of the CEO, the District Chief of Staff or the member pursuant to subsections 8.7, and 8.8.*

The same concerns about time limits apply to PRC as well as DMAC. The waiver of one time limit was interpreted to mean an extension of all of the limits specified by the Disciplinary Bylaws.

Sections 8.7 and 8.8 specify the rights of the member, the CEO, and the District Chief of Staff to make presentations to the PRC.

> *8.7 The CEO and the District Chief of Staff may provide written submissions to the PRC and, with consent of the PRC, may make oral submissions and both forms of submissions shall be made within 10 days of receiving notice or such other period as the PRC in its discretion may deem appropriate.*
>
> *8.8 The PRC shall notify the member of his or her right to make written submissions to the PRC and, with consent of the PRC, may make oral submissions and both forms of submissions shall be made within 10 days of receiving notice or such other period as the PRC in its discretion may deem appropriate.*

The member, the CEO and the District Chief of Staff (VP Medicine in the case of Capital Health) may provide written submissions to the PRC and, with consent of the PRC, may also make oral submissions. They have ten days after receiving notice. PRC has ten days after receiving the submission to make recommendations. Once PRC issues a notice, there are ten days for the receipt of submissions and a further ten days within which recommendations must be made. The PRC has discretion to set a different deadline if it deems it appropriate.

Although the Bylaws are silent on this matter, it is well established that bodies such as PRC must exercise this discretion with due care and diligence. In the opinion of this Committee, exercising discretion to extend time deadlines from a number of days to what became a number of years does not meet this standard of due care and diligence.

Section 8.9 specifies the power of PRC to negotiate a settlement with the member.

> *8.9 After the District MAC refers a matter to the PRC pursuant to section 8.5, the PRC may, at any time prior to PRC making a recommendation pursuant to subsection 8.11, negotiate either directly or through counsel, a Proposed Agreement with the member.*

This Section specifically allows PRC to negotiate a Proposed Agreement with the member at any time between the DMAC reference and PRC making a recommendation. There are no explicit limits on what may be negotiated.

A matter that arose in the case of Dr. Horne concerned this power to recommend a Proposed Agreement. Dr. Horne, Dalhousie, and CDHA all agreed to use an external mediator to attempt to reach an agreement to settle the matter. Dr. Horne met with a representative of Dalhousie and the CEO of Capital Health, all of whom purported to have authority to conclude a binding agreement and all of whom had competent legal counsel. PRC refused to honour the agreement reached and asserted that only PRC had power to recommend an agreement to the CDHA Board and only the Board could agree to a settlement of an action taken under the Disciplinary Bylaws. Dr. Horne sought to enforce the mediated settlement by requesting a court order that the mediated settlement was binding on all parties. The Court ruled that the CDHA CEO who had signed the mediated settlement had no authority to do so because the Board had been delegated authority regarding hospital privileges by the Minister of Health and could not sub-delegate its authority. As a result, the mediated settlement was deemed not to be a binding agreement.

Sections 8.10 and 8.11 specify the duties of the PRC in the absence of a negotiated agreement with the member.

> *8.10 If no Proposed Agreement is negotiated pursuant to subsection 8.9, the PRC shall consider any reports, submissions and recommendations submitted to it under clause 8.5.4 and subsections 8.7 and 8.8 and make any investigation that it deems necessary.*
>
> *8.11.1 The PRC shall, subject to final approval by the Board, and*
>
> > *8.11.1.1 subject to a CEO or member seeking a hearing before the Board pursuant to clause 8.12.1: and*
> >
> > *8.11.1.2 subject to a member seeking an appeal or a hearing before the Provincial Appeals Board pursuant to subsections 8.16 or 8.17,*
>
> *make a recommendation with respect to the member's appointment and privileges and inform the member and the CEO of such recommendation.*
>
> *8.11.2 In making a recommendation pursuant to clause 8.11.1, the PRC may determine that there shall be no variation, suspension or revocation of the member's privileges, that a Proposed Agreement shall take effect, or that there shall be a variation, suspension or revocation of the member's privileges.*

The PRC considers the case and makes a recommendation only if no Proposed Agreement is negotiated. PRC must therefore determine if there is a Proposed Agreement. In the case of Dr. Horne, PRC refused to recognize an agreement that clearly did exist because PRC had played no role in reaching that agreement. PRC also asserted that Dalhousie could not be a party to any settlement of the privileges matter with Dr. Horne because Dalhousie had no legal standing in determining privileges.

PRC must consider material submitted to it by DMAC. This consists of the submission of the member to DMAC and the DMAC recommendations. It must also consider any further submissions to it by the CEO, District Chief of Staff and the member.

The PRC shall make any investigation that it deems necessary. This is the same provision that applies to DMAC. PRC is therefore subject to the same requirements in their investigation and recommendations that are described above for DMAC. In particular, they have the power to seek independent external expert testimony.

The PRC informs the member and the CEO of its recommendation. It can recommend that the member's privileges be varied, that the member's privileges not be varied, or that a Proposed Agreement take effect.

PRC recommendations are subject to final approval by the CDHA Board, as discussed below, and are also subject to appeal by the member to the Provincial Appeal Board.

Sections 8.12 and 8.13 specify the role and powers of the Board once PRC submits its recommendations to the member and the CEO.

> *8.12.1 Within 10 days of receiving the PRC's recommendation pursuant to subsection 8.11, the CEO or the member may give notice of intention to proceed to a hearing before the Board.*
>
> *8.12.2 In the event that the Board does not receive notice pursuant to clause 8.12.1, then the PRC shall forward its recommendation or the settlement agreement to the Board who shall, without having a hearing, make a final determination with respect to the matter, subject to the member's right to a hearing by the Provincial Appeal Board pursuant to section 8.17, and the Board shall inform the member and the CEO within 10 days of such determination.*
>
> *8.13 Upon the Board receiving notice from the CEO or the member of their intention to proceed to a hearing, the PRC shall forward to the Board all the documentation that it received pursuant to clause 8.5.4 and subsections 8.7 and 8.8 and any additional documentation it has gained through any investigations.*

Either the CEO or the member can proceed to a hearing before the CDHA Board by giving notice within ten days of receiving the PRC recommendation. If no notice is given, the Board makes a final determination, subject to the right of the member to a hearing by the Provincial Appeals Board. The Board informs the member and the CEO within ten days of its decision.

When the Board receives notice of intention to proceed to a hearing, the PRC forwards the submission of the member to DMAC, the DMAC recommendations, any submissions to PRC by the CEO, District Chief of Staff, and the member, and any "… *additional documentation it has gained through any investigations* …." These might, for example, include the written judgments of any independent external experts as to whether the cases considered to represent a risk to patients do so in fact.

Sections 8.14 and 8.15 specify the role and powers of the Board in holding a hearing.

> *8.14 In holding a hearing, the Board shall give written notice of the hearing to the member and the CEO and the notice shall include:*
>
> > *8.14.1 the place and time of the hearing,*
> >
> > *8.14.2 the purpose of the hearing, and*
> >
> > *8.14.3 a copy of the Medical Staff (Disciplinary) Bylaws.*
>
> *8.15 The Board shall, after holding a hearing, make a decision concerning the member's appointment and privileges, subject to the member's right of appeal to the Provincial Appeal Board.*

The Board shall give proper notice of the hearing, and, after the hearing, shall make a decision concerning the member's privileges. The member may appeal the Board's decision to the Provincial Appeals Board. The Board may also establish a committee to hear and decide the case. When it does so, the committee has all the powers and responsibilities of the Board. In the cases of both Dr. Horne and Dr. Goodyear, the Board did establish a committee to hear the cases.

Section 11.2 specifies the rules of evidence that the Board must follow in holding a hearing.

> *11.2.1 Written or documentary evidence, expert evidence, or testimony of any other witness is not admissible unless the opposing party,*
>
> > *11.2.1.1 in the case of written or documentary evidence, has an opportunity to examine the evidence, or*
> >
> > *11.2.1.2 in the case of the evidence of an expert, a copy of the expert's written report or if there is no written report, has a written summary of the evidence, or*
> >
> > *11.2.3 in the case of testimony of any other witness, knows the identity of the witness*
>
> *at least 10 days before the hearing.*
>
> *11.2.2 Notwithstanding clause 11.2.1, the Board … may, in its discretion, allow the introduction of evidence that would be otherwise inadmissible under clause 11.2.1 and may make directions it considers necessary to ensure that a party is not prejudiced.*

The parties must know, at least ten days before the hearing, the documents, expert evidence, and witnesses to be presented. The Board may admit other evidence but must ensure that a party is not prejudiced by its doing so. These are standard procedures in hearings which are required to provide the protections of natural justice.

Section 11.3 to 11.5 specify that natural justice applies to hearings of the Board, but not to the activities of DMAC or PRC, and specifies other procedural matters for hearings of the Board.

> *11.3.1 At a hearing, all parties are entitled to all the rights of natural justice, including the right to be represented by legal counsel, to know all the evidence considered by the PRC, to present evidence and to cross examine witnesses.*
>
> *11.3.2 For greater certainty in the interpretation of these Bylaws,*
>
> > *11.3.2.1 hearings held by the Board … are judicial in nature and the principles of natural justice apply, and*
> >
> > *11.3.2.2 the activities of … District MAC, and the PRC are not judicial or quasi-judicial in nature.*
>
> *11.4 The Board … may adopt such written rules as are consistent with this section.*
>
> *11.5 If a member of the Board … has participated in a hearing becomes unable, for any reason, to complete the hearing or to participate in the decision, the remaining member(s) may complete the hearing and give a decision.*

The Board may adopt written rules for hearings provided they include all the rights of natural justice. Specifically a member may be represented by legal counsel, know the evidence considered by PRC, present evidence, and cross-examine witnesses. Where the evidence considered by PRC involves transcripts of witness testimony, those witnesses should be available for cross-examination at the hearing.

Specifying that the activities of DMAC and PRC are not judicial or quasi-judicial meant that a great deal of the evidence in the cases of Drs. Horne and Goodyear had not been properly tested prior to the hearing of the Board. Although the protections of natural justice applied during the Board hearings, Dr. Horne was denied access to a hearing with the protections of natural justice for four years and Dr. Goodyear for six years. Such a situation is a disservice, not only to Drs. Horne and Goodyear, but to CDHA as a whole.

Section 13.2 provides for waiving time limits.

> *13.2 All time limits in these Bylaws may be waived upon the mutual consent of the CEO and the member concerned.*

The normal time limits require that the PRC provides its recommendations to the member and the CEO within forty-one days of the original variation of privileges.

However, there is no constraint on the extent by which the parties may extend the time limits by mutual agreement. It is unclear whether the intent of this clause is that any one of the many time limits can be waived by mutual consent or if the intent is that every one of the time limits is waived if any one of them is waived. In the case of Dr. Goodyear, the initial waiver of time limits was deemed to apply to all time limits. The result of that decision was that extending

the ten-day time limit in the first stage of the investigation to allow for a proper external evaluation of Dr. Goodyear's practice resulted in an open-ended process with no time limits that extended for six years. In the opinion of this Committee, such an extreme result could not reasonably have been the intent of the Bylaws.

Summary of maximum normal time limits

Action	Day	Bylaw Section
Privileges varied	0	8.1
Notice given to member, DMAC, CEO, approval of CEO	1	8.2.1, 8.3
Written submission to DMAC and/or request for oral presentation by member	11	8.2.2
DMAC investigation complete, DMAC recommendations to member, CEO, VP Medicine, PRC	21	8.5
Written submission to PRC and/or request for oral presentation by member, CEO, VP Medicine	31	8.7, 8.8
PRC investigation complete, PRC recommendations to member, CEO	41	8.6
Notice of intention to proceed to a Board hearing by member or CEO	51	8.12.1
PRC forwards recommendations and associated documents to Board	No limit	8.13
Board provides notice of hearing	No limit	8.14
Disclosure of documents, expert evidence, witness list shared by parties	X	11.2
Board Hearing	At least X+10	11.2

Board decision	Y	8.15
Member's notice of appeal to Provincial Appeals Board	Y + 10	8.17.1
Provincial Appeals Board provides written notice of hearing	Y + 40	8.17.3
Provincial Appeals Board hearing and decision	No limit	8.17.5

Section 9 of the Medical Staff (Disciplinary) Bylaws

Section 9.1 specifies who can request a special review of the privileges of a member of the Medical Staff.

> *9.1 The CEO, the Site Manager, the Site-based Medical Leader, the District Chief of Staff, or the District Department Chief (but not their designates) may request a special review of the privileges of any member of the Medical Staff at any time and shall advise the District MAC and the member concerned within 24 hours of such action.*
>
> > *9.1.1 In making such a request for a special review, the person requesting the special review shall indicate the grounds giving rise to such a review and the remedy or remedies that are sought*

The Department of Medicine Chief could have requested a special review of the privileges of Dr. Horne or Dr. Goodyear, indicating the grounds giving rise to the review and the remedy or remedies sought. As discussed below, variation of privileges is a very serious matter for a physician, and such a review must be done with high standards of procedural protections.

Sections 9.2 and 9.3 specify how the special review is carried out.

> *9.2 The District MAC shall review the performance and conduct of the member and shall notify the member of his or her right, within 10 days of receiving the notice, to make written submissions to the District MAC and to request the consent of the District MAC to make oral submissions.*
>
> *9.3 The process shall continue pursuant to subsections 8.5 to 8.17 inclusive.*

The review begins with the District MAC and continues using the same process as is used for a summary variation of privileges, described above.

The effect of a special review is to conduct the same investigation as for the summary variation under Section 8, but the member's privileges remain unchanged during the

investigation. In both the cases of Dr. Horne and Dr. Goodyear, maintaining their privileges while the investigation proceeded would have avoided a great deal of the damage that accumulated during the long period before the case was finally heard by the Board.

Section 10 of the Medical Staff (Disciplinary) Bylaws

Section 10.1 specifies that a Member's privileges shall be automatically suspended by certain persons in specific circumstances.

> *10.1 A member of the Medical Staff shall be suspended by the CEO, the Site Manager, the District Chief of Staff, or the District Department Chief when*
>
> > *10.1.1 a member fails to complete a patient's record within the Rules and Regulations of the DHA and has failed to comply within a 14 day notice period for completion which is given by the CEO, the Site Manager, the District Chief of Staff, or the District Department Chief*
> >
> > *10.1.2 a member has ceased to be a member of the Canadian Medical Protective Association or to carry and have in force equivalent malpractice insurance ...; or*
> >
> > *10.1.3 a member's licence has been suspended or revoked or a reprimand has been noted by the College of Physician's and Surgeon's pursuant to the Medical Act ...*

The people who shall automatically suspend a member are the same persons who may vary the member's privileges. Grounds for automatic suspension are failure to complete a patient's record after receiving notice to do so, failure to maintain malpractice insurance, or a reprimand, license suspension, or license revocation by the College of Physicians and Surgeons. Section 5.19 requires a member to notify the CEO immediately and in writing if any of the conditions of Sections 10.1.2 and 10.1.3 occur.

Section 10.2 specifies that a Member's privileges shall be automatically reinstated when the violation has been corrected.

> *10.2 An automatic suspension given pursuant to clause 10.1.1 shall continue until the violation has been corrected at which time the CEO shall automatically reinstate the member.*

Section 5: New applications for privileges

New applications for privileges are submitted to the CEO who refers them for a recommendation to the District Department Chief.

The Credentials Committee considers the recommendation(s) from the District Department Chief and CEO and "… *may carry out such investigations as it deems necessary* …" before making a recommendation to the District MAC.

In turn, DMAC "… *shall conduct any investigation it deems necessary* …" before making a recommendation to the PRC. Finally, the PRC shall "… *make any investigations that it deems necessary* …" before forwarding its recommendation to the Board for a decision.

If privileges are approved, the Board shall "… *specify the extent and limitation of the privileges granted* …"

Both Dr. Goodyear and Dr. Horne had been subject to these provisions when they first applied for privileges. Dr. Goodyear had requested and been granted privileges using this privileges procedure seven times during the two and a half years he held a *locum tenens* appointment. Either these various bodies did not deem an investigation necessary at that time, or the results of the investigation were satisfactory.

Sections 5 and 14: Term of privileges

Sections 5.17 and 14.1 specify that appointments to the Medical Staff are normally for three years and terminate if they are not renewed. Section 14.1.2 specifies exceptions whereby privileges are for a shorter period, one of which is (Section 14.1.2.6) that "… *in Capital Health, the member's annual performance appraisal result is unsatisfactory or no appraisal has been provided by the District Department Chief.*"

One of the considerable powers of the District Department Chief is to conclude that a member of the Medical Staff has unsatisfactory performance, or not to do such an appraisal. The District Department Chief could also recommend against renewal of privileges, which could cause the privileges to be terminated after the three-year review.

Section 7: Reappointments with privileges

The CEO forwards reappointment applications to the member at least 120 days prior to the completion of the member's current term. The review process is essentially the same as that used for a new appointment.

Every three years, the member of the Medical Staff must receive a renewal of privileges in order to continue in his or her position. These temporary appointments do not provide the secure appointment that is needed for proper protection of academic freedom. It leaves a member of the Medical Staff very vulnerable to termination and does not provide the expected procedural safeguards against unjust terminations. The procedures of DMAC and PRC specifically do not provide the full protections of natural justice.

Commentary

Variation of privileges

Variation of privileges is an extremely serious matter for a physician. According to Casey:[19]

> *For most physicians, the ability to practice medicine fully and effectively required extensive use of hospital services, and the consequences for a doctor who fails to obtain adequate hospital privileges are frequently serious, and sometimes calamitous. Specialists have the most to gain or lose through access to staff privileges. Most of them spend the bulk of their practice in the hospital environment and depend on the regular use of sophisticated services and equipment, assistance of other health professionals, and consultation with other doctors — all of which are available only in the hospital*
>
> *For any doctor, the inability to acquire privileges, the loss of such privileges, or even undue restrictions placed on his ability to practice medicine in a hospital, may mean the loss of some or all of his practice or income. Once lost, privileges will be harder to acquire elsewhere. A doctor without privileges may suffer deterioration in his professional standing and will be deprived of the experience and continuing education that is an informal but vital by-product of close association with other doctors in the hospital.*

Privileges are such an important issue for doctors that a very high standard is required for any action that varies or removes a doctor's privileges. Again, according to Casey:[20]:

> *The principle of natural justice or procedural fairness have been found to apply where a statutory body has the power to make a decision which will effect an individual's rights or interests. … generally, an individual is entitled to know the allegations made against him or her, is entitled to provide a response and to have the decision made by an impartial and non-biased decision maker. A loss or restriction of privileges can have a devastating impact on a doctor's practice, income and professional standing.…*
>
> *The duty of fairness has been found to apply in a variety of circumstances including … the cancellation of privileges, a reduction in privileges, a failure to renew privileges, and a disciplinary suspension of hospital privileges.*

In particular, summary variation of privileges carries with it, within the medical community, the damaging stigma that the physician involved must have done something terribly wrong or such serious steps would not have been initiated.

Summary variations are usually the result of some form of egregious behaviour such as a gross violation of medical ethics, substance abuse, gross incompetence presenting an actual and

[19] Casey, James T, *Regulation of Professions in Canada*, Chapter 18: 18–1, Carswell (Scarborough, Ontario), 1994
[20] Casey, James T, op. cit. 18–4

immediate threat to patient safety, or criminal activity. Rightly or wrongly, physicians subject to summary variation of their privileges are seen in that stark light by their colleagues. Summary variation of privileges should therefore be reserved for such serious misbehaviour. The cases considered by this Inquiry were far removed from that level of seriousness and urgency, and were ultimately found not to be grounds for variation of privileges for either Dr. Horne or Dr. Goodyear. However, by the time that ruling was made by the CDHA Board, a great deal of damage had been done.

Another important question is whether tools other than variation of privileges should play a larger role in the Disciplinary Bylaws. Because of its major threat to the career of a physician, any attempt to vary privileges is emotionally charged, may appear punitive to the physician who is the focus, and is therefore quite likely to develop into an adversarial process. Once the process is adversarial and each side vigorously defends its actions, trust can break down, antagonism can build, and long-term relationships can be damaged, perhaps irreparably. The participants can become unjustly convinced of the strength of their arguments, and diminishing trust can prevent all parties to the dispute from taking the risks that are needed to reach a mutually agreeable solution. While the focus should rightly be on the potential damage to the accused, it must be understood that there is a risk of major damage to all parties in such a process.

Another aspect of using variation of privileges as a disciplinary tool is that concerns are inevitably phrased in terms that appear accusatory to the physician who is the focus of the variation. Such a situation is not helpful if the intended message is that the physician needs to pay more attention to the honest concerns of his or her colleagues and address those concerns. In that case, what is needed is language that is encouraging and supportive of change. Reliance on accusatory language fosters a defensive posture. A physician subject to a possible variation of privileges may well want to provide a response to actual or perceived “charges.” Such a response may then be characterized, as it was in the words of the Department of Medicine Chief to Dr. Goodyear, as the physician not having insight into how his or her behaviour contributed to the concerns expressed. In fact, the physician is likely to have very clear insight into the fact that these accusations are a threat to his or her continued career. This sequence played itself out in this way in the cases of Dr. Horne and Dr. Goodyear.

Another concern is that once a formal legal process is begun under the Bylaws, the demands of that formal process can take precedence over solving the problem. It is entirely proper that the legal process be carried out conscientiously. However, in the case of Dr. Horne, an attempt by PRC to impose a particular interpretation of the letter of the Disciplinary Bylaws resulted in the failure of an actual mediated resolution of the dispute, agreed to in writing by all parties. That failure substantially increased the time required to reach a decision regarding Dr. Horne’s privileges.

It would be more effective to give more *a priori* consideration to whether the Bylaws are an appropriate tool in the circumstances. Such consideration would involve identifying clear criteria which must be met before a variation of privileges under the Bylaws is initiated. One such criterion is that the Bylaws should only be invoked when there is a clear and direct impact on patient safety. When concerns arise about a physician’s clinical practice or relationships with colleagues that have no direct and immediate impact on patient safety, mechanisms other than the Bylaws should be preferred. There must also be proper checks and balances to ensure that

issues are not inappropriately framed as *"patient safety."* Even in the case where patient safety is clearly involved, there need to be robust and consistent means of discussing patient safety with physicians and assisting them to make improvements, all of which should be exhausted before consideration is given to a proceeding under the Bylaws to vary or suspend privileges.

It would also be more beneficial to provide effective resources to counsel and support decision makers before a decision is made to proceed under the Bylaws. There is a striking imbalance between the resources consumed by the Bylaws process itself and the resources applied — or, more correctly, not applied — in support of the Department of Medicine Chief and the Acting CDHA CEO before the decision to vary the privileges of Dr. Horne and Dr. Goodyear was taken. As a result of the decision to vary the privileges of Drs. Horne and Goodyear, many thousands of pages of documents were produced over an extended period involving untold numbers of hours of legal billings as well as time and energy spent by the CDHA participants in the Bylaw process.

There are also all of the issues related to how to repair damage done to a physician's reputation if the process ultimately finds in the physician's favour. All of these matters were demonstrated in the cases of Dr. Horne and Dr. Goodyear.

As will be discussed later in this report, it is the opinion of this Inquiry that the disciplinary Bylaws — including the *"New Bylaws"* — have serious deficiencies which must be addressed, and in many ways are unsuited for productive solutions to disputes about physician performance. An improved disciplinary process is required, and forms one of the recommendations of this Inquiry.

Other approaches were possible

The position taken by Capital Health in Dr. Horne's case that the action taken to vary Dr. Horne's privileges "… *was the absolute minimum to ensure patient safety in the circumstances* …,"[21] does not stand up to a scrutiny of the Medical Staff (Disciplinary) Bylaws. Indeed it appears to have been the most intrusive approach allowed by those Bylaws. There were a number of other approaches available in place of varying the privileges of Drs. Horne and Goodyear.

Using mentors, involving communication facilitators, and clarifying expectations for all the involved parties in the manner of the "*Minutes of Settlement*" reached by Dr. Horne and other parties at a later date, the Department of Medicine Chief might have attempted to resolve the perceived underlying problems without assigning blame or setting in motion procedures whose outcome would prove disastrous and costly, in every sense of the word, to everyone involved. This could have been coupled with an understanding that matters considered unacceptable would be scrutinized during the next regular review of privileges and appointment if they were not adequately corrected.

[21] Capital Health Submission to DMAC, Nov 20, 2002, p12

Section 9 of the Bylaws could also have been used to request a special review of the privileges of Dr. Horne and Dr. Goodyear. This would have triggered a process which is the same as that followed for a summary variation to determine if a variation of privileges is justified, but Dr. Horne and Dr. Goodyear could have continued their work while the process unfolded. In retrospect, invoking this procedure would have prevented the most damaging results of the action for all concerned, and at least in part mitigated the injustice of the lengthy delay in making a final determination of the cases.

There is a major difference between these two approaches. A choice to use Section 8 essentially made a judgment that the behaviour of Dr. Horne and Dr. Goodyear was so egregious, and so well established by the facts in possession of the Department of Medicine Chief, that protection of patients and delivery of patient care required the immediate removal of Dr. Horne and Dr. Goodyear. In the opinion of this Committee, such a judgment requires a very high standard of evidence.

It should reasonably have been known that the impact of a variation of their privileges on the careers of Dr. Horne and Dr. Goodyear would be extremely serious, as it has proven to be. The effect of a summary variation of privileges was punitive for Drs. Horne and Goodyear whether or not it was the intent of the decision maker(s) to punish the individuals. To justify such an action requires the highest level of incontrovertible evidence.

The CDHA Board ultimately determined that there was not sufficient cause to vary the privileges of either Dr. Horne or Dr. Goodyear. The assessment of this Committee is that the available evidence on which the variation of privileges was based did not approach the standard required to invoke Section 8 of the Bylaws. There was no clear evidence that any of Dr. Goodyear's patients had failed to receive an appropriate standard of care, despite some clearly biased attempts to obtain such evidence, which is discussed in Chapter 7 of this report. There does not seem to have been an attempt to determine the facts of any of the cases in which Dr. Horne was accused or to refer them to outside experts, despite the fact that, at almost the same time, some of Dr. Goodyear's cases were referred to outside experts. In the opinion of this Committee, a decision to vary privileges requires a high degree of due diligence, which was not evident in the cases investigated.

But the fault does not lie entirely with the original decision that privileges be varied. The CEO must approve any action taken under the terms of Section 8, and is required to withhold approval unless convinced that the evidence met that high standard. This Committee is unaware of any attempt by the CEO to verify independently that the evidence presented met that standard. Once the impact of the variation of privileges on Drs. Horne and Goodyear became clear, the CEO could have reconsidered the decision and/or could have invoked the powers provided in the Bylaws to temporarily reinstate privileges while the investigation was completed, thereby preventing the most serious damage to the careers of Dr. Horne and Dr. Goodyear and the good name of the Dalhousie Faculty of Medicine.

The "New Bylaws"

During the lengthy time that the cases of Dr. Horne and Dr. Goodyear were under consideration under the terms of the Disciplinary Bylaws, an amended version of those Bylaws was enacted and came into effect on May 1, 2007.

Those *"New Bylaws"* or *"2007 Bylaws"* provide that they shall govern any complaint arising "… *before the original approval of these Bylaws on May 23, 2002 and thereafter …,*" which explicitly included discipline matters. Because the complaints concerning Dr. Horne and Dr. Goodyear arose in October 2002, the *"New Bylaws"* explicitly applied to the cases of Drs. Horne and Goodyear after May 1, 2007. Using the *procedures* of new Bylaws to complete ongoing matters is not unusual. However, the *"New Bylaws"* were not the same as the *"Former Bylaws"* in some material ways.

The "*New Bylaws*" establish a process for a special review of privileges that did not exist in the *"Former Bylaws,"* and explicitly provide for emergency variation of privileges. The "*New Bylaws*" also remove the investigative role of the PRC.

The variation of the privileges of Dr. Goodyear and Dr. Horne in October 2002, and the suspension of the privileges of Dr. Goodyear in January 2003, were carried out under Articles 8.1, to 8.3 of the *"Former Bylaws."* These Articles were replaced by Articles 9.1 to 9.5 of the *"New Bylaws."*

When the Board ultimately heard the cases of Dr. Horne and Dr. Goodyear, it relied upon Article 9 of the *"New Bylaws*,*"* which specifically applies to emergency variation or suspension of privileges, but is otherwise similar to Article 8 of the *"Former Bylaws"* used by the Department of Medicine Chief and the Acting CEO.

The provisions of Article 9.1, 9.1.1 and 9.1.2 of the *"New Bylaws"* require that a Member's privileges may only be varied or suspended if the Member "… *has been found to be engaged in or is engaged in …*" certain conduct. The only difference between these Articles and Articles 8.1, 8.1.1 and 8.1.2 of the *"Former Bylaws"* under which the original variation of privileges was taken is the addition of the words "… *or is engaged in …*" in the *"New Bylaws."*

Under both sets of Bylaws, the conduct that can give rise to a variation or suspension of privileges must involve actual, or reasonably likely, harm or injury, or actual, or reasonably likely, adverse impacts on patient care. There had been no attempt to demonstrate, as required, the harm, injury, or adverse impact on patient care that was the basis of the variation or suspension of the privileges of Dr. Goodyear or Dr. Horne.

Under the *"Former Bylaws,"* action could be taken only on the basis of a finding supported by an investigation. This Committee saw no documentary evidence that a proper investigation had been conducted before varying Dr. Goodyear's privileges in October, 2002, or suspending them in January, 2003, nor before varying Dr. Horne's privileges in October, 2002.

Under the *"New Bylaws,"* action could be taken on an emergency basis when a person "… *is engaged in …*" actions which involve actual, or reasonably likely, harm or injury, or actual, or

reasonably likely, adverse impacts on patient care. Action could be taken without an investigation under the "*New Bylaws*" only if a person is clearly engaged in some action that, with certainty, meets the criteria for variation or suspension of privileges. An example that might meet those criteria for acting without an investigation might be the case of a physician threatening a patient or another staff member with a weapon. In order to act without an investigation there must be incontrovertible evidence of conduct that meets the required standard for variation or suspension of privileges.

The *"New Bylaws"* make it explicit that this Article is for use in emergency situations only. An emergency situation is one in which there is a reasonable apprehension of actual harm occurring that can only be prevented by acting urgently rather than waiting for the normal process for review of privileges to take place.

Article 8 of the *"New Bylaws"* provides for a "*Special Review*" of privileges which can lead to a variation or suspension after DMAC has "… *conduct(ed) any investigation it deems necessary ...*" and makes a recommendation. There is no similar provision under the *"Former Bylaws."*

Once DMAC has made a recommendation under Article 8 of the *"New Bylaws,"* the member has the right to a hearing before the CDHA Board. Article 8.10 of the "*New Bylaws*" provides that "… *The Board shall, subject to the Member's right of appeal to the Provincial Appeal Board, after holding a hearing, make a final decision concerning the Member's appointment and privileges…"* Article 8.11.2 also states, "… *Unless the Member gives notice to the Provincial Appeal Board of an intention to proceed to appeal pursuant to clause 8.11.1, the Board's decision shall be the final disposition of the Member's privileges …"*

The role of DMAC

DMAC has an important role in providing medical leadership, in developing policy, and in giving advice to the Board on a wide range of matters. It also has an important role in appointments, reappointments, and granting privileges to members of the Medical Staff. These functions effectively determine who is appointed to the Medical Staff and the rules, regulations, and policies that govern their work.

It is not at all clear that a body that establishes those terms should then have a role in recommending disciplinary actions to enforce them, or in judging whether the evidence supports the allegations. In representative democracies, it is common practice, for important reasons, to establish a separation of legislative, executive, and judicial powers. In the context of Capital Health, a body with the required skills and experience to establish effective policies may not have the required skills and experience to administer those terms, investigate allegations of violations of those terms, or judge the strength of the evidence presented.

Recommendations for an improved disciplinary process are discussed in Chapter 9.

The role of DMSA

The role of the DMSA is explicitly stated in the Bylaws to be an advocate for physicians, both collectively and individually. All Medical Staff are required to be members of DMSA and pay dues to it. In principle, these terms could provide a strong basis for a role as an advocate and representative of medical staff, except for some implicit impediments. An important feature missing from the current Bylaws is explicit recognition that an individual member of the Medical Staff may choose to be represented by the DMSA in a grievance or dispute. In addition, the effectiveness of DMSA as a representative of individual members of the Medical Staff is impeded by the provision that all CDHA physicians, including those who hold administrative positions, are members of the DMSA. Consequently, DMSA could be in the position of representing both the member of the Medical Staff with a grievance and the Administrator who took the action or made the judgment that is the subject of that grievance. These impediments could be removed with appropriate amendments to the Bylaws.

There are a number of implications of recognizing the role of DMSA as advocate and representative. Whenever any meeting is being arranged with a member of the Medical Staff by a Division or Department Chief or other member of the CDHA Administration, that member of the Medical Staff should be advised that he or she has the right to have a representative of DMSA present and that he or she may be both advised by and/or represented by the DMSA. DMSA was not, however, involved in the meetings held by the Department of Medicine Chief with either Dr. Horne or Dr. Goodyear to discuss the concerns that subsequently led to the variation of her or his privileges. There is a considerable power imbalance implicit in such meetings between a member of the Medical Staff and the person who has the power to recommend that his or her privileges be varied. Having an advocate and/or representative present is one way of at least partly correcting that imbalance.

There are other important reasons for having an advocate or representative present at those meetings. Because the member of the Medical Staff may well feel threatened by the content of the meeting, (s)he may not be as aware of the details or understand statements that are made as well as would a representative who is not emotionally involved. A representative may also prevent the member of the Medical Staff from making statements that are not in his or her interest. For example, the representative can set the expectations for the meeting by making a simple statement that he or she and the member of the Medical Staff are present to hear what the Department Chief has to say and intend to make no response until there has been an adequate opportunity to consider the information they have received. The representative can ask questions to clarify what the Department Chief intends to do and under which provisions of the Bylaws.

Lack of a grievance process

The Bylaws are seriously deficient in not providing a grievance process that can be used by a member of the Medical Staff if he or she believes he or she is being unfairly treated or that the Administration is acting contrary to the terms of the Bylaws, rules, regulations, or policies. Such grievance processes are a standard feature of academic collective agreements and faculty handbooks in institutions with voluntary recognition of a body to represent faculty. Generally, both the aggrieved individual and/or the body with the power to represent them can file a

grievance. Grievance processes usually involve a number of steps to attempt to resolve the differences and always have some mechanism, usually involving an independent arbitrator or arbitration panel, to provide a final and binding resolution. They generally also have strict time limits for the various stages leading to a final resolution.

Had the DMSA, or some other body, been formally recognized to have the power to act as advocate and/or representative of the Medical Staff, and if there had been an appropriate grievance procedure in place, there would have been a greater opportunity to limit the damage to Drs. Nassar, Horne, and Goodyear and reach a final and binding resolution in a much shorter time frame.

Income maintenance

The Bylaws are also silent on another crucial matter, the effect that any suspension may have on the income of the individual whose privileges have been suspended. An individual accused of wrongdoing that might result in a variation or suspension of privileges should continue to receive his or her full income and benefits until the completion of the disciplinary process. For example, Dr. Goodyear's income was reduced by 85% during much of the time that his case was being considered. That is punitive, and exacerbates an already major imbalance between the resources available to the individual to pursue the case and those available to the Administration. This imbalance is particularly acute when the discipline process is essentially open-ended once there has been a waiver of the time limits.

Removal of an individual from the workplace

Individuals should be removed from the workplace only if their presence can be shown, on sound and reasonable grounds, to present a real and current danger to patients, staff, or the public. The onus is on the Administration to prove that such danger exists, and the action to remove individuals should be subject to the grievance process. The restrictions on the participation of the accused should not exceed what is reasonably necessary to remove the threat of danger.

For example, in the case of Dr. Goodyear there was an allegation that his practice constituted a threat to the well-being of certain patients, and Dr. Goodyear was removed from caring for any new patients. However, the CDHA Administration also imposed restrictions on Dr. Goodyear's academic work that did not involve patients, such as attendance at academic conferences to deliver research papers. Those restrictions were unjustified. However, Dr. Goodyear had no access to an appropriate grievance procedure to challenge those restrictions.

Justification for disciplinary action

Disciplinary action may be taken only for just and sufficient cause, and the penalty must be just and appropriate for the offence. The onus is on the Administration to prove that just and sufficient cause exists and that the penalty was just and appropriate for the offence.

Implementing a ruling by the Board

The Bylaws are silent on what means can be used to ensure that a ruling of the CDHA Board is fully implemented. This is a serious defect. The Board ruled in the cases of both Dr. Horne and Dr. Goodyear that they be returned to the status they held prior to the variation of their privileges. As discussed in Chapter 6, that reinstatement was not fully accomplished in the case of Dr. Horne, and new disputes arose as Dr. Horne attempted to resume her position. As discussed in Chapter 7, Dr. Goodyear was not allowed to return to his former privileges in Medical Oncology, effectively terminating his career. The Bylaws should provide for a binding process to settle any disputes about whether or not the ruling of the Board has been implemented.

Chapter 5 | Case of Dr. Bassam A. Nassar

Introduction

Unlike the cases of Dr. Horne and Dr. Goodyear, which took place within the Department of Medicine at CDHA and Dalhousie, the case of Dr. Nassar involved the Department of Pathology and Laboratory Medicine at CDHA and the Department of Pathology at Dalhousie. The case of Dr. Nassar had its basis in a cascade of unresolved disputes between Dr. Nassar and the Chief of those Departments dating back into the 1990s. Unlike the cases of Dr. Horne and Dr. Goodyear, the case of Dr. Nassar did not involve a variation of Dr. Nassar's privileges or actions against Dr. Nassar under the provisions of the CDHA Medical Staff Disciplinary Bylaws. All of the matters concerning Dr. Nassar involved procedures and policies of CDHA and Dalhousie, or were carried out in the absence of such procedures and policies.

This Inquiry considers the initiating event for the matters under investigation to be a memorandum received by Dr. Nassar (and others) on September 30, 1999, from the Chief of the Department of Pathology and Laboratory Medicine. The memorandum concerned an upcoming performance evaluation of Dr. Nassar, who was Division Chief of Clinical Chemistry, a unit within the Department of Pathology and Laboratory Medicine. Dr. Nassar objected to the proposed form of this performance evaluation on the basis of concerns that, in his opinion, the process did not assure an honest, fair, or credible process. Dr. Nassar was concerned that the proposed form might create a record detrimental to a reappointment of Dr. Nassar.

This memo brought to the fore a decade of building distrust between Dr. Nassar and his Department Chief concerning repeated and public criticism by Dr. Nassar of the Chief of Pathology and Laboratory Medicine concerning the privatization of certain medical laboratory services to a private company in which the Chief had a pecuniary interest. Those unresolved disputes led to allegations by the Chief of Pathology and Laboratory Medicine that Dr. Nassar's conduct was unprofessional and disruptive of normal team relationships to such an extent as to render those teams dysfunctional. Dr. Nassar denied the allegations.

Dr. Nassar alleged that the Chief of his Department abused the authority of his office to the detriment of Dr. Nassar, and that, in particular, his Department Chief created a hostile work environment for Dr. Nassar, subjected Dr. Nassar to malicious prosecution, and defamed Dr. Nassar on a number of occasions. When Dr. Nassar sought relief from Capital Health and Dalhousie, he became dissatisfied with their response in a number of ways and requested the current investigation.

Both Dalhousie University and CDHA were formally aware of Dr. Nassar's concerns from an early stage. Indeed, the VP of Medical Services of CDHA's predecessor organization, the Victoria General Hospital (VGH), was fully aware of differences between Dr. Nassar and his Department Chief, and was involved in some unsuccessful attempts at resolution as early as 1993.

This situation demanded effective action by Dalhousie and CDHA leading to a timely and final resolution of the disputes. Unfortunately, such a resolution did not occur, and the events under investigation unfolded. Indeed, the dispute between Dr. Nassar and his Department Chief

remained unresolved at the time of final editing of this report and is the subject of ongoing litigation in the Supreme Court of Nova Scotia.

As will be discussed below, the Committee finds that: (1) the working relationship between Dr. Nassar and his Department Chief was dysfunctional in important ways; (2) relevant officers of CDHA and Dalhousie were well aware of this problem; (3) an unacceptably long time passed without this matter being adequately addressed and resolved by either Dalhousie or CDHA; (4) officials of CDHA and Dalhousie appear to have been working at cross purposes on occasion, without a clear understanding of what each was doing to attempt to resolve the dispute; (5) both Dalhousie and CDHA viewed certain issues as being in the exclusive domain of the other, contributing to the lack of a comprehensive approach to resolving the disputes; (6) serious violations of the academic freedom of Dr. Nassar occurred; (7) Dr. Nassar was under repeated threat of violations of his academic freedom for a lengthy period; (8) the Department Chief was left in a difficult position for an extended period without appropriate support, advice, and direction; (9) and great harm resulted, principally to Dr. Nassar, but also to the Department Chief, Dalhousie, CDHA, and, by extension, the people of the Atlantic Region.

As with the other cases investigated and discussed elsewhere in this report, a major contributor to this unacceptable state of affairs is the underlying framework within which the Dalhousie Faculty of Medicine operates with its partner CDHA, including the Affiliation Agreement, the terms and conditions attached to appointments at Dalhousie and CDHA, the arrangements for payment of clinical faculty, and the lack of appropriate policy and procedural structures, such as an appropriate Grievance Policy, to reach fair, final, and binding resolution of disputes in a timely manner.

Dr. Nassar's employment background

Prior to coming to Nova Scotia in 1984, Dr. Nassar had completed a BSc in Chemistry and Biology at the American University of Beirut, Lebanon (1972); a PhD in Physiology at the University of Newcastle upon Tyne, England (1976); an M.B., B.Ch. at the Faculty of Medicine of the University of Cairo, Egypt (1980); and a residency in General Surgery and Otolaryngology at the American University of Beirut Medical Centre, Lebanon (1981–84). In 1984, Dr. Nassar immigrated to Canada as Research Scientist at a private-sector research institute in Kentville, NS.

Dr. Nassar's first position at Dalhousie University was as a resident in Medical Biochemistry at the Victoria General Hospital (VGH) in the Division of Clinical Chemistry of the Department of Pathology between 1986 and June 1989. In December 1989, Dr. Nassar obtained his Royal College specialty qualification FRCP(C) in Medical Biochemistry and then went to McGill University for a year to continue a Molecular Biology post-doctoral fellowship in Medical Genetics.

In January 1991, Dr. Nassar returned to Dalhousie University as an Assistant Professor in the Department of Pathology and to the VGH as a member of the Active Medical Staff in the Division of Clinical Chemistry. In those capacities, Dr. Nassar headed the Special Chemistry section, established a Molecular Biology laboratory, and had responsibility for the Medical

Biochemistry Residency training program. In 1994, Dr. Nassar became Head of the Hematology-Immunology section in the Division of Hematology, and became responsible for the Routine Chemistry Section in Clinical Chemistry. He was promoted to Associate Professor of Pathology by Dalhousie in 1995. In 1996, after a competition, he was appointed Chief of the merged Division of Clinical Chemistry at QEII HSC (successor to VGH) and Director of the Dalhousie Division of Clinical Chemistry. In the former capacity he was also responsible for managing the Environmental Chemistry Section.

In 1997 Dr. Nassar was reappointed by Dalhousie University to a position governed by the provisions of the Continuing Appointment with Periodic Review (CAPR). He was promoted to Professor in the Dalhousie Department of Pathology in 2000 and was cross-appointed as Professor to the Dalhousie Department of Medicine in 2001. Dr. Nassar was reappointed with credentials to the Active Medical Staff at QEII HSC on June 7, 2001, based on favourable assessments and a recommendation from his Department Chief. Over the years, Dr. Nassar developed a broad range of collaborative research projects with other researchers at Dalhousie and VGH.

Background events

The matters under investigation are rooted in a series of difficulties that arose between Dr. Nassar and his Department Chief, difficulties that created mutual distrust and that were not successfully resolved. These unresolved difficulties became the core of later events.

University Avenue Laboratory Medicine Associates (UALMA)

The physician-pathologists at VGH, including both Dr. Nassar and his Department Chief, were members of a group practice partnership offering pathology services to the VGH and academic and research services to Dalhousie. This partnership, University Avenue Laboratory Medicine Associates (UALMA), allowed opportunities for private entrepreneurship to its members. A significant part of the remuneration of the members for their services to the VGH and Dalhousie arose from UALMA.

Path Scientific Research (PSR) and Fenwick Laboratories

Dr. Nassar's Department Chief had been one of the shareholders of a private company, Path Scientific Research Limited (PSR), which provided certain medical laboratory services.

In the late 1980s, PSR formed two partnerships with the VGH and the VGH Charitable Foundation (one of which also involved Dalhousie as a partner) to conduct research and to provide analytical and consulting services to government departments and agencies requiring testing of water and other samples for organic and inorganic chemicals. These partnerships operated from the site of the Environmental Chemistry Laboratory (ECL) at VGH, and some work originally referred to the ECL became for-profit work of PSR. The hospital provided space, personnel, and services to PSR as part of the agreements. The VGH Foundation advanced funding for equipment, which was to be recovered from partnership profits over a five-year

period. The hospital's costs were also to be recovered from a share of the profits of PSR, and both Dalhousie University and the VGH Foundation were to receive a share of the profits. Senior management at VGH and the VGH Foundation considered it to be financially prudent to direct the hospital's environmental testing business to PSR in order to ensure there would be profits to meet these commitments. Detailed agreements to implement these matters were concluded between PSR and the Dalhousie Dean of Medicine, the VGH CEO, and the CEO of the VGH Foundation.

These arrangements attracted the attention of the Auditor General of Nova Scotia, and it was recognized that the doctors who were partners in PSR also worked for the hospital and made decisions regarding what tests should be made and then decided if those tests should be assigned to PSR, in which they had a personal financial interest.

Subsequently, the Nova Scotia Department of Health required that PSR cease operations from the VGH location and that any work to be undertaken by PSR on behalf of the hospital follow a tendering process.

In mid-1990, PSR acquired a 100% interest in the partnerships with which it was previously associated with Dalhousie University and the VGH Foundation, and then amalgamated with another company to form Fenwick Laboratories Ltd., which operated from premises outside the hospital.

By the time Dr. Nassar joined the Active Medical Staff of the VGH and became a faculty member of Dalhousie University in January 1991, in his opinion, the principals of the original PSR controlled the Department of Pathology, the Division of Clinical Chemistry, and the Environmental Chemistry Laboratory by virtue of their positions as Chief or Director of each of those bodies. At the same time, the principals of the original PSR were simultaneously running Fenwick Laboratories. In the opinion of Dr. Nassar, Fenwick Laboratories was, in many respects, a competitor of the ECL.

Since that time, Dr. Nassar has repeatedly stated his opposition to the establishment of these partnerships; the use of VGH Foundation funds in support of a private company; the use for private gain of publicly funded hospital facilities and resources such as the original co-location of the private partnerships with the ECL; the referral of water testing from the public VGH laboratories to the private partnership in order to provide the cash flow necessary to meet the guarantees of the Fenwick bank loans by the VGH Foundation; and what Dr. Nassar believed was a real and apparent conflict of interest between the private interests of the partners of PSR (and its successor Fenwick Labs), and their public responsibilities as officers and employees of the University and Hospital. This perception of a conflict of interest features prominently in Dr. Nassar's ongoing concerns.

Faculty members at typical Canadian universities have long enjoyed the right to engage in outside professional activities on a remunerative basis, with certain caveats. Those caveats are typically that the entrepreneurial activities do not interfere with regular duties to the university or hospital, they are approved by the Dean and/or Vice-President, they do not create a conflict of interest, and the costs of any university or hospital facilities used are fully reimbursed at

reasonable market rates. It is generally recognized that such professional activities may benefit the university and hospital as well as the individual.

The agreements reached between PSR and its partners had included approvals from the Dalhousie Dean of Medicine, the VGH CEO, and the CEO of the VGH Foundation, although the Auditor General found them deficient, and that the for-profit status of PSR was in direct contravention of Department of Health conditions. It appears that these entrepreneurial activities had been discussed in advance with the relevant authorities, as required. One component of such discussions would normally be a mutual agreement that these activities are compatible with the University and Hospital responsibilities of the entrepreneurs concerned.

Controversies over the privatization of previously public medical services were a common feature of the Canadian medical system at that time, and continue today. There are many examples of privatization of diagnostic services, such as chemical testing, medical imaging, and the like, taking place in the face of opposition for reasons similar to those advanced by Dr. Nassar and supported by arguments like those of the principals in PSR/Fenwick Labs. These debates are often vigorous and exceptionally important for the future of the medical system. It is not at all unusual that two colleagues would hold diverging views on these matters, and engage in vigorous and public debate. Indeed, one of the fundamentally important purposes of academic freedom is to empower university faculty members to provide their professional expertise, experience, and opinions to such debates without fear of recriminations. Such contributions are exceptionally important to the development of Canadian public policy.

Dr. Nassar's academic freedom guaranteed him the right to criticize the approved PSR arrangements and those University and VGH officers who had approved them. In particular, it was within Dr. Nassar's rights to question whether these entrepreneurial activities constituted a conflict of interest, notwithstanding any approval by University or Hospital authorities.

Canadian universities also typically have statements concerning the criteria by which a conflict of interest may be identified. Normally, a conflict may be deemed to exist if the entrepreneurial activity was substantially similar to, and competed with, activities already undertaken for clients by the Hospital or University and could adversely affect the ability of the University or Hospital to attract contracts, or could adversely affect the research activity of the University or Hospital.

Dr. Nassar held the view that all of these sorts of conflicts arose in the context of PSR/Fenwick. Dr. Nassar repeatedly stated his opinion that work referred to PSR/Fenwick would normally be undertaken by the ECL, was the same as work already done at ECL, and losing it would adversely affect the revenues of the ECL and threaten its future. Dr. Nassar alleged that the principals in PSR/Fenwick Labs encouraged customers to use those labs in preference to the ECL. He also repeatedly stated that it was inappropriate for people with a financial interest in PSR/Fenwick to be making decisions about what tests were to be sent to PSR/Fenwick by ECL.

This Inquiry makes no judgment as to whether or not Dr. Nassar's opinions were supported by the facts. However, demanding that these points be considered and appropriately answered is well within Dr. Nassar's rights, and his academic freedom protects him from recriminations for doing so. Most of the issues raised by Dr. Nassar had already been raised by others prior to Dr.

Nassar's return to Halifax. Dr. Nassar was not the instigator of these complaints, but he did repeatedly criticize the arrangements between PSR/Fenwick and others within the Department of Pathology.

In summary, the principals in PSR/Fenwick had the right to engage in approved entrepreneurial activities and Dr. Nassar had the right to criticize both those activities and their approval by Dalhousie and VGH officers. The basic difference of opinion between Dr. Nassar and those entrepreneurs were within the bounds of normal academic discourse on such matters of public policy. What is unusual in this case is that those differences of opinion continued to have a marked effect on the Department so many years after the fact.

Appointment of a new Chief of Pathology

Shortly after Dr. Nassar took up his position at VGH/Dalhousie in 1991, there was a competition for a new Chief of the Department of Pathology. Dr. Nassar originally supported one candidate, but subsequently withdrew that support on the basis of his perception that that candidate had a potential conflict of interest between his responsibilities to the Environmental Chemistry Lab and his entrepreneurial activities in PSR. Dr. Nassar also disagreed with alleged attempts by that candidate to change the rules by which UALMA operated.

That candidate was subsequently appointed as Chief of Pathology on the express condition that the perception of conflict of interest between the operation of PSR and the Environmental Chemistry Lab be eliminated to the satisfaction of all involved. There was no prescribed mechanism for resolving this matter or for ascertaining whether any proposed solution was satisfactory to all parties, nor was there a definition of which parties were to be satisfied. The VGH President and CEO and the VGH Vice-President of Medical Services met with a number of Clinical Chemistry faculty, including Dr. Nassar, to discuss the perception of conflict of interest.

That candidate became the Chief of the Department of Pathology at Dalhousie, Chief of Pathology at VGH, and remained Chief of the Division of Clinical Chemistry. In all of those roles, he held a supervisory position over Dr. Nassar and had the potential to exercise power over Dr. Nassar, a situation which Dr. Nassar had identified and opposed. Among other matters, one potential exercise of power by the Chief of Pathology was the recommendation required from the Chief during consideration of Dr. Nassar's CAPR appointment at Dalhousie and his privileges at VGH.

That candidate has subsequently stated repeatedly that all his shares in the private entities were disposed of when he was appointed as Chief.

Lingering "perception of conflict of interest"

The "*perception of conflict of interest*" remained apparent in September 1993 when the Executive Committee of the VGH Board approved in principle the appointment of an ad hoc committee reporting to the VGH Board Audit Committee. The role of the ad hoc committee was to appoint an auditor to examine whether there had been misuse of hospital funds or facilities; whether there was a current conflict of interest; and, if so, how it could be removed.

The VGH Vice-President of Medical Services informed Dr. Nassar that his concerns were under review by the Audit Committee. Over the next decade, Dr. Nassar repeatedly demanded that VGH and Capital Health officials release these findings, if they exist, but to no avail. After a considerable period of time, Dr. Nassar filed a *Freedom of Information Act* request for the findings of the Audit Committee and supporting documents. Finally, on November 20, 2003, legal counsel for CDHA responded to Dr. Nassar's *Freedom of Information Act* request that no such documents could be located. If the audit occurred at all, no record of its findings remains.

It appears that the Search Committee requirement that the "*perception of conflict of interest*" be eliminated went unfulfilled, at least for a lengthy period after the appointment of the new Chief of Pathology. Leaving such a divisive issue to fester was a great disservice to the Chief of Pathology, the Department, and its members, including Dr. Nassar. It is apparent that this festering dispute played a role in polluting other matters and relationships among the protagonists, and in undermining Dr. Nassar's trust in VGH officials.

Pathology Department Chief's reprimand of Dr. Nassar

While the "*perception of conflict of interest*" and its related disputes involving Dr. Nassar and his Department Chief festered throughout 1992 and 1993, Dr. Nassar was issued a letter of reprimand by his Department Chief alleging unprofessional interpersonal behaviour by Dr. Nassar, including his attitude toward the Chief, and persistent challenges to the authority of the Chief arising from Dr. Nassar's perception that a conflict of interest existed. Dr. Nassar was told that he had an obligation to be a team player and should consider planning his future elsewhere if he could not comply. Dr. Nassar was also told that a further review would be made after three months and that if the matters were unresolved, the VGH Vice-President of Medical Services would be involved to consider further disciplinary action. Dr. Nassar denied all allegations, requested that the letter be withdrawn, and requested that the Vice-President of Medical Services arbitrate the issues.

The Vice-President of Medical Services asked for written submissions from Dr. Nassar and his Department Chief, interviewed a number of colleagues, and made recommendations that, in the opinion of the Vice-President, would resolve the dispute. In late December 1993, Dr. Nassar wrote the Vice-President of Medical Affairs describing the terms agreed upon to resolve the dispute. Among other matters, the agreement required that the letter of reprimand and every document relating to this issue be expunged from all records and files and destroyed, the Vice-President of Medical Affairs accelerate the Audit Committee's review of the Hospital-PSR-Fenwick relationship, and Dr. Nassar cease making allegations of perceived conflict of interest and permit the Audit Committee to deal with the issue.

What should have been a final resolution of this matter apparently unravelled. There is no record extant of the work of the Audit Committee, the supposedly expunged files were placed in a secret file in the office of the Vice-President of Medical Affairs, and, within months, Dr. Nassar was again asserting a perceived conflict of interest on the part of the Chief of Pathology.

These circumstances around the letter of reprimand and its aftermath were of fundamental importance in determining the course of later events. It appears to have had a formative role in

establishing Dr. Nassar's views on a number of topics, and there are many references in later documents to what Dr. Nassar saw as the injustice of these events. In particular, without consulting Dr. Nassar, the Vice-President of Medical Affairs interviewed several colleagues of Dr. Nassar and reached a number of written conclusions on important matters, which were critical of Dr. Nassar's behaviour, without providing Dr. Nassar an opportunity to respond. Dr. Nassar perceived these actions taken by the Vice-President of Medical Affairs to be an unfair investigation without due process, not a mediation as Dr. Nassar had expected. Furthermore, the Chief of Pathology later refused to participate in a proposed mediation with Dr. Nassar on other matters, citing the failure of this mediation by the Vice-President of Medical Affairs.

The motion of non-confidence in the Chief of Pathology

During the time leading up to the reprimand of Dr. Nassar, a number of other important related events were happening. In November 1993, there was an announcement that the clinical laboratories of the VGH and those of the Camp Hill Medical Centre (CHMC) were to be integrated. These arrangements had been made without consultation with the members of the VGH Division of Clinical Chemistry, for which the Chief of Pathology later apologized to his colleagues. Several members of the Department of Pathology, including Dr. Nassar, objected to this process, requested a hearing by the Board Executive Committee, and voted no confidence in the Department Chief. Several other members expressed full support for the Department Chief, criticized the lack of consultation of the opposing group in formulating the non-confidence motion and suggested that the motivation for the vote of non-confidence lay in the personal and professional agendas of some individuals, implicitly including Dr. Nassar in their criticism.

These events led to a hearing by the Executive Committee of the Board in January 1994. Those appearing on behalf of the non-confidence voters objected to the proposed procedures, which did not allow them to hear all presentations made, and did not allow them to respond to those presentations. At the hearing, the Chair of the Board questioned the role of practice plans in making appointments to the medical staff and asked which of the hospital, the university and the practice plan was subordinate to whom. Major differences of opinion were expressed about the limits of the authority vested in the Department Chiefs by the Board. Following the hearing, the Board unanimously confirmed the authority of the Chief of the Department of Pathology. The Board stated that it expected past differences to be put aside and that it also expected that all members would work in a collaborative and constructive manner to achieve the objectives of the Department. The Board, however, did not provide any guidance as to how these ends might be achieved. The "authority-based" model of leadership favoured by the Board was at odds with the "consultative-leadership" model favoured by those who voted non-confidence in the Chief. This difference on a fundamental point regarding the role of a Department Chief reappeared on a number of occasions in the case of Dr. Nassar. Dr. Nassar repeatedly expressed concerns that the Department Chief was improperly using his position to take actions against the interests of Dr. Nassar. Dr. Nassar later described these actions as an abuse of authority by the Chief of Pathology leading to a hostile working environment for Dr. Nassar.

Dr. Nassar's appointments and reappointments

It was not long after these events that Dr. Nassar was recommended for a promotion to the rank of Associate Professor at Dalhousie by his Department Chief.

The QEII Health Sciences Centre emerged in January 1995 out of an amalgamation of previously independent Halifax institutions, including VGH and CHMC. As part of the amalgamation, the laboratory services of the VGH and CHMC were integrated and competitions were held for the Chief of the Department and Chiefs of Service. In January 1996, Dr. Nassar was recommended for the position of Chief of Service, Division of Clinical Chemistry, in the Department of Pathology and Laboratory Medicine, by the Pathology Department Chief.

In November of 1999, Dr. Nassar was recommended for promotion to the rank of Professor by the Chief of the Department of Pathology and Laboratory Medicine. These recommendations occurred despite the concerns expressed by Dr. Nassar that the Department Chief might use the power provided by these recommendations against Dr. Nassar's interests.

The complaint of harassment against Dr. Nassar

In April 1997, the Secretary for the Division of Clinical Chemistry filed a formal complaint of harassment against Dr. Nassar. The Secretary provided four documents setting out her complaint, consisting of twenty-two alleged incidents.

Two difficulties with processing this complaint soon emerged, both arising from the relatively recent amalgamation that formed the QEII HSC. First, QEII did not have an approved policy regarding harassment and the procedures to be used in the event of a complaint. Second, the QEII Board had not approved Medical Staff Bylaws until September 16, 1996, and those Bylaws had not yet been approved by the Minister of Health. Section 6(3) of the *Hospitals Act*[22] stated "*No bylaw of the Board of a hospital has any effect until it has been approved by the Minister,"* which approval did not take place until June 5, 1998. A choice was made to process the harassment complaint using the unapproved bylaw provisions.

Among other things, the unapproved bylaws provided for a Medical Triad consisting of the VP Medical Services, the President of the Medical Staff, and the Department Chief. This was the same Department Chief with whom Dr. Nassar had been in conflict for many years. The unapproved bylaws empowered the Medical Triad to conduct an initial interview with the complainant, and to determine if an interview with the accused member of the Medical Staff was required. After those interviews, the Medical Triad first had to determine if further investigation was necessary and had the power to agree to a resolution that involved a letter of reprimand and counselling. If they decided that further investigation was necessary, they could appoint the person(s) to do the investigation, receive the report of the investigation, and decide if further action were required. If further action were required and the circumstances could lead to a change in the privileges of the member of the Medical Staff, the Medical Triad would refer the

[22] The Hospitals Act, R.S.N.S. 1989, c.208

matter to the Medical Advisory Committee, which was to make a recommendation to the QEII Board.

During the interview with the complainant, in response to a question from one of the Medical Triad, the complainant described an additional incident that had not been included in the written submission. When Dr. Nassar was interviewed, he was not advised of this additional complaint, and he, therefore, had no opportunity to present relevant information about that incident.

The Medical Triad, including the Pathology Department Chief, made a number of decisions that had a direct bearing on the case. In particular, they appointed an investigation team to investigate the harassment complaint and make a finding as to whether or not harassment occurred, and to recommend what action the hospital should take, if any. Counsel for Dr. Nassar expressed a concern that the committee had no basis for the authority to make findings of fact or to make recommendations. Counsel for QEII responded that the investigation would be conducted in a manner consistent with the principles of natural justice and would provide Dr. Nassar with copies of all documentation provided to it. Subsequently, counsel for Dr. Nassar objected to the inclusion of the Department of Pathology Chief on the Medical Triad on the basis that the Chief was to be a witness before the investigation committee concerning the relationship between Dr. Nassar and the complainant. The Chief of Pathology was replaced on the committee, and the process continued.

Dr. Nassar provided a written response to all twenty-two allegations known to him. The Investigation Committee decided to use the *Canadian Human Rights Act* definition of harassment because QEII had no written policy and the committee viewed the former VGH policy to be flawed. When Dr. Nassar was interviewed by the Committee, he was asked about the additional incident described by the complainant, of which he had no advance notice. Dr. Nassar denied that the incident had occurred. The Committee presented a report that relied, in part, on the testimony of a number of witnesses who had been guaranteed anonymity. Dr. Nassar knew the list of witnesses, but not what they had testified, and had no opportunity to cross-examine or to challenge the evidence they provided as to fact, interpretation, or weight.

The Investigating Committee found that many of the incidents described by the complainant did not, on their face, constitute harassment and needed no further consideration. They found that none of the original twenty-two allegations by the complainant constituted harassment. However, they also found that the additional incident introduced during the interview with the original Medical Triad (including the Pathology Department Chief) constituted harassment because the alleged act, if it occurred, constituted intimidation. Based on testimony of several unnamed witnesses, who were unknown to Dr. Nassar and whose testimony he had no opportunity to rebut, the Committee found that it was not beyond the bounds of probability that Dr. Nassar had behaved as described. The Committee also referred to a letter of reprimand issued to Dr. Nassar by the Chief of his Department regarding inappropriate behaviour toward colleagues. This comment referenced the reprimand that supposedly had been expunged from Dr. Nassar's record and destroyed in December 1993, and at any rate was based on allegations that Dr. Nassar denied and that had never been proven.

After receiving the report and meeting with Dr. Nassar and his legal counsel, the Medical Triad issued a "*letter of counselling and reprimand*" to Dr. Nassar. Counsel for Dr. Nassar rejected the "*letter of counselling and reprimand*" and proposed that the matter be referred to the Medical Advisory Committee as provided by the unapproved Bylaws. Counsel also set out the application he proposed to make before the Supreme Court of Nova Scotia to have the decision quashed. The matter was not referred to the Medical Advisory Committee and counsel for Dr. Nassar filed the application to quash the decision.

The Honourable Justice Arthur J Leblanc heard the application and issued an order in August 1999 quashing the decisions made by the Medical Triad, including the letter of counselling and reprimand. Justice Leblanc provided detailed written reasons for his decision. Among them were that there were no valid bylaws in place, and consequently the Medical Triad had no authority for its procedures and actions; the decisions taken impacted directly on Dr. Nassar's privileges and rights, and could potentially be very detrimental; and the lack of timely disclosure of the additional incident to Dr. Nassar amounted to nondisclosure when the Bylaws that were purportedly being followed provided for written disclosure.

After the ruling of Justice Leblanc, counsel for QEII Health Sciences Centre informed Dr. Nassar's counsel that all copies of the Report of the Investigation Committee had been destroyed, and all references to the matter had been removed from Dr. Nassar's credentialling file. In effect, from the point of view of the formal record at the QEII, it was as if these events had never occurred.

Nevertheless, these events played a major role in a later dispute when Dr. Nassar applied for a licence from the College of Physicians and Surgeons of Ontario (CPSO). To the detriment of Dr. Nassar, questions arose about whether this allegation of harassment had been rejected on a legal technicality without addressing the substance of the complaint. The events related to the CPSO will be described in a later section of this Chapter.

Changes in the Environmental Chemistry Lab (ECL)

Before Dr. Nassar was appointed as Chief of the ECL, there had been consideration of transferring some, or all, of the functions of the ECL from the QEII to the private sector. Dr. Nassar had long held the view that investments should be made in the ECL to improve its capabilities with an enhanced role as a public resource and as a generator of revenue for the VGH, and he had been critical of the role of previous ECL management in outsourcing tests to private enterprises. Following Dr. Nassar's appointment as Director of the ECL, he took steps to reduce the number of tests referred out to private labs, and proposed new investments in equipment for the ECL.

The trade association representing private environmental testing labs requested that VGH restrict the ECL from competing against the private sector or at least require market pricing for the work of the ECL. In March, 1999, Dr. Nassar proposed a new business plan to QEII management based on test prices that included overhead charges and an allowance for corporate taxes to make the ECL charges more comparable to those in the private sector. The Pathology Department Chief complained that there had been no opportunity for him to comment on the

proposed business plan, and Dr. Nassar repeated his previous claims of a conflict of interest on the part of the Department Chief. The mutual distrust and conflict involving Dr. Nassar and his Department Chief increased again, amid a replay of many of the former charges and counter-charges between Dr. Nassar and the Pathology Department Chief, which were to continue for more than two years. During that time, there were a number of claims of misconduct directed by Dr. Nassar against the Pathology Department Chief and vice versa. Complicating the situation was the previously described failure of VGH authorities to issue a report of the promised audit of the arrangements between VGH and the private labs.

This conflict reached a critical point in November 2001 when the Pathology Department Chief recommended against renewal of Dr. Nassar's CAPR appointment at Dalhousie, in part based on an allegation that Dr. Nassar lacked personal integrity because of some of his alleged actions while the ECL conflict simmered. The events surrounding the CAPR appointment renewal are discussed below.

Also during this period, the CEO of QEII issued what was known as a "*letter of good standing*" confirming that Dr. Nassar was an Active Staff Member of the QEII Medical Staff in the Department of Pathology and Laboratory Medicine, Chief of the Division of Clinical Chemistry, and, on the recommendation of his Department Chief, had been, from the time of his initial appointment in July 1989, reappointed each year as a member in good standing. The question of a "*letter of good standing*" like this one for Dr. Nassar was to become a major issue three years later, in early 2002. A nearly identical letter was issued by the VP Medicine on February 9, 2001. These later events are discussed below.

Allegation of hostile working environment

Assessments of Dr. Nassar in 1999

All of the foregoing provides the context not only for Dr. Nassar's allegation of a hostile work environment, but also for the many events that flowed from that allegation.

Dr. Nassar objected to a process unilaterally proposed by the Pathology Department Chief for gathering opinions from colleagues for use in making recommendations for appointments, for credentialling, and for promotions. In particular, the process would have requested input from a colleague with whom Dr. Nassar had longstanding conflicts. The proposed process was not uniformly used throughout the hospital and had not been formally approved by the Medical Staff. Dr. Nassar was concerned that the process could potentially result in documents that had not been subject to appropriate scrutiny being placed in files used for credentialling, reappointment, and other critical employment matters. Given those concerns, Dr. Nassar declined to participate. Notwithstanding Dr. Nassar's concerns and lack of participation, his Department Chief recommended Dr. Nassar's credentials be renewed and that he be promoted to Professor.

The harassment complaint revisited: complaint of hostile work environment

Only four days after Dr. Nassar received notice of the proposed new assessment process, counsel on his behalf wrote to the CEO of QEII providing a detailed critique of the process used in the harassment complaint that had subsequently been quashed by Justice Leblanc. Subsequent to meetings between Dr. Nassar and his counsel, and the CEO and legal counsel for QEII, the CEO wrote to Dr. Nassar in December 1999 "*… to express our sincere apology for putting you through a process that was determined by Mr. Justice LeBlanc to be faulty. I am sure this has been very difficult for you, and I hope this apology will help you bring some closure to this matter …"* The CEO also discussed this matter and disclosed the contents of the letter to Dr. Nassar at the Quarterly Medical Staff Meeting in January 2000. Dr. Nassar also discussed the matter at a meeting of the Laboratory Executive Committee of the Department of Pathology and Laboratory Medicine in January, 2000.

Nine months later, in September, 2000, a new legal counsel for Dr. Nassar wrote the CEO stating that the letter of apology was not satisfactory because it referred to the process and not to the merits of the matter itself. Dr. Nassar's legal counsel alleged that Dr. Nassar was the victim of abuse, harassment, a hostile work environment, and a malicious prosecution whose objective was to destroy his reputation. It was also alleged that Dr. Nassar had been the target of a sustained campaign to isolate, intimidate and silence him following his opposition to the private for-profit use of public resources by certain individuals, in particular his Department Chief.

Dr. Nassar's counsel set out a number of conditions for resolving matters, including a clear and substantive apology, steps to remediate damage to Dr. Nassar's reputation, and steps to ensure there could be no repetition of these events. In the absence of a satisfactory resolution, counsel stated he had been instructed to commence malicious prosecution actions against QEII and appropriate parties who participated in the complaint against Dr. Nassar.

The CEO responded that the matter had been resolved by the previous apology on behalf of QEII to Dr. Nassar and the related announcements, with which he believed Dr. Nassar was satisfied. The CEO admitted the errors that had been made by CDHA, described the steps that had been taken in an effort to right past wrongs, and then rejected the conditions set out by Dr. Nassar's counsel.

In December 2000, counsel for Dr. Nassar wrote the VP Medicine describing the response of the CEO as unacceptable and proposing a meeting to resolve the matter. He provided a detailed critique of the prosecution of Dr. Nassar during the harassment complaint, introduced a claim of a hostile work environment for Dr. Nassar, and provided a critique of the apology written to Dr. Nassar by the CEO.

In late January 2001, Dr. Nassar provided the VP Medicine with extensive documentation of his concerns and perspective. In early February 2001, the VP Medicine issued a "*letter of good standing*" concerning Dr. Nassar nearly identical to the one that had been issued by the CEO of QEII as previously described. In late February 2001, the VP Medicine wrote to Dr. Nassar refusing to return to the harassment issue, but saying the complaint of a hostile work

environment was very serious. The VP Medicine proposed appointing an external mediation consultant to provide a fair and just process with the aim of resolving the matter once and for all. In a written response to this proposal, Dr. Nassar explained, from his perspective, the reasons for the failure of the previous effort at mediation proposed by the Vice-President of Medical Services regarding the letter of reprimand issued to Dr. Nassar by his Department Chief. Dr. Nassar also stated his objectives for the proposed mediation, including a clear statement that the allegation of harassment against Dr. Nassar, which had been the basis for the ruling by Justice Leblanc, had been false.

In May 2001, Dr. Nassar and the VP Medicine agreed on a mediator to conduct the proposed mediation. In August 2001, counsel for Dr. Nassar then agreed to the proposed mediation, with a number of conditions. In October 2001, the Pathology Department Chief refused to participate in the proposed mediation, citing events of the failed mediation years earlier by the Vice-President of Medical Services, including his opinion that Dr. Nassar had failed to abide by commitments arising from that previous mediation. Clearly, the unresolved events from 1993 were an obstacle to resolving events in late 2001, nearly eight years later. Ultimately, the VP Medicine decided to engage an outside party to conduct an external review, as discussed in a subsequent section of this Chapter.

In May 2002, Dr. Nassar again wrote the CEO with a request for additional remedies for this matter, and to object to the manner in which the Pathology Department Chief had described in writing to the Dean of Medicine the overturning of the finding in the harassment case, namely that the court quashed the findings of the investigation on the grounds that Medical Staff Bylaws had not been in force because the Minister had not approved them. Counsel for Dr. Nassar asked for CDHA to confirm that, by being quashed, "… *the 'investigation' was a legal and substantive non-entity* …"

During 2001, there were a number of other time-consuming disputes between Dr. Nassar and his Department Chief, which were not resolved. These included a dispute about alleged statements by Dr. Nassar that there had been bias at the Department level against Dr. Nassar's grant proposals to the Dalhousie Medical Research Fund, and a demand from the Pathology Department Chief for a retraction and apology; and a dispute about an inappropriate remark made about a graduate student, and immediately retracted, by the Chief of Pathology at a Department meeting. Both matters resulted in copious correspondence, including with the Dean of Medicine and the President of Dalhousie, and these matters also played a role in the 2001 CAPR assessment of Dr. Nassar.

Dr. Nassar's 2001 CAPR assessment

Review of the provisions for CAPR appointments

As discussed in Chapter 2 of this report, clinical faculty members at Dalhousie University Faculty of Medicine do not have tenure. The standard appointment for regular full-time faculty is a Continuing Appointment with Periodic Review (CAPR). Under the terms of these appointments, as the name implies, faculty undergo periodic performance reviews, which can

result in termination of their appointment at Dalhousie. The CAPR review is under the control of Dalhousie. According to the terms of the Affiliation Agreement between Dalhousie and Capital Health, termination of the Dalhousie appointment may also result in termination of the appointment at CDHA. As a result of these provisions, CAPR reviews can have career-threatening consequences. The CAPR review of a faculty member requires a recommendation from the faculty member's Department Chief.

In the midst of the many events described in the preceding sections, and a planned mediation process to attempt to resolve them, Dr. Nassar was subject to a CAPR review beginning in late July 2001. Dr. Nassar's Department Chief was a central character in the many ongoing disputes and the person against whom Dr. Nassar had filed a complaint of a hostile work environment.

In order to be reappointed to a new term of a CAPR appointment, a candidate must meet appropriate standards in eight categories:[23] (1) meet all terms and conditions of appointment; (2) demonstrate a commitment to work with colleagues; (3) demonstrate a high level of personal integrity; (4) perform satisfactorily in teaching and demonstrate commitment to programs; (5) demonstrate a satisfactory professional performance in the delivery of clinical care; (6) meet three of the following four criteria: a) be recognized as a role model for students; b) exhibit commitment to professional values of beneficence, autonomy, responsibility; c) show commitment to evidence-based practice; d) be committed to implement improvements in quality of care, and participate in quality management processes; (7) demonstrate a willingness to serve on appropriate departmental, hospital and university committees; (8) satisfy program, clinical and budgetary considerations of the department and faculty. One of the stages of assessment is the written recommendation of the Department Chief on these categories. The Dalhousie Senate Guidelines state, in part, "… *Assessment of clinical members' performance will include teaching effectiveness; research and professional clinical service; ability and willingness to work with colleagues, so that the academic units concerned function effectively; and personal integrity."*

Dr. Nassar's CAPR review

Dr. Nassar was requested to provide the required CAPR documentation by late September 2001 so that the departmental Appointment and Promotions Committee could consider it and make a recommendation. Those with major administrative functions, such as Dr. Nassar, were advised to obtain an extra peer letter and a letter from an administrator. The Department Chief advised that a suitable administrative referee would be someone with a higher rank, such as another Department Chief, and that perhaps the most suitable referee for a Service Chief, such as Dr. Nassar, would be one of the VPs. In the case of Dr. Nassar, the VP Medicine declined to provide a reference, in part because of a perceived potential conflict because of her role in investigating the allegation by Dr. Nassar of a hostile work environment (although other reasons were given at other times). The Vice-President of Diagnostic and Support Services was deemed inappropriate by Dr. Nassar because that VP had responsibilities on the Medical Triad during the harassment complaint against Dr. Nassar that had resulted in the ruling of Justice Leblanc. As a result, there was no senior administrator recommendation for Dr. Nassar.

[23] CAPR Guidelines, approved by Senate, February 1997.

Shortly before the late September deadline for submissions, legal counsel for Dr. Nassar sent a request for a stay of the CAPR review of Dr. Nassar to the VP Medicine and the Dalhousie University Dean of Medicine. The stated reason for the request was that the matters to be considered by the proposed mediation should be dealt with before a CAPR review because many of those matters were relevant to the CAPR review. In particular, from Dr. Nassar's perspective, one of the questions at issue was procedural fairness and whether Dr. Nassar's Department Chief had exercised undue authority over Dr. Nassar, including, among other matters, acting in the role of Department Chief despite apparent conflict of interest. In early November, legal counsel for Dalhousie refused to stay the CAPR proceedings and noted that Dr. Nassar could make whatever representations he considered appropriate to either the Departmental Committee or the Dean of Medicine.

The case of Dr. Nassar's CAPR reappointment was discussed at an initial meeting of the Pathology Department Appointments and Promotion Committee. The primary and secondary reviewers both supported reappointment of Dr. Nassar. The Committee was informed that no recommendation should be made by the Committee until there was an administrative reference from a VP. In late November 2001, the Committee reported to the Dean of Medicine that it could not make a recommendation because of difficulties assessing Dr. Nassar's ability to work in a collegial manner with colleagues and because there was no administrative reference. The Committee stated that it would recommend reappointment based solely on Dr. Nassar's academic contributions if there were no administrative issues and if the ongoing investigations were to conclude that there were no serious problems relating to Dr. Nassar's interactions with other faculty members.

In late November 2001, Dr. Nassar's Department Chief provided a recommendation to the Dean that Dr. Nassar's CAPR appointment not be renewed. The assessment was that Dr. Nassar "*readily*" met the standards for all categories except standards 2 and 3, which were considered unsatisfactory. Categories 2 and 3 are, respectively: demonstrated commitment to work with colleagues, which is referred to as "*collegiality*" by the Department Chief; and high level of personal integrity. The Department Chief gave a lengthy account of his perceptions of Dr. Nassar's conduct in many of the disputes discussed in this report. The Department Chief concluded that Dr. Nassar failed to meet the required CAPR standards for collegiality and personal integrity.

In mid-January 2002, Dr. Nassar wrote to the Chair of the Faculty CAPR Committee to provide an extensive commentary on the Department Chief's allegations. These comments were also subsequently submitted to the external Reviewer hired by the VP Medicine, as discussed in a later section of this Chapter. Dr. Nassar also described his perception of the role of his Department Chief in contributing to Dr. Nassar's perception of a hostile work environment. As well, Dr. Nassar asserted that many of the issues raised by the Department Chief were hospital matters, despite which Dr. Nassar's Department Chief had recently supported renewal of Dr. Nassar's hospital appointment, his promotion to Professor, and his cross-appointment to the Department of Medicine.

In late January 2002, the Chair of the Faculty CAPR Committee provided a recommendation to the Dean of Medicine concerning Dr. Nassar's CAPR reappointment. The Faculty CAPR Committee found that Dr. Nassar met all of the academic criteria for a CAPR

reappointment but the Committee could not reach a conclusion regarding Standards 2 (described as "*Collegiality*") and 3 "*personal integrity*." The Committee Chair explained that the Department Chief recommended against Dr. Nassar on these matters whereas two internal peer letters supported Dr. Nassar and the Department CAPR Committee made no recommendation. The Committee Chair reported that the Committee realized that the basis of the Department Chief's negative recommendation was a long-standing conflict with Dr. Nassar. During the review process a number of colleagues, both internal and external to Dalhousie, provided letters of reference supporting Dr. Nassar, and commenting positively on his integrity and character. When legal counsel for Dr. Nassar asked for the minutes of the meeting to confirm that the recommendation from the Chair of the Committee accurately recorded the decision of the Committee, he was informed that there were no minutes of the CAPR Committees other than the recommendation letters written by the Committee and the reference letters received by the Committees. Dr. Nassar's counsel was assured that, other than the letter from the Department Chief, none of the letters evidenced any failure by Dr. Nassar to meet the required standard.

In early March 2002, the Dean of Medicine invited Dr. Nassar to provide written comments on the "*collegiality*" and "*personal integrity*" standards. Dr. Nassar detailed his perceptions of the many matters in dispute over many years. Dr. Nassar stated that the origin of the claim that he lacked integrity and collegiality ultimately originated from a single source, his Department Chief, and arose after Dr. Nassar had pursued a complaint of workplace harassment against his Department Chief in 2001. Dr. Nassar also summarized his views on collegiality and personal integrity in academic medicine, with reference to the ways in which his behaviour over many years was in accordance with his understanding of those terms. He denied that his behaviour and relationships with others impaired the effectiveness or vitality of the Division.

The deadline for the Dalhousie Dean of Medicine to submit a recommendation to the Dalhousie President concerning Dr. Nassar's CAPR reappointment was extended to early May 2002. The Dean recommended a limited term appointment for two years with a further review for a possible CAPR reappointment after that time. The Dean reviewed the recommendations received and provided a brief summary stating that the Department and Faculty Committees did not reach a conclusion on the "*collegiality*" and "*personal integrity"* standards while the Department Chief concluded that these standards had not been met. After reviewing the evidence, the Dean concluded that all evidence indicated that the remaining standards had been met.

The Dean then considered Standard 2, "*collegiality*," noting that the University criterion is "*…The faculty member must have demonstrated a willingness to work with colleagues so that the academic unit functions effectively ..."* and the Faculty requirement is "*… The faculty member must have demonstrated a commitment to academic and clinical vitality and a willingness to play an effective part in the work of the department."* The Dean summarized the "*collegiality*" requirements to be the demonstration of: "*… 1. willingness to work with colleagues so that the academic unit functions effectively; 2. commitment to academic and clinical vitality; 3. willingness to play an effective part in the work of the department ..."*

Regarding Standard 3, "*personal integrity*," the Dean noted that the criterion is "*… The faculty member must have demonstrated a high level of personal integrity …*" and that the method of evaluation is the letters from the Department Chief and an internal peer.

The Dean noted that Dr. Nassar's case was highly unusual in a number of ways. There were longstanding, strongly held, and divergent views of Dr. Nassar and his Department Chief on a significant number of issues of different types. The Dean had received correspondence too numerous to cite on various issues and events primarily between Dr. Nassar and his Department Chief, the likes of which had not previously been seen in a CAPR file, or any other file. The Dean also could not recall another case where a Department and Faculty Committee failed to reach a conclusion.

The Dean also reviewed the relationship between Dr. Nassar and his Department Chief, identifying many differences of opinion and numerous disagreements over many years. The Dean noted that the guidelines required that a decision "… *be based on an overall assessment of performance and that no member may be awarded a continuation of CAPR if performance in any characteristic is less than satisfactory…"* The Dean noted that Dr. Nassar spent a considerable amount of time, energy, and thought on the pursuit of various matters that might be appropriate and even desirable and admirable. The Dean expressed the opinion that discretion is required in determining if it is appropriate to "*persistently and relentlessly*" pursue some incidents without apparently considering a way to work toward a clear goal or resolution, particularly in the context of ongoing relationships with colleagues.

The Dean concluded that Dr. Nassar had not demonstrated a willingness to play an effective part in the work of the Department as part of a collective, and had therefore not met Standard 2 ("*collegiality*"). Regarding Standard 3, the Dean judged that Dr. Nassar's actions were well-intentioned but misguided and were not dishonest or insincere. The Dean stated that there was insufficient information to reach a firm conclusion, but it appeared that, on balance, Standard 3 ("*personal integrity*") had been met.

The Dean recommended a limited term appointment for two years and that a CAPR reconsideration take place in the fall of 2003. The Dean expressed a hope that such an appointment would allow a focus on the resolution of the outstanding issues, and provide a basis for the Department and Faculty Committees to make clear recommendations on all the guidelines. At a later time, when Dr. Nassar was applying for a licence from the College of Physicians and Surgeons of Ontario, this unusual recommendation raised the question of whether the limited term reappointment subject to reconsideration was to be considered a period of probation. However inadvertent, the Dean's unusual recommendation of a limited term appointment of Dr. Nassar worked to the detriment of Dr. Nassar.

In mid-May 2002, counsel for Dr. Nassar requested the President of Dalhousie to agree personally to receive evidence and an oral submission from Dr. Nassar regarding the renewal of Dr. Nassar's CAPR appointment. Counsel pointed out that the Dean's recommendation was heavily dependent on the recommendation of the Department Chief with whom Dr. Nassar had a difficult relationship, some of which involved Dr. Nassar's disagreement with the exercise of administrative authority by his Department Chief. Following a recommendation by the Dean of Medicine, the Dalhousie President and Board of Governors approved an extension of Dr. Nassar's current CAPR appointment to November 1, 2002. The CAPR appointment carried no salary from Dalhousie.

In a letter to the Dean responding to the Dean's recommendation, Dr. Nassar described his perspective on many of the previous disputes involving his Department Chief and provided a critical commentary on the recommendation of the Dean and of the Department Chief. Dr. Nassar also pointed out that his complaint of a hostile work environment remained unresolved. In mid-September 2002, Dr. Nassar provided this response to the Dalhousie President. Near the end of September 2002, Dr. Nassar made a verbal presentation to the President of Dalhousie, followed two weeks later with a further extensive written submission. The extension of Dr. Nassar's current CAPR appointment expired on November 1, 2002.

On November 5, 2002, the Dalhousie President announced that he was recommending that the Board of Governors extend Dr. Nassar's CAPR appointment by five years, to June 30, 2007. The President stated that he concurred with the Dean's recommendation except regarding Standard 2 "*collegiality*" and that he was not prepared at this time to conclude that Dr. Nassar's performance in this standard was less than satisfactory. The President commented that the extensive documentation made it clear that collegial relations in the Department of Pathology were not what they should be. He then suggested that the unit was, indeed, dysfunctional in some important respects, but he also believed that a CAPR review was an inappropriate mechanism to deal with that concern. The President stated that he had asked the Dean of Medicine to establish appropriate mechanisms to deal with those issues. The President understood that Dr. Nassar had been an active participant in a number of unresolved disputes in both the distant and recent past and said he expected Dr. Nassar to cooperate fully with the Dean in helping the Department to move on and establish a more positive and effective working environment and better collegial relations.

Also on November 5, 2002, the President wrote to the Dean to convey his decision to approve a five-year CAPR reappointment for Dr. Nassar and, in a manner similar to that used in his letter to Dr. Nassar, to discuss the situation in the Department. He asked the Dean to develop an appropriate methodology to intervene in the Department to assist its members to establish more effective collegial relations and a more positive work environment. The President asked the Dean to decide whether to use third parties to provide facilitation, mediation, individual coaching, or other assistance, and asked the Dean to provide the President with periodic detailed updates regarding the progress being made to resolve the outstanding issues in the Department. The President stated that he did not believe that fault-finding was helpful at this point and suggested means be found to put aside past arguments, let the emotions related to them recede, and move on to a new level of collegiality and cooperation in the Department.

In mid-December, the Dean asked to meet with Dr. Nassar early in the new year to follow up on the President's letter. Counsel for Dr. Nassar and counsel for Dalhousie exchanged views on procedures to be used by the Dean or any third parties involved, and on the scope of issues to be considered. Among other matters, issues discussed were what restrictions might be placed on the purposes for which any information gathered in this process could be used, whether all individuals would be able to see all information provided by others, and what issues from the past would be considered.

Department external review by a single Reviewer

While the processes related to Dr. Nassar's CAPR reappointment proceeded at Dalhousie from approximately May 2001 to November 2002, a second set of processes at CDHA related to Dr. Nassar's complaint of a hostile work environment were proceeding in parallel. A proposal for mediation of the dispute between Dr. Nassar and his Department Chief was discussed for several months, with Dr. Nassar expressing the need to have the mediation completed before he was required to submit materials for his CAPR review at the end of September, 2001. In late October, 2001, Dr. Nassar was informed that mediation would not proceed because of the reluctance of Dr. Nassar's Department Chief to participate in the process.

At the end of October, 2001, a single external Reviewer was engaged by CDHA to conduct a confidential review of the Department of Pathology and Laboratory Medicine, and to prepare a written report with findings and recommendations. The Reviewer was to review the functioning of the Department, including investigating Dr. Nassar's complaint of a hostile work environment; assessing relationships within the Department in terms of collegiality and cohesive functioning, with a focus on relationships involving the Department Chief and others in the Department; assessing whether the current work environment compromised the quality of service offered by the Department; and making recommendations regarding any corrective action required. Dr. Nassar was requested to meet with the Reviewer on the day after the Reviewer's appointment and to bring with him any documentation he wished to present. Dr. Nassar declined.

During November and December 2001, there were ongoing exchanges regarding the terms of reference and procedures for the Reviewer, including to whom the Reviewer would report; whether Dr. Nassar would have full procedural protections during the review; whether Dr. Nassar would have full opportunity to respond to material provided to the Reviewer, and to any draft report, before a final report was submitted; and whether Dr. Nassar would receive a copy of the final report. CDHA determined that information provided to the Reviewer was confidential and would not be disclosed to others; a draft report would not be provided for comment, but any person negatively affected by the report would be made aware of the general context of significant facts that would materially affect the Reviewer's recommendations; the Reviewer's report would be submitted to the VP Medicine. After reviewing the report, CDHA would decide on its course of action. CDHA was not prepared to make a prior determination concerning to whom the report would be available. Dr. Nassar was informed that CDHA believed that the proposed review was not a formal legal proceeding. As a result, in the opinion of CDHA, no one had the right to disclosure of information and documentation as would be the case were the process to have been a formal legal proceeding including a discovery phase, and, further, CDHA had no legal duty of fairness in a review.

In late November, 2001, Dr. Nassar's Department Chief submitted a recommendation that Dr. Nassar's CAPR appointment not be renewed, as has been discussed above.

In mid-January 2002, Dr. Nassar met with the Reviewer and provided a lengthy document describing many events over a number of years going back to 1993, and specifying thirteen "*complaints*" against his Department Chief. Dr. Nassar provided similar documentation to the Faculty CAPR Committee in support of his case for a CAPR reappointment, although the thirteen "*complaints*" had become fourteen "*comments*."

In mid-February, 2002, CDHA was informed that Dr. Nassar had lost confidence in the effectiveness and integrity of the process undertaken by the Reviewer, and CDHA was provided with a detailed critique of events occurring during Dr. Nassar's meeting with the Reviewer. Counsel for Dr. Nassar asserted that CDHA had a legal responsibility to comply with fundamental duties of procedural fairness during the review.

In early March 2002, the Dean asked Dr. Nassar for comments before formulating a Dean's recommendation regarding his CAPR appointment. At the end of April 2002, the President of the Medical Staff Association asked the VP Medicine when the report of the Reviewer was expected, in view of a request by Dr. Nassar for a "*letter of good standing*."

As previously discussed, in May 2002, the Dean recommended against renewing Dr. Nassar's CAPR appointment for the normal five year period. In mid-September 2002 Dr. Nassar made his case for a CAPR reappointment to the President of Dalhousie and on November 5, 2002, the President recommended that the Board extend Dr. Nassar's CAPR appointment for five years. The President also asked the Dean to develop an appropriate methodology to intervene in the Department in order to alleviate the ongoing difficulties.

Months passed. In July 2003, the Reviewer informed Dr. Nassar that he intended to proceed expeditiously with the investigation and that the delay had not been of his doing. The Reviewer subsequently informed Dr. Nassar that a draft report had been submitted fifteen months earlier but not completed because the Reviewer had been told that ongoing negotiations between Dr. Nassar and CDHA made the completion of his report unnecessary. The CDHA, however, had advised the Reviewer in May 2003 that the negotiations had been unsuccessful and a final report had been requested. In late October 2003, CDHA denied that the Reviewer had been told not to complete the report, and claimed privilege over the preparation of the report. Dr. Nassar was informed that there had been a period during which the Reviewer awaited information from CDHA, and therefore, CDHA had refrained from asking that the report be completed.

Between mid-July 2003 and late February 2004, there were a number of exchanges between Dr. Nassar and CDHA concerning the external review, apparently triggered by a request that CDHA confirm that no materials, drafts, or documents evidencing any conclusions or tentative conclusions of the Reviewer would be circulated or disclosed to anyone without Dr. Nassar's consent. These exchanges contained various criticisms and responses regarding the external review and its procedures, the positions taken by each party on those matters, and the behaviour of various parties during this process.

In mid-February 2004, counsel for Dr. Nassar informed counsel for both Dalhousie and CDHA of his intention to file an originating notice and statement of claim with the Supreme Court of Nova Scotia seeking an order enjoining CDHA or their agents from using the report of the Reviewer or disclosing it in any manner.

In late February 2004, Dr. Nassar was informed that the VP Medicine had completed the examination of Dr. Nassar's complaint of a hostile work environment and of relationships within the Department of Pathology and Laboratory Medicine as a whole. Subsequently, the VP Medicine requested a meeting with Dr. Nassar to discuss current impressions of the issues and

concerns raised by Dr. Nassar, the report of the Reviewer, possible forms of resolution, and possible next steps. Dr. Nassar was informed that the report contained detailed advice and commentary in regard to Dr. Nassar's expressed concerns and his function as Division Chief, and of the performance and responsibilities of the Department Chief. Dr. Nassar was informed that a second meeting would be scheduled at which Dr. Nassar could respond with any additional information or correction of factual background. Both Dr. Nassar and the Department Chief were expected to maintain strict confidentiality regarding all matters contained in the report but could discuss those matters with their respective counsel on the basis that counsel would also be bound by strict confidentiality. The VP Medicine did not intend to release the report of the Reviewer publicly or to the Department, and information would be shared by the VP Medicine on a need-to-know basis at the sole discretion of the VP Medicine.

In early March 2004, another extended exchange occurred among counsel, including respective positions on a wide range of matters related to the allegation of a hostile work environment, the behaviour of various parties, the external review, and the proposed meetings with the VP Medicine. Dr. Nassar did not meet with the VP Medicine as requested, but the Department Chief did.

On March 19, 2004, a statement of claim was filed in the Supreme Court of Nova Scotia. In that statement, Dr. Nassar alleged a number of failures by CDHA to fulfill its obligations to him in its investigation of his complaint of a hostile work environment, including specifically that CDHA had dealt with him in bad faith and that the method and approach of the investigation violated the CDHA Bylaws. CDHA denied all allegations of bad faith or breach of obligations to Dr. Nassar in regard to their treatment of Dr. Nassar and/or the investigation process. CDHA also denied that the report of the Reviewer had been used or disclosed inappropriately.

On March 22, 2004, Dr. Nassar was asked to schedule a meeting with the VP Medicine. This proposed meeting was to be conducted for the same purpose, and under the same terms, as the meeting previously proposed in February 2004. Counsel for Dr. Nassar proposed a "without prejudice" meeting including counsel. Counsel for CDHA proposed an on-the-record meeting including counsel for Dr. Nassar as an observer but not as a participant. This Committee has seen no document indicating that such a meeting took place.

In June 2004, Dr. Nassar's Department Chief left that position and ceased to hold the positions of authority that were at the root of Dr. Nassar's claims of a hostile work environment.

Other concurrent events

On February 28, 2002, Dr. Nassar was informed of an imminent review of the Division of Clinical Chemistry, of which Dr. Nassar was Chief, to consider and make recommendations on the aims and objectives of the Division; Division resources; research programs, grants, and publications; clinical quality assurance reports; plans for the future; continuation of the Division; activities of the University Division; and the reappointment of the Chief of Clinical Chemistry (i.e., Dr. Nassar).

Dr. Nassar objected to this review on a number of grounds, among them that the Technical Manager of the Division, who reported to Dr. Nassar and with whom Dr. Nassar had worked closely, was excluded from the review committee in favour of a relatively recently appointed Technical Director, who reported to the Department Chief; and this process was not being used by other Divisions, had not been authorized as a standard procedure, and did not comply with reasonable standards of procedural fairness. Of particular concern to Dr. Nassar was the perceived tainting of the process by the intended role of the Department Chief, against whom Dr. Nassar had filed an unresolved complaint of a hostile work environment. Dr. Nassar was concerned that the Department Chief would have input into the work of the committee and would receive the report of the committee, to which Dr. Nassar would have no reasonable opportunity to respond.

CDHA responded that a review of appointments of Division Chiefs (such as Dr. Nassar) was required every five years, a Divisional Review had been postponed after Dr. Nassar's request for assistance in his application for a license in Ontario to pursue further educational opportunities (discussed below), and Dr. Nassar was required to comply with a review.

In late January 2003, the Chair of a Survey of the Department of Pathology reported that the survey committee had no review of the Division of Clinical Chemistry to use in its work.

Regarding that Survey Report, Dr. Nassar pointed out that there was no mention of the as yet unresolved complaint of a hostile work environment made by Dr. Nassar against the Pathology Department Chief or of the recommendation by the Pathology Department Chief that Dr. Nassar's CAPR appointment at Dalhousie not be renewed. The Survey Committee Chair responded that the committee was well aware of the disputes involving Dr. Nassar and the Department Chief but that their mandate was to review the Department as a whole, not to attempt to resolve those disputes. The Chair pointed out that the report made reference to evidence of dysfunctional behaviours that were having a negative impact on the ability of the Department to move forward, and had recommended that the Dean and CDHA CEO take a leadership role in helping to reestablish collegial relations and a more positive and effective working environment in the Department.

The Dalhousie President had been copied on these exchanges and requested a meeting with Dr. Nassar and legal counsel, which took place in mid-March 2003. The Dalhousie President's summary of this meeting included a request that Dr. Nassar consider his contribution to these ongoing issues and take advantage of the opportunity the report provided for moving on.

In late April 2003, the Dean and the CDHA CEO met with members of the Department of Pathology to discuss the Report of the Survey Committee. Among other matters, they undertook to take a leading role in re-establishing collegial relations in the Department and creating a more positive and effective working environment. It was proposed that a professional facilitator be contracted to assist with development of constructive communication, team building, and consensus development, as well as to assist members of the Department in developing a strategic plan, mission statements, goals, and objectives. The Dean and CEO stated that the intent was to move forward and not revisit the past, and that a search for a new Department Chief was in progress. They stated that this search process had been approved by the Faculty Council and CDHA and that results were expected within six to eight months.

Letter of good standing

Beginning in March 2002, there were ongoing exchanges between Dr. Nassar and CDHA regarding a "*letter of good standing*" for Dr. Nassar, which Dr. Nassar had been requesting from officials at CDHA since December 2001 but which had not as yet been issued. While attempting to obtain assistance from the President of the Medical Staff Association (MSA), Dr. Nassar alleged that the refusal to provide such a letter constituted abuse, harassment, and an extension of the hostile work environment. The President of MSA had been advised that CDHA awaited the report of the Reviewer before issuing a "*letter of good standing*" and the MSA President also requested information from CDHA about when the Reviewer's report would be completed.

Counsel for CDHA described a "*letter of good standing*" as a letter confirming that a physician has an appointment with defined privileges, that there were no current suspensions, and that no appointment had been revoked for disciplinary reasons. Counsel also asserted that CDHA had no legal obligation to provide such a letter and that such a letter did not replace the normal reviews and assessments. There was a request for an explanation of Dr. Nassar's repeated requests for such a letter. Counsel for Dr. Nassar provided a draft of an application to the Nova Scotia Supreme Court seeking a declaration that withholding a "*letter of good standing*" by CDHA was unlawful. Part of the application was an affidavit by Dr. Nassar that, among other things, stated that such a letter is customary evidence that a physician is considered to be in compliance with competency, disciplinary, and ethical standards at the current institution if there is consideration of a move to another institution or province.

Discussions began in May 2002 between Dr. Nassar, the CDHA VP Medicine, and their respective legal counsel concerning arrangements under which Dr. Nassar might leave the current work environment at QEII to undertake additional training in a two-year Hematopathology Residency program in Ontario. Negotiations continued unsuccessfully through August 2002. While the negotiations proceeded, Dr. Nassar initiated an application for a license from the College of Physicians and Surgeons of Ontario (CPSO). In response to a question from CPSO as to whether Dr. Nassar had been subject to an investigation of his professional conduct, counsel for Dr. Nassar sought the agreement of CDHA that the harassment complaint against Dr. Nassar did not constitute such an investigation because it had been vacated by the Nova Scotia Supreme Court. Counsel for Dr. Nassar also advised that the recommendation by the Dean that Dr. Nassar's CAPR appointment be extended for two years and be reevaluated did not amount to "*probation*."

In early September 2002, Dr. Nassar informed the new Acting CEO of CDHA that he had instructed counsel to prepare documents to commence legal action against CDHA concerning "*well known and documented*" matters, which, among other issues, included the external review conducted by the Reviewer and the underlying complaint of a hostile working environment. Counsel for CDHA characterized this action as an indication that Dr. Nassar was not interested in continuing to work toward a resolution of the issues in contention and suggested that legal action would destroy the trust between Dr. Nassar and the other members of management at CDHA. Counsel for Dr. Nassar responded that given the position of CDHA on matters such as the letter of good standing and the complaint of harassment against Dr. Nassar, Dr. Nassar had been unable, in conscience, to submit a licensing application to the CPSO. Counsel for CDHA

objected to Dr. Nassar's position, offered a letter confirming Dr. Nassar's appointment and privileges at CDHA and agreed that, since the Supreme Court had quashed Dr. Nassar's harassment reprimand, it had no legal existence. Counsel for Dr. Nassar stated that, based on these assurances, Dr. Nassar had proceeded with an application for an Ontario licence, and suggested that negotiations resume. The VP Medicine requested that the CPSO expedite Dr. Nassar's application and offered to make CDHA documents available to facilitate their review. The VP Medicine also confirmed the positions and credentials held by Dr. Nassar at CDHA.

On November 4, 2002, counsel for Dr. Nassar informed CDHA that he had been instructed to file an originating notice to the Supreme Court in the event that negotiations were not successfully completed by November 12, 2002.

In response to Dr. Nassar's application for a licence to practice in Ontario, on November 20, 2002 CPSO requested that the CDHA CEO provide a letter attesting to Dr. Nassar's good standing in the Hospital. The Acting CEO of CDHA responded with a letter that repeated the description of Dr. Nassar's positions and credentials at CDHA; stated that Dr. Nassar had been licensed to practice medicine in Nova Scotia; stated that Dr. Nassar had full privileges at CDHA and that there were no disciplinary matters pending pursuant to the Hospital Bylaws.

When Dr. Nassar was interviewed by the CPSO in late November 2002, he became aware that the CPSO knew of the harassment allegation and the court case arising from it. Dr. Nassar sent a long letter to the Acting CEO of CDHA reiterating his many criticisms of CDHA and his Department Chief, the failure of CDHA to deal satisfactorily with his complaint of a hostile work environment, and his perspective regarding the damage the actions of CDHA and his Department Chief had caused to him. Counsel for CDHA was critical of the tone of Dr. Nassar's letter, objected to a number of points in the letter, and indicated that all correspondence from Dr. Nassar not addressed through CDHA legal counsel would be returned unread by the recipient.

Dr. Nassar continued to pursue the option of a residency in Ontario, with a target commencement date of July 1, 2003. Dr. Nassar authorized the newly appointed CDHA CEO in mid-February 2003 to provide documents from the CDHA files to CPSO regarding the alleged harassment matter which had been overturned by the courts. CPSO continued to defer a decision on licensing Dr. Nassar.

At the end of March 2003, Dr. Nassar informed the CDHA CEO that the CPSO had requested additional information from CDHA about the investigation of the complaint of harassment against Dr. Nassar. The CPSO had received information that Dr. Nassar had been subject to a hospital investigation that lead to disciplinary action that had been dismissed by the Supreme Court on the grounds of procedural unfairness. As a result, they wished to know the facts of the matter over which there was dispute. Dr. Nassar described his perception of the matter and authorized the CDHA CEO to disclose to CPSO such facts as CDHA possessed concerning this matter that were factual, honest, documented, and complete.

In early April, CDHA confirmed that CDHA had not involved the Pathology Department Chief in any way regarding the processing of Dr. Nassar's application to CPSO for a licence, and would investigate any specific allegation of inappropriate involvement by the Department Chief that Dr. Nassar wished to make.

In late April 2003, Dr. Nassar informed the CDHA CEO that he understood the CPSO wished to remove any impression that the underlying allegation of harassment against Dr. Nassar had not been addressed by reason of a legal technicality. In early May 2003, discussions took place regarding what response the CDHA CEO should make to the CPSO. The CEO identified some difficulties with the request: none of the current Department Chiefs was involved in the complaint except Dr. Nassar's Department Chief, who had been identified as biased by Dr. Nassar during the proceedings; CDHA had limited ability to respond to the request because information with respect to specific events and the substance of the investigation had been destroyed as part of the apology by QEII to Dr. Nassar; the CEO had legal advice that once the hospital had made a decision, it exhausted its authority to deal with the matter and therefore had no authority to conduct a rehearing after the Supreme Court issued its order quashing the reprimand of Dr. Nassar. According to the CEO, these difficulties left the CDHA unable to state categorically to the CPSO that the incident on which the subsequently quashed reprimand had been based had occurred or had not occurred. Counsel for Dr. Nassar responded with a detailed criticism of the CEO's proposed response. Dr. Nassar responded directly to the CPSO, providing his perspective on the many issues. Counsel for CDHA objected to this response, took issue with Dr. Nassar's account on a number of points, and suggested Dr. Nassar's response was an attempt to embarrass CDHA, which Dr. Nassar denied.

In late June 2003, Dr. Nassar wrote the CDHA CEO, with a copy to the CDHA Board Chair, to restate his position on a wide range of topics and to criticize the actions and inaction of CDHA on a number of matters. Dr. Nassar reviewed his previous correspondence to the VP Medicine and a former CDHA CEO on these matters. Dr. Nassar objected to the CDHA decision not to address his complaint of a hostile work environment using the CDHA Bylaws. He repeated his criticisms of the process involving an external review by a Reviewer, the negative recommendation by his Department Chief during the CAPR review, and most of the other events that have been discussed previously. Several additional exchanges occurred among counsel concerning these letters, and other matters which were in dispute. These exchanges did not lead to final resolution of any of the matters in dispute.

Court cases involving Dr. Nassar since 2004

On March 8, 2004, a Statement of Claim was filed in the Supreme Court of Nova Scotia on behalf of Dr. Nassar. The Defendants are CDHA and Dr. Nassar's Department Chief and this action focuses on the claims against the Department Chief. Dr. Nassar's claim is that the Defendants damaged his reputation and treated him unfairly. In the Statement of Claim, Dr. Nassar stated that the Department Chief played a role in encouraging a manufactured complaint of harassment against Dr. Nassar. Dr. Nassar also claimed that his Department Chief used his position to affect negatively Dr. Nassar's future reviews, reputation, and career. Dr. Nassar claimed that the effect of his Department Chief's actions was to create a hostile work environment.

Dr. Nassar sought an order declaring that the Defendants had wrongfully exercised their respective authorities and by so doing had interfered with Dr. Nassar's career. Dr. Nassar also sought an order that the exercise of the harassment matter in respect of Dr. Nassar's standing within CDHA had been wrongful and an abuse of power by CDHA and the Chief of the

Department of Pathology. Dr. Nassar also sought an order enjoining the Defendants or their agents from interfering with his career and progression within CDHA and Dalhousie University. Dr. Nassar sought damages, which he claimed to be aggravated in the circumstances, and special damages for interference with his University reappointment.

The Statement of Defence of the Chief of the Department of Pathology denied that he acted inappropriately in regard to the use of his powers as Chief of Pathology. He also denied that he acted inappropriately personally in regard to the harassment complaint. He also claimed a qualified privilege for his actions and statements with respect to the matters in the Statement of Claim. The Department Chief also held that some of the matters included in the Statement of Claim had been dealt with in an internal mediation in 1993 and therefore could not form the basis of a complaint of wrongful conduct at this time.

On March 19, 2004, a second Statement of Claim was filed by Dr. Nassar against CDHA. Dr. Nassar alleged that CDHA failed to fulfill its obligations to him in its investigation of his complaint of a hostile work environment, which Dr. Nassar alleged arose from the actions of his Department Chief. Dr. Nassar claimed that the process for the investigation had been agreed upon prior to its start and that CDHA changed the process without consultation with Dr. Nassar. Dr. Nassar stated that he had refused to participate further because of what he believed was the demonstrated incompetence of the Reviewer. As a result of these changes in procedures, Dr. Nassar claimed that CDHA had dealt with him in bad faith and had violated CDHA obligations to him by continuing with the investigation outside of the agreed procedures. Dr. Nassar also claimed that the method and approach of the investigation violated the CDHA Bylaws. Dr. Nassar claimed that the report arising from the external investigation had been inappropriately released or used by CDHA. Dr. Nassar sought an order enjoining CDHA or their agents from using the report of the investigation or disclosing it in any manner. Dr. Nassar also sought general damages for violation of obligations and bad faith.

The Statement of Defence of CDHA denied all the allegations of bad faith or breach of obligations in regard to their treatment of Dr. Nassar and/or the investigation process. CDHA denied that there was a contractual agreement or obligation to Dr. Nassar regarding the procedure for the investigation. CDHA stated that they intended no harm and acted in good faith with their dealings with Dr. Nassar. They also denied that the report had been used or disclosed inappropriately. CDHA also stated that Dr. Nassar's claims were vague and did not form the basis of an appropriate cause of action.

In June of 2004, the District Chief of the Department of Pathology and Laboratory Medicine at CDHA and Chief of the Department of Pathology at Dalhousie University left Dalhousie and CDHA. Mere weeks after the court cases were filed, the Department Chief ceased to hold the positions of authority that were the basis of Dr. Nassar's claims of a hostile work environment.

The court cases dragged on, over many years. The two cases were subsequently combined by the Court. There were a number of related actions involving disputes over examination for discovery, production of documents, and other matters. The court record shows a remarkably large number of letters from lawyers on a wide array of legal matters.

An amended Statement of Claim was filed on June 30, 2008. That statement of claim had expanded to forty-two pages and 243 paragraphs. It identifies six types of wrongful action by the Defendants: Abuse of Public Office by CDHA through the actions of the Chief of Pathology and otherwise; negligence by CDHA by breaching its duty of care owed to Dr. Nassar, thereby negligently causing him harm; defamation of Dr. Nassar by the Department Chief; injurious falsehood by the Department Chief, including in exercising the authority of his office, by making and publishing statements that harmed Dr. Nassar; abuse of Public Office by the Department Chief intending to cause harm and causing harm to Dr. Nassar; intentional interference with economic relations by the Department Chief acting intentionally to interfere with the professional, academic, and economic relationship of Dr. Nassar to CDHA. All but the first twenty-seven and the last two paragraphs set out various particulars of the claims by Dr. Nassar. The Defendants denied all allegations.

The Relief claimed by Dr. Nassar was an order declaring the defendants had wrongly exercised their authority and interfered with Dr. Nassar's career and progression; an order declaring the CDHA's exercise of authority in the "*harassment*" matter was wrongful and an abuse of authority; an order enjoining the defendants and their agents from interfering with Dr. Nassar's career and progression within CDHA, the University, and elsewhere within his profession; general damages, and that such damages are aggravated in the circumstances by CDHA failing to take the opportunity to mitigate harm caused to Dr. Nassar; special damages for interference with Dr. Nassar's University reappointment and Dr. Nassar's capacity to be appointed Chief of Pathology, or restrictions or interference with his prospect of securing alternative or additional professional appointments elsewhere; punitive and exemplary damages; costs; and such further relief as might be deemed just and appropriate by the Court.

As of the time of final editing of this report, the only decision issued by the Court was one by Justice Robert W. Wright on October 4, 2011. That decision did not consider the substance of the case, but rather a derivative matter concerning release of documents. Under the well-established "*applied undertaking rule*," a plaintiff may not use any documents disclosed in the course of litigation for any extraneous or collateral purpose without first obtaining a court order. During the course of the action, the parties had produced "*voluminous documents*" and there had been extensive discovery examinations with more scheduled at the time of the decision. Dr. Nassar had sought court permission to place pertinent documents, assembled in the course of the litigation, directly before the Board of Governors of Dalhousie and also the CDHA Board of Governors so that those Boards might take such action as they saw fit. Justice Wright dismissed the application on the grounds that he was not persuaded that a superior public interest would be served to justify overriding the "*applied undertaking rule*" concerning non-release of such documents.

In his written decision, Justice Wright provided a brief summary of the matters involved in the litigation. According to Justice Wright, Dr. Nassar sued the defendants for various reasons, "*… foremost of which is a claim for damages for abuse or wrongful exercise of public authority … There are a number of instances or events where the plaintiff says that he was wronged by these abuses of public authority … dating back some 10 years ago …*" From the extensive discovery of documents and witnesses "*… the plaintiff has formed the belief that there were systemic flaws and abuses by a number of senior administrators, and especially* [the Chief of the

Department of Pathology], *in the administration of the CAPR and DMRF processes in which he was involved, which remain unrectified to this day … the plaintiff believes that abuses of public authority occurred which should not be allowed to be repeated. He has therefore embarked on a campaign to bring these perceived systemic abuses to the direct attention of the Board of Governors of Dalhousie University and the Board of Directors of CDHA respectively, for remedial action … The stated purpose behind the motions is to allow the plaintiff, by judicial leave, to place the pertinent documents directly before the Board of Governors of Dalhousie University and the Board of Directors for CDHA respectively … and to let those Boards take such action as they see fit. Clearly, however, the objective is to trigger an internal investigation or review, and corrective action, by each Board on its area or areas of responsibility. That is plainly the plaintiff's expectation, gleaned both from the original and follow-up letters written by plaintiff's counsel …. The plaintiff's allegations are that a number of individuals abused their positions of public authority or responsibility; that the problems were systemic … and that therefore there is a public interest in placing these documents before the respective Boards of those two institutions for investigation and corrective action if required. Put another way, he contends that it is in the public interest that the Boards who are entrusted with responsibility for the administration of the operations of these institutions be given the opportunity to investigate and to act as required …"*

Justice Wright summarized the Defendant's argument as follows "… *the intended use of these documents by the plaintiff is for a purely collateral purpose extraneous to this litigation, namely, one designed to generate an investigation of the impugned individuals and events as a parallel battle front over the same issues, serving as a further attempt to discredit these individuals. They view this case as a determination of the plaintiff's private and personal interests from his <u>own</u> involvement with the impugned processes and not as a public interest case … It is also strenuously argued on behalf of the defendants that the materials before the Court on these combined motions do not provide actual evidence of any systemic abuse that might otherwise present grounds for relief in the public interest. Rather, it consists of allegations and speculation on the part of the plaintiff, which are summarized in his counsel's letters … which, of course, do not constitute evidence coming in that form … the main thrust of their submissions is that the plaintiff has failed to demonstrate a superior public interest in the disclosure sought …"*

Justice Wright stated "… *In my estimation, this is first and foremost a private personal matter, obviously of great concern to the plaintiff given the tenacity with which he has been litigating this action. It is apparent that he seeks not only monetary damages for how the alleged wrongdoings have adversely affected him, but also vindication of his position against his adversaries … The plaintiff is bound to be confined to this litigation to achieve those ends in the use of the documents disclosed unless he can demonstrate, <u>by evidence</u>, that there is a superior public interest in the disclosure sought in the need to curb systemic abuses in the impugned processes. I find that need has not been established by the plaintiff … I would add parenthetically, as attenuating circumstances here, that the plaintiff's allegations … are to be taken as already well-known to persons of high positions of responsibility within both CDHA and Dalhousie University through this protracted and intensive litigation. Indeed, the subject documentation has largely emanated from these two institutions in the first place. If either of these two institutions were to become aware of systemic abuses of public authority, either past or present, there would be no impediment to their launching an appropriate investigation on their*

own initiative by the personnel charged with such responsibilities … It is also to be observed that the merits of the plaintiff's allegations … will ultimately be fully adjudicated upon by the Court at trial …"

Lessons from the case history

The case of Dr. Nassar was the first to arise of the three cases this Inquiry examined, and it has been ongoing for the longest time. Unlike the cases of Drs. Horne and Goodyear, the case of Dr. Nassar did not involve the use of the CDHA Disciplinary Bylaws. It depended solely on internal CDHA[24] and Dalhousie policies and procedures, and certain aspects of what might be called the medical academic culture at the medical facilities that were to be amalgamated to form CDHA. The CDHA Chiefs, Heads, and Vice-Presidents involved in the case of Dr. Nassar are, for the most part, different from those involved in the cases of Drs. Horne and Goodyear.

Weakness of CDHA/Dalhousie policies, procedures and culture

Chapter 2 discusses the threats to academic freedom posed by: misunderstanding of the basic principles of academic freedom; provisions in the Affiliation Agreement; the appointment terms at CDHA and Dalhousie; the reliance on group practice plans such as the Alternate Funding Plan of the Department of Medicine and UALMA for much of the remuneration of Medical Staff; and misunderstanding and misuse of the concept of collegiality. Chapter 2 also discusses hospital privileges and fairness, and the importance of formal dispute resolution procedures.

Chapter 3 discusses weaknesses in the foundational documents at CDHA/Dalhousie, particularly the Affiliation Agreement. There is also discussion of codes of ethics as they applied in the cases considered.

The lessons that emerged from the analysis presented in those chapters were evident in the case of Dr. Nassar. Additional specific lessons in the case of Dr. Nassar are now discussed.

Some fundamental principles were misunderstood

As discussed more extensively in Chapter 2 of this report, academic freedom and the concept of collegiality are essential principals which must be broadly understood and embedded in policies, procedures, and the medical academic culture more broadly. There were serious misunderstandings exhibited in the case of Dr. Nassar. Dr. Nassar had the right to criticize the entrepreneurial activities of some of his colleagues and the University and VGH officials who approved them, including to question whether those activities posed a conflict of interest. He did so relentlessly. His academic freedom protected his right to do so without fear of retribution. Such criticism is to be expected, even valued, and does not represent disrespect for the authority of Department Chiefs. The principles of academic freedom, and the requirements that must be in

[24] The Capital District Health Authority (CDHA) was the end result of a series of amalgamations of health care facilities in the Capital District surrounding Halifax. CDHA is used for simplicity in this context, and refers to any and all of the institutions then extant which eventually became part of the CDHA.

place to protect academic freedom properly, are discussed in Chapter 2 of this report. Dr. Nassar's academic freedom was under threat for lengthy periods and there was inadequate protection for Dr. Nassar.

Dr. Nassar was also alleged to lack "*collegiality*," and that allegation was one of the principal reasons for the recommendation against renewing his CAPR appointment. This allegation was based on a fundamental misunderstanding of the concept of collegiality, which is likewise discussed fully in Chapter 2 of this report.

Final and binding settlements of disputes is essential

There were repeated failures to reach final and binding settlements of the many disputes involving Dr. Nassar and his Department Chief. Without resolution, the original disputes spawned new disputes and a cycle of increasing distrust and tension continued over a lengthy period to the detriment of all involved. In some places there were no policies and procedures to use to resolve disputes, and in other cases the policies and procedures proved ineffective. Recommendations for improved policies and procedures are given in Chapter 9.

Many procedures lacked procedural fairness and natural justice

A common concern of Dr. Nassar was the use of procedures that did not allow him to know the testimony of others, or to respond to that testimony. There was a particular concern that testimony or opinions that Dr. Nassar considered to be biased or inaccurate would become part of the official record on which decisions about renewal of privileges, renewal of CAPR appointments, and other matters determining his employment status would be based. His concerns were particularly evident during the discussions of the procedures to be used by the external Reviewer, and the potential circulation of any report that the external Reviewer might provide. On some occasions CDHA specifically excluded the right to procedural fairness and natural justice during certain proceedings, with the result that there were lengthy exchanges among legal counsel which hampered progress of those proceedings.

It would be helpful to have clearly written and widely disseminated procedures on how any official record is compiled, how to access that file, who may access the file, how copies of the file are to be obtained, how material may be added and/or removed, and for what purposes the file may be used. Many of the difficulties that occupied so much time in the case of Dr. Nassar could have been avoided if it was established policy that the official record used to reach decisions is open to review and comment by the member of the Medical Staff involved before decisions are reached.

Group Practice Partnerships have inordinate power

Before Dr. Nassar joined the Medical Staff at CDHA, certain events had set the stage for what was to follow. The person who was to become the Chief of the Department of Pathology and Laboratory Medicine took a leading role in establishing University Avenue Laboratory

Medicine Associates (UALMA), a group practice partnership offering pathology services to the Victoria General Hospital (VGH) and research services to Dalhousie.

Group practice partnerships such as UALMA and the Alternate Funding Plan of the Department of Medicine provide a major source of income for the independent contractors who make up most of the Medical Staff at CDHA. Through their control of the income of the Medical Staff, these group practice partnerships have inordinate power within CDHA that appears to be outside the control of either CDHA or Dalhousie.

This power was displayed when Dr. Nassar and CDHA were attempting to negotiate an arrangement by which Dr. Nassar could undertake additional training in Ontario. CDHA proposed that UALMA, not CDHA, provide funding for this arrangement. As a result, the best interests of CDHA to reach a settlement with Dr. Nassar were held hostage to decisions by other bodies. No agreement was reached, and another opportunity to work toward a resolution of the conflicts involving Dr. Nassar was missed.

During the lengthy dispute, others of the initial members of UALMA became supporters of the Chief of the Department of Pathology and Laboratory Medicine, and opponents of Dr. Nassar. Dr. Nassar also alleged that he had been pressured improperly to support certain initiatives by the Department Chief to change the membership arrangements in UALMA.

Department Chiefs have extraordinary powers

Anyone who has the authority to vary privileges at CDHA, to recommend against a CAPR renewal at Dalhousie, to determine the revenue share to be paid by the group practice plan, and to hear appeals of those revenue share assignments, has extraordinary power. Dr. Nassar was concerned that his Department Head also had a motive to use that power to the detriment of Dr. Nassar.

There were also examples in the case of Dr. Nassar where the Department Chief made unilateral decisions on matters of great importance to the Department. In one such case, the Executive Committee of the VGH Board reaffirmed the authority of the Department Chief to make such decisions and admonished the members of the Department for their opposition. This affirmation of unilateral authority, combined with the extraordinary power concentrated in the hands of that individual, poses an unacceptable threat to academic freedom. The authority-based model of leadership was readily apparent, and consultative or collegially-based leadership was missing.

One of the reasons given by the Department Chief for issuing a reprimand to Dr. Nassar was Dr. Nassar's persistent challenge to the authority of the Department Chief. Dr. Nassar alleged that the Chief was in fact abusing that authority and creating a hostile work environment. No final resolution of the complaint of abuse of authority by the Department Chief and the creation of a hostile work environment for Dr. Nassar was ever reached. That matter is still before the Courts.

Entrepreneurial activities need to be transparent

Another action that set the stage for later events was the establishment of a private for-profit laboratory by, among others, the person who was to become the Chief of the Department of Pathology and Laboratory Medicine. The principals in this entrepreneurial activity had the right to engage in these approved activities, under certain clearly defined conditions, and Dr. Nassar had the right to criticize both the activities and their approval by Dalhousie and VGH officials.

When the person who was to become Chief of the Department became a candidate for that position, Dr. Nassar became concerned that the new Chief would be in a position to use his substantial powers against Dr. Nassar's interests in retribution for Dr. Nassar's criticisms. The recommendation by the search committee that the appointment as Chief be conditional on removing the "*perception of conflict of interest*" was an unusual requirement, and seemed to recognize that these criticisms made by Dr. Nassar needed to be resolved. The Chief repeatedly stated that his shares in the private laboratory had been sold but there was no public accounting and the criticism continued.

Promises made must be promptly fulfilled

When specific conditions are attached to an appointment, there must be means to confirm that the conditions have been met. For the first of many times, Dr. Nassar turned to a senior administrator, the VGH VP Medical Services, for resolution of his concerns. Dr. Nassar was told that his concerns were under review by the Board Audit Committee, but no record of such an audit remains. Dr. Nassar's criticisms of conflict of interest continued. To resolve a dispute, promises made must be promptly and visibly fulfilled. This was the first of many occasions on which an opportunity to resolve the dispute was missed and the issue was left to fester.

Robust grievance procedures are required

When the Chief issued a written reprimand to Dr. Nassar the VP Medical Services became involved again. There appeared to be no other mechanism available by which Dr. Nassar could challenge the reprimand. A robust grievance procedure would have allowed Dr. Nassar to challenge the reprimand, and a final and binding resolution of the matter could have been achieved.

Instead, the VP Medical Services carried out what was variously described as an arbitration or a mediation. An arbitration requires an external and independent third party to hear the evidence and make a ruling. The VP was clearly not neutral because the Chief had threatened to ask the VP to take additional disciplinary action if Dr. Nassar's behaviour did not change. Nevertheless, the VP interviewed a number of individuals without the knowledge of Dr. Nassar and drew a number of conclusions. Dr. Nassar later described this process as an unjust investigation because he had no opportunity to challenge the information provided by those other individuals or even to know what information they had provided. The VP Medicine did succeed in reaching a written agreement between Dr. Nassar and the Chief, which is more characteristic of a mediation.

There were a number of other occasions during the case of Dr. Nassar when he sought resolution of disputes by relying on senior administrators such as the VPs. Unfortunately, no senior administrator succeeded in resolving definitely any of these disputes.

There are dangers in trying to expunge files

The letter of reprimand issued to Dr. Nassar was supposed to be expunged from the record and all records and files destroyed. But four years later, the committee investigating the allegation of harassment against Dr. Nassar referred to the letter of reprimand in its report. Either all copies had not been destroyed or memories had lingered and were transmitted orally to the committee.

When Dr. Nassar was issued a letter of reprimand and counselling in the harassment case, he appealed to the Courts who quashed the finding against Dr. Nassar. Dr. Nassar's counsel was informed that all copies of the report of the investigating committee had been destroyed and all references to the matter had been removed from Dr. Nassar's credentialling file. In effect, from the point of view of the formal record at the QEII, it was as if these events had never occurred. Nevertheless, when Dr. Nassar applied for a licence from the College of Physicians and Surgeons of Ontario (CPSO), questions arose about whether this allegation of harassment had been rejected on a legal technicality without addressing the substance of the complaint. CPSO were informed that there were no available documents to provide the basis for an adequate response to the query. Recommendations are made in Chapter 9 for placing such documents in restricted files that may be accessed only by specified individuals and for specified purposes.

What happens if a mediated agreement is not implemented?

The first mediation involving Dr. Nassar and his Department Chief failed because it was not implemented in a timely manner. There needed to be a schedule for implementation and an agreement about what would happen if there were problems with the implementation. The same issue occurred in the mediated settlement of Dr. Horne's dispute. In that case, the parties agreed that the mediator would have jurisdiction if any disputes arose about the implementation. There were disputes, but the mediator did not intervene and the agreement was never implemented.

Lack of transparency created problems

The search committee for a new Chief of Pathology recommended the appointment on the condition that the perception of a conflict of interest be removed. It appears that there was no public accounting for how that was accomplished, or even if it was accomplished. Later, during the mediated settlement of the dispute over the letter of reprimand to Dr. Nassar, he was told to wait for the audit to do its work. There is no record of the audit results ever being shared with the Department, or indeed ever having been conducted. A grievance process, or a body representing Medical Staff with the authority to demand that the Administration provide evidence that the conditions had been met, might have been able to resolve the matter. Left unresolved, there was increased distrust and additional ongoing disputes.

When the Executive Committee of the VGH Board heard the parties for and against the motion of non-confidence in the Chief of Pathology, neither party was allowed to be present or to comment on the presentation of the other. This caused distrust on the part of those voting non-confidence. A better approach would have been to ask each side for a written brief and to allow each to file a brief in response to that of the other.

Standard policies and procedures are required

In several instances in the case of Dr. Nassar, there were no policies or procedures in place when events requiring a response occurred. As new procedures were proposed or carried out, Dr. Nassar perceived these procedures to be disadvantageous to him and raised a number of objections. When procedures or policies are formulated after an event, a reasonable apprehension of bias can arise, and certainly did with Dr. Nassar.

On one occasion, the Department Chief used a new procedure for obtaining comments during a performance assessment, which was different from the procedures used in other Departments. There had also been no consultation with the Department beforehand, the procedures had not been vetted or approved by the Medical Staff, and it appeared to Dr. Nassar that the Department Chief was unilaterally imposing procedures that would disadvantage Dr. Nassar. In particular, there was a concern that unvetted documents could be placed in Dr. Nassar's credentialling file as a result of this process.

Policies and procedures must be carefully vetted in advance, should be in writing, should be approved through a collegial process by the Division or Department concerned, and the approved versions circulated to all parties. Similarly, there were no formally approved definitions of a number of terms, such as "harassment," and no criteria for establishing that alleged acts amounted to harassment.

A striking example was that during the investigation of the allegation of harassment by Dr. Nassar, there was no pre-agreed definition of harassment and the procedures used were based on Bylaws that had not been approved by the Minister and hence were not in force. The investigation committee found that if Dr. Nassar had acted as described by the complainant, it was an act of intimidation, and hence could be seen as harassment. There were also no procedures and policies in place for external reviews of Departments when the VP Medicine appointed an external Reviewer, thus disadvantaging the Reviewer, who appears to have been confused about his role. In both cases, lengthy disputes arose and interfered with obtaining results.

The standard of proof must be defined in advance

When disciplinary action is initiated against an individual, it is important for there to be in place an agreed standard of proof required to be used to determine if there was just and sufficient cause. That standard of proof may depend on the matter under investigation. As discussed in Chapter 4 of this report, a decision to suspend privileges is career-threatening and requires a very high standard of proof, particularly if it has been a summary suspension of privileges. On matters of less import, the standard sometimes applied is that the preponderance of the evidence supports

the action taken. During the investigation of the allegation of harassment by Dr. Nassar, the standard applied was that it was not beyond the bounds of probability that Dr. Nassar had behaved as alleged. This is an unusually impressionistic and fallible standard. Furthermore, the conclusion was based, in part, on the testimony of anonymous individuals whose testimony was unknown to Dr. Nassar and which he had no opportunity to rebut, and also depended on the supposedly expunged letter of reprimand, which should not have been entered as evidence.

Anonymous testimony is a threat to justice

Anonymous testimony was used in some cases involving Dr. Nassar. The VP Medical Affairs did so during his intervention in attempting to resolve the letter of reprimand situation in the case of Dr. Nassar, as did the investigating committee during the harassment allegations. There were also instances where Dr. Nassar was unable to hear testimony provided by persons who were known, and to respond to that testimony. Both procedures are a threat to justice because they could disguise bias and allow false or distorted evidence to be seriously considered.

Conflict-of-interest guidelines are required

There must be clear guidelines to establish when individuals have a conflict of interest that requires them to abstain from involving themselves in certain proceedings. During the procedure to investigate the harassment allegations against Dr. Nassar, the Department Chief originally acted on the Medical Triad established under the procedures used. The disputes involving Dr. Nassar and his Department Chief were well known; moreover, the complainant had been a long-term employee of the Department Chief and had consulted the Department Chief while preparing her allegations. The Department Chief was subsequently listed as a witness during the investigation committee proceedings. All of these matters raised a reasonable apprehension of bias. On the other hand, the VP Medicine declined to provide a reference letter for Dr. Nassar on the basis that the VP Medicine had been involved in attempting to resolve Dr. Nassar's complaint of a hostile working environment (although there were also other explanations offered at different times).

There need to be definitions and guidelines to be followed in determining if a conflict of interest exists and whether an individual should therefore recuse himself or herself. In cases where questions of ethics arise, it might also be useful if there were a senior position to offer advice on matters of ethics and to assist more generally in difficult situations. In the case of Dr. Nassar, it seemed that removing people with perceived conflicts of interest depended on objections raised by Dr. Nassar or his counsel. A more proactive decision could have reduced the level of distrust that often builds when a reasonable apprehension of bias arises.

Strengths/weaknesses of harassment investigation process

The unapproved Bylaws used to investigate the allegation of harassment in the case of Dr. Nassar had some clear strengths. An interview of the complainant by three ranking CDHA administrators demonstrated that the complaint was being considered seriously. It also provided

an opportunity to screen out unsupported or frivolous complaints before interviewing the person accused.

Once the allegations of the complainant and the response of the accused had been considered, the Medical Triad could then determine if further investigation was needed. If the facts were agreed, or an offence had been admitted, the Medical Triad could decide that no investigation was required, and could either dismiss the case or issue a letter of reprimand and counselling. This procedure could result in a prompt resolution in cases where the evidence was unequivocal.

If the Medical Triad decided that further investigation was required, they would appoint a committee to conduct the investigation and issue a report and recommendations on which the Medical Triad could then decide to take, or not to take, disciplinary action. If the disciplinary action might lead to a change in hospital privileges, at the request of the accused member of the Medical Staff the case would be referred to the Medical Advisory Committee for consideration and ultimately to the Board for a final decision.

This procedure ensured that, before any disciplinary action was taken, there would be an investigation. The involvement of more than one senior administrator, and an investigation prior to taking disciplinary action, would have been helpful in the cases of Drs. Horne and Goodyear.

Aside from the problems that arose in the implementation of the policy in the case of Dr. Nassar, which have been discussed above, there were also some structural deficiencies in the Bylaw. The requirement to appoint an ad hoc committee to conduct an investigation would likely delay the investigation. It might have been better to establish a standing panel to hear cases that might be referred to them. In addition, it should have been understood that any finding that behaviour amounting to harassment had occurred would be likely to pose a threat to the hospital privileges of the accused. The option of referring the matter to the Medical Advisory Committee, and ultimately the Board, should have been automatic.

An additional lesson from this case was that when a published procedure is adopted, even one that has not been approved and does not provide authority for the actions taken as a result of the proceedings, the published procedures must actually be followed. In the case of Dr. Nassar, the procedure provided for written disclosure of the complaints. The Court found that the fact that the additional incident on which the case was based was not disclosed to Dr. Nassar in a timely manner amounted to nondisclosure.

The harassment complaint continued to create problems

The unproven harassment allegation continued to do damage to Dr. Nassar's career because there had been no definitive resolution of the complaint. Harassment is a very serious matter, and the suggestion that a member of the Medical Staff had engaged in harassment is likely to have a detrimental impact on his or her career. This is another example of why final and binding resolutions of disputes must be achieved.

The Court ruling in the harassment case led to the CDHA CEO issuing an apology to Dr. Nassar for "*putting you through a process that was determined by Mr. Justice LeBlanc to be faulty."* Dr. Nassar originally accepted the apology, but changed his mind when it later became apparent that some had interpreted this apology to indicate that the case had been decided on the basis of a technicality, rather than on the merits. Dr. Nassar began to insist that there be a clear statement that the allegation of harassment was false. This Committee has seen no such document from CDHA. When the Ontario College of Physicians and Surgeons enquired about the facts of the case, CDHA responded that all of the materials related to the case had been destroyed, and that CDHA had no legal authority to rehear the case after the Court quashed the reprimand of Dr. Nassar. As a result, according to CDHA, CDHA was unable to state categorically that the incident on which the subsequently quashed reprimand had been based had occurred or had not occurred. This is another example of why the actual destruction of records presents major risks to all parties to a dispute.

There was a major imbalance of resources

During most of the time he was involved in the disputes considered by this Inquiry, Dr. Nassar engaged legal counsel at his own expense, except for some limited assistance from the Canadian Medical Protective Association. There was also little record of assistance for Dr. Nassar from the District Medical Staff Association or any other representative organization. Medical Staff are at a distinct disadvantage when they are required to protect their rights on their own and at their own expense. This is a major threat to their academic freedom and other rights.

Summary

Dr. Nassar had the right to exercise his academic freedom and to be free of retribution for doing so. A lengthy series of interconnected disputes between Dr. Nassar and his Department Chief, well known to senior administration at CDHA and Dalhousie, remained unresolved for an inordinately long time, and remain unresolved to the date of final editing of this report more than two decades after the earliest events.

As in the cases of Drs. Horne and Goodyear, the failure to provide timely, fair, and final resolutions of known disputes led to an ever-broadening set of disputes deriving, in part, from the initial disputes. In all cases, the lengthy delays caused major damage to the life and careers of Drs. Horne, Goodyear, and Nassar.

Unlike the cases of Drs. Horne and Goodyear, the case of Dr. Nassar was not delayed by flaws in the Disciplinary Bylaws, which were not used in his case.

Dr. Nassar's case exposed flaws in the basic policies and procedures, or the lack of policies and procedures, of both CDHA and Dalhousie. On several occasions, in different circumstances, there were no well-defined, collegially approved, policies and procedures to deal with the matters at hand. This resulted in several failed attempts to implement a new procedure to fit the specific circumstances. Dr. Nassar perceived these new procedures to be specific to him and directed against his interests. Consequently, they failed because of a lack of trust that the proposed procedures would provide the procedural protections of natural justice to Dr. Nassar. In

some cases those protections of natural justice were specifically excluded from the process, and where they were included, they were not adequately implemented. Only the mediation of the dispute involving the reprimand of Dr. Nassar by the Chief of the Department of Pathology and Laboratory Medicine appeared to have been a success initially. However, that apparent agreement unravelled when the terms of the agreement were not promptly and fully implemented, and this failure led to the collapse of a later attempt at mediation of a different dispute.

As one example of an inadequate policy and procedure framework, had Dr. Nassar been able to use procedures like the standard grievance procedures found in all collective agreements to reach a final and binding resolution of these disputes, much of what transpired could have been avoided.

As a faculty member of Dalhousie University, Dr. Nassar had academic freedom, and was free to criticize Hospital decisions and policies, and the Hospital officials involved in those decisions and policies, without fear of retribution. When one of those criticized officials became a candidate for Head of the Department of Pathology, and was subsequently appointed, Dr. Nassar became concerned that the substantial powers of that office could be used to the detriment of Dr. Nassar's career.

In the opinion of this Committee, the origins of the many cascading disputes involving Dr. Nassar and the Head of the Department of Pathology arose from a concern by Dr. Nassar that his academic freedom would not be respected and that he could be subject to retribution using the powers held by his Department Head over certain aspects of Dr. Nassar's career. Dr. Nassar was repeatedly told to respect the authority of the Department Chief, whereas Dr. Nassar considered the actions of the Department Chief to be an abuse of that authority.

The failure to reach a final and binding resolution of the many disputes caused a great deal of damage. To avoid further disputes of this type in the future, the prevailing culture at CDHA needs to be based upon a broadly held understanding of, and support for, core concepts like academic freedom and collegiality. Exceptional authority in the hands of Department Chiefs, without appropriate collegial and procedural checks and balances, poses a threat to academic freedom and to those members of the Medical Staff and Faculty who exercise their academic freedom.

Recommendations based on the lessons learned from the case of Dr. Nassar are discussed in Chapter 9 of this report.

Chapter 6 | Case of Dr. Gabrielle Horne

Introduction

The core event involving Dr. Horne was the summary variation of Dr. Horne's privileges by the CDHA Chief of Medicine on October 21, 2002, confirmed by the acting CEO of Capital Health on October 22, 2002. The context in which that action was taken will first be described. The many consequences of that action will then be briefly presented.

The summary variation of Dr. Horne's privileges set in motion proceedings under the Medical Staff Disciplinary Bylaws, which are discussed in detail in Chapter 4 of this report. The basic premise of the Section of the Bylaws used in the case of Dr. Horne is that a District Chief may take summary action to vary the privileges of a member of the Active Medical Staff in order to protect patients, staff, or the public from real or apprehended harm. The Bylaws then specify a time-limited process by which the substance of the variation of privileges will be adjudicated, culminating in a hearing before the CDHA Board conducted with all the protections of procedural fairness and natural justice.

As discussed in Chapter 4, the maximum time specified in the Bylaws before a case is referred to the Board for a hearing was fifty-one days. That time limit suggests that a decision should have been made by the Board before the end of 2002, or shortly thereafter. In fact, the Board did not issue its decision until nearly four years later, in September, 2006.

Ultimately, the Board determined that there was insufficient reason to invoke the emergency variation of Dr. Horne's privileges and ordered that Dr. Horne revert to the status she held on the morning of October 21, 2002. By that time, a great deal of irrevocable damage to the career of Dr. Horne had been done.

This decision by the Board was based on consideration of a preliminary motion by counsel for Dr. Horne concerning whether there was sufficient evidence on October 21, 2002, to justify summarily varying Dr. Horne's privileges. The Board did not hold a hearing on any other matters.

During the lengthy period between the variation of Dr. Horne's privileges and the hearing held by the CDHA Board, the various proceedings and related events resulted in the production of thousands of pages of documents, many but not all of which were available to this Committee of Inquiry. Those documents set out in great detail the perceptions of the various parties to the events as well as the parties' different interpretations of those events and their effects, and the parties' differing positions about what needed to be done to resolve the many intertwined disputes. There was also considerable debate among the parties regarding the interpretation of the Bylaws and the procedures to be followed. Legal counsel involved at various times were those for Dr. Horne, the CDHA Administration, Dalhousie University, the District Medical Advisory Committee, the Privileges Review Committee, and the CDHA Board. During the stages of the process involving the District Medical Advisory Committee, Dr. Horne was represented by the Canadian Medical Protective Association (CMPA), and subsequently by legal counsel personally engaged by Dr. Horne. In addition to the ruling of the Board, a number of matters were also referred to the courts for judgment, and one legal action is still before the courts at the time of the final editing of this report.

This Inquiry concluded that the fundamental cause of the problems that arose at Capital Health/Dalhousie was a deeply flawed set of foundational documents, Bylaws, policies, procedures, and regulations and an underlying culture at CDHA that did not appropriately value reaching final and binding resolutions of disputes in a timely manner. This Inquiry has chosen not to look backward and attempt to reproduce the lengthy deliberations and the many exchanges of documents or to make specific judgments on the matters in dispute. In particular, this Inquiry has made no findings regarding the actions, or inactions, of any individuals. Those matters have been judged by the CDHA Board and have been, or still are, before the courts. Rather, the Committee has chosen to look forward and make a number of recommendations directed to improving the foundational documents, culture, Bylaws, policies, procedures, and regulations with the intent of ensuring that similar events will not occur in the future.

Accordingly, this report will not reproduce and comment upon the many disagreements and events that transpired during that very long time between the summary variation of Dr. Horne's privileges and the order by the Board that they be restored. Instead, the focus will be on briefly describing the main events and the way in which those events exposed the systemic flaws and demonstrated the need for profound change at Capital Health/Dalhousie.

Dr. Horne's academic background

Dr. Horne held an MB BS degree (St. Thomas' Hospital, University of London, 1986), was admitted as a member of the UK Royal College of Physicians (MRCP (UK)) in 1989, was granted Royal College of Physicians and Surgeons of Canada (RCPSC) specialty qualifications in Internal Medicine (University of Calgary, 1994), and a PhD in cardiovascular physiology (University of Calgary, 1993).

Dr. Horne started her Cardiology residency at Dalhousie with MD/PhD credentials and had a strong performance, including being appointed Chief Resident in Cardiology. In particular she had excellent scores on such matters as attitude, maturity, acceptance of criticism, sense of responsibility, ethical and moral aspects of practice, responsibility, and insight. Her oral communication skills were also rated highly.

Despite her early demonstration of a high level of these core skills for working in a collegial environment, during the case under study by this Committee Dr. Horne was alleged to lack collegiality and/or insight. It was also alleged that Dr. Horne exhibited difficulties in dealing with people in authority over her. None of these alleged difficulties were apparent from the records of Dr. Horne's residency assessments.

Dr. Horne was granted Royal College of Physicians and Surgeons of Canada (RCPSC) sub-specialty qualifications in Cardiology in November 1996. She was awarded a Sobey Fellowship by the Dalhousie Medical Research Foundation for two years of post-doctoral study and research at the world renowned Krannert Institute of Cardiology, Indiana University. The Sobey Fellowship is a prestigious award made to an individual who indicates a desire to return to Dalhousie University to a research appointment. By awarding Dr. Horne the Sobey Fellowship, Dalhousie University was making a considerable investment in a young clinician/researcher with the expectation that she would return to a research position at Dalhousie. The Division of

Cardiology was working to increase its research activity and profile and was investing in Dr. Horne in the hope that she would assist in meeting that goal.

Dr. Horne's appointment to QEII HSC and Dalhousie

On October 7, 1996, the VP Medicine at QEII HSC authorized recruitment of a physician to fill a vacancy in Cardiology. Dr. Horne had strong preparation for the advertised Cardiology position at Dalhousie. She held a PhD in cardiovascular physiology, a specialist Fellowship in Cardiology, and had done post-doctoral research in a field of molecular biology relevant to cardiology. Dr. Horne had published one peer-reviewed paper, had two papers submitted and three others in preparation. She also had published a book chapter and seven abstracts for conferences.

Dr. Horne was the successful candidate. Dr. Horne's appointment as a member of the Active Medical Staff in the Division of Cardiology, with privileges in Cardiology, was approved by the QEII Board on the recommendation of the Credentials Committee and the Medical Advisory Committee. The appointment was effective December 4, 1998 "… *and in accordance with the current Medical Staff Bylaws, will cover a period ending one year*…" Dr. Horne was also appointed to the associated position in the Dalhousie University Department of Medicine. Subsequently, QEII HSC became part of an amalgamation which became the Capital District Health Authority (CDHA or Capital Health).

At the time of her appointment, Dr. Horne was the only cardiologist at CDHA/Dalhousie who also held a PhD. She later told her Department Chief that she believed she had experienced gender discrimination as a result of being the only female PhD trained cardiologist in Canada at the time.

Dr. Horne became an Assistant Professor with a three-year probationary review-track appointment. The duties were thirty per cent clinical, ten per cent teaching and the remaining sixty per cent in research. The offer specified "… *to maintain the proposed research profile (60% protected time) you will be expected to secure extramural funding for partial salary support within the first three years of your contract ..."* The patient care responsibilities included "… *clinical cardiology service, including cardiology ward and consults ... diagnostic echocardiograms ... ambulatory care activities of the division including the specialized Congestive Heart Failure Clinic* …" All of these matters at the core of Dr. Horne's appointment were to become the subject of various disputes in the aftermath of the summary variation of Dr. Horne's privileges, specifically the 60% of Dr. Horne's time which was protected for research, Dr. Horne's clinical work and research related to the Congestive Heart Failure Clinic, and the 30% of Dr. Horne's salary related to her clinical duties..

Dr. Horne was required to secure "*extramural funding for partial salary support within the first three years.*" This requirement meant that Dr. Horne had to compete for external grant funding as a condition of her contract. Impediments to Dr. Horne doing so were to become an issue in dispute when her privileges were later varied. When Dr. Horne was appointed, the Research Director of the Division of Cardiology acted as a mentor to facilitate Dr. Horne's research activities and provide advice about obtaining external research funding. That mentor

relationship was productive and ended naturally after about three years as Dr. Horne became more experienced and was awarded her first external grants.

Dr. Horne's remuneration was 70% provided by Dalhousie, recognizing that 10% of her duties were teaching and 60% were research. The remaining 30% was for clinical duties in the Division of Cardiology. However, at the time Dr. Horne's privileges were varied in October 2002, all remuneration was being paid through the Department of Medicine Alternate Funding Plan (AFP) described in Chapter 3 of this report. The origin of Dr. Horne's remuneration was to have major significance during the dispute about Dr. Horne's privileges. Dalhousie continued to provide to the AFP the 70% of Dr. Horne's remuneration associated with research and teaching, although the Department of Medicine AFP reduced Dr. Horne's revenue share. By contrast, a considerably larger portion of Dr. Goodyear's remuneration came from the Department of Medicine AFP for clinical and teaching duties and his total remuneration was more strongly curtailed during his privileges dispute.

Within a year of her initial appointment, Dr. Horne had identified Adult Congenital Heart Disease (ACHD) and echocardiology of ACHD as special interests when she applied for renewal of her privileges and appointment. Dr. Horne had been invited to join the ACHD clinic and also attended a Mayo Symposium on ACHD echocardiology.

Dr. Horne's application for renewal of her hospital privileges after the first year demonstrated a considerable teaching dossier, including praise for her dedication to teaching and the "*Teacher of the Year*" award from the cardiology residents. Dr. Horne also demonstrated considerable research activity. She listed seven invited talks, workshops, and presentations; two papers on aspects of heart failure submitted to the *Canadian Journal of Cardiology*, one with her Calgary colleagues and one with colleagues from Halifax; an abstract with Halifax colleagues; and a book chapter with one of her Indiana colleagues. It is important to keep this record of Dr. Horne's collaborative work in mind, because one of the principal allegations against Dr. Horne later was that she was uncollegial and did not collaborate sufficiently with other Halifax cardiologists.

In Dr. Horne's hospital privileges renewal, it was noted that she had attended one of three General Medical Staff Meetings, had been excused from five of seven Departmental Meetings, and had not attended any Cardiology Division Meetings. These attendance figures were assessed as not meeting the requirements of the Medical Staff Bylaws. All other assessments were positive, and the Board approved Dr. Horne's reappointment and privileges on March 1, 2000.

Another later criticism of Dr. Horne was her attendance record at meetings. This Committee has seen no record of how Dr. Horne's attendance compared with that of her peers, particularly the other physicians with major research responsibilities.

Dr. Horne's research program begins

Beginning in 1999, there is a substantial record of external peer reviews of various research proposals by Dr. Horne. Those who reviewed her grant proposals noted that her training was excellent for the research she proposed, and generally praised the proposed research as

important, clinically relevant, interesting, original, challenging, well thought out, and likely to provide important novel information.

It was also noted by several reviewers that Dr. Horne's research accomplishments to date were limited, and that Dr. Horne showed promise but needed to establish herself in research. Some reviewers suggested that Dr. Horne enlist a collaborator or co-investigator. One reviewer praised Dr. Horne's decision to involve a senior researcher as a mentor and predicted that the research would provide the funding required for Dr. Horne to establish a track record and compete for additional external funding. Dr. Horne's research proposals subsequently attracted significant external funding.

The Cardiology Division Chief was later critical of Dr. Horne for not involving more of her CDHA/Dalhousie colleagues as collaborators and attempted to insist that she do so. It is important to keep in mind that Dr. Horne's academic freedom allowed her to choose collaborators, if any, for her research.

None of the reviewers expressed any ethical or safety concerns about Dr. Horne's proposed research, and the CDHA Research Ethics Board (REB) subsequently provided approval of the scientific validity and ethical acceptability of her research protocols and patient consent forms. Despite these approvals, one of the allegations later raised against Dr. Horne was that her research was unsafe in some regards and some aspects were unethical.

Some reviewers made reference to the patient population and the help of the HFC clinic being sufficient to allow recruitment to occur in the proposed timelines, and referred to the support and endorsement of the HFC group. In her response to the reviewers' comments, Dr. Horne stated that it was likely that sufficient patients could be recruited from the HFC to meet the requirements of her research. The ability to recruit patients from the HFC to research studies, and the procedures and approvals required to do so, were to become a source of contention between Dr. Horne and the Director of the HFC, who had the support of the Chief of the Cardiology Division. When Dr. Horne was subsequently summarily removed from her duties in the HFC, recruitment of patients to her studies collapsed, resulting in serious negative impacts on her research.

At about this same time, the Division of Cardiology was actively discussing the procedures and criteria for approving research within the Division, and various changes that might improve communication about proposed and ongoing research, and mitigate conflict or competition among studies for resources and recognition. There was no general agreement about the forum in which to present and discuss research underway or proposed. There was a range of opinions on these matters and a more formalized process for the review of new clinical trials was proposed, but there was no written and approved Division of Cardiology policy. There was also a concern that attendance at the meetings considering research should be improved, and there was ongoing discussion of how that goal might be achieved.

The review process that was to be required for research protocols was to become a point of contention between Dr. Horne and others, notably the Chief of the Division of Cardiology and the Director of the HFC.

It appears clear to the Committee that at this very early stage in her career, among the many positive signs, the seeds of what were to become future difficulties were already present.

Concerns are raised by the Director of the HFC

In mid-July 2000, Dr. Horne was notified that an external granting agency had approved funding for one of her research projects. Dr. Horne planned to recruit patients for this study from among the patients in the HFC. Within a week of receiving this notice, the Director of the HFC asserted that it was inappropriate for multiple persons to recruit patients from the HFC and that he should be the person to review patients' charts to identify patients suitable for certain studies and to supply information regarding that patient to any researcher. Dr. Horne considered this single-point-of-entry procedure to be unwarranted interference in her recruitment of subjects for her research.

The procedures by which HFC patients could be recruited to her studies was to be a major disagreement between Dr. Horne and the Director of the HFC.

There were other disagreements, which led to tension and a degree of mutual distrust between Dr. Horne and the Director of the HFC. One related to disagreement on a clinical matter and what both parties perceived to be inappropriate communication by the other. The complaint to the Cardiology Division Chief about Dr. Horne's behaviour was framed in terms of safety, quality of care, and lack of collegiality. In turn, Dr. Horne complained of a lack of appropriate professional respect. These were to become common themes in future complaints by both parties about each other.

Another cause of concern involved research proposals. In October 2000, Dr. Horne signed a confidential disclosure agreement with a leading medical device manufacturer regarding her research and invited their representatives for an on-site exploration of possibilities for collaboration. Dr. Horne invited a number of colleagues to participate, including the Director of the HFC. Shortly after the visit, a research proposal was circulated by the Director of the HFC that Dr. Horne considered to have been inappropriately based on information about her research disclosed during the visit of the manufacturer, a contention that was vigorously denied by the Director of the HFC.

According to Dr. Horne, a draft of the research protocol that was to become SMART-HF (described below) was distributed for discussion during the visit of the medical device manufacturer. Dr. Horne had developed certain insights for improved therapy in heart failure based on unpublished research she had carried out before being appointed to the Division of Cardiology at Dalhousie. She believed these ideas were completely new and provided her with a competitive advantage for her research, which she wished to have time to exploit. In Dr. Horne's opinion, the research proposal distributed by the HFC Director might have allowed other researchers to identify these insights and thus result in Dr. Horne losing her advantage. Dr. Horne chose not to make an allegation of plagiarism but decided not to share her research proposals with the HFC Director or invite him to participate as a co-investigator on her projects. Dr. Horne's academic freedom protects her right to make those choices. One of the consequences of this choice was that Dr. Horne did not share the final version of the SMART-HF protocol with

the HFC Director. The fact that the HFC Director had not seen the SMART-HF protocol when recruitment of patients from the HFC began was to become a central issue in the variation of Dr. Horne's privileges.

Dr. Horne's three-year CAPR reappointment was approved in late 2000. The recommendation noted, among other positive features, that Dr. Horne had demonstrated an ability to work with colleagues. Despite such assessments, it was not long before Dr. Horne was being criticized for not showing this ability.

Dr. Horne's research gathers momentum

By early 2001, Dr. Horne had been cross-appointed to the Dalhousie School of Biomedical Engineering and had been approved as a member of the Faculty of Graduate Studies so that she could supervise graduate students. She had applied for a Dalhousie Clinical Scholar Award, and had recruited a cardiac sonographer who was to become central to Dr. Horne's research program. Dr. Horne had reached a sponsored research relationship with a leading medical device manufacturer and had established research collaborations with a number of researchers from other institutions. Dr. Horne also showed initiative in encouraging the Division to make a Canada Research Chair nomination in myocardial repair, an important area of heart failure research.

Collaborating with other researchers in this way is standard practice for most young researchers building their programs, and is normally encouraged. Few researchers have the entire range of expertise that their chosen research program demands, and young researchers can benefit more generally from the experience, wisdom, and research contacts that more experienced colleagues can offer. Dr. Horne chose collaborators who could make needed contributions to advancing the research. On the basis of the research program developed by Dr. Horne, those collaborators chose to work with her. That willingness to collaborate is an important indication that Dr. Horne had developed interesting research proposals that she was voluntarily opening to others for their involvement. These developments are an important indicator of the strengths of Dr. Horne's interpersonal skills, initiative, and collegiality.

As discussed in Chapter 2 of this report, academic freedom protects the right of researchers to make these choices of co-investigators for themselves, without coercion. Equally important to academic freedom is the ability to choose not to collaborate with certain others, and to suffer no negative consequences for making those choices. An apparent misunderstanding of this core aspect of academic freedom by some at CDHA was a significant contributor to some of the difficulties later experienced by Dr. Horne. In particular, Dr. Horne was directed by the Cardiology Division Chief to make active participation in her research projects available to every cardiologist in the Division and she was also told that the fact that she had not included the Director of the HFC as a co-investigator had been noted with disapproval.

The sponsored research was for a study called Septal Mechanics and Resynchronization Therapy in Heart Failure (SMART-HF), which was prominent in the later difficulties experienced by Dr. Horne. The Chief of the Division of Cardiology had informed the REB that Cardiology fully supported this clinical trial. He was later to say that he had done so mistakenly.

SMART-HF had received all required REB approvals for scientific validity and ethical acceptability.

During 2001, there was strong praise for Dr. Horne's training, skill, and achievements from a range of sources, particularly in recommendation letters for Dr. Horne's nomination for the Clinical Scholar Award, the New Investigator Award of the Heart and Stroke Foundation, and the Research Excellence Award. In particular, there was praise for Dr. Horne's success in brokering collaborative relationships across departments and serving as a mentor to multiple trainees at different levels in her research. These responses provide strong evidence of Dr. Horne's collegiality and ability to work well with others.

Despite this record of praise, by October of 2002 alleged deficiencies in Dr. Horne's interpersonal skills and collegiality were invoked by the Chief of the Department of Medicine, and deemed to be sufficiently serious to vary summarily Dr. Horne's privileges. This action was to have a serious impact on the same research programs that had been the basis for so much praise for Dr. Horne during the previous year.

The award of a Dalhousie University Clinical Scholarship to Dr. Horne provided funding to allow her to devote 75% of her time to research. Later, Dr. Horne took the position that the summary variation of her privileges prevented her from meeting the requirements of the Clinical Scholar Award, and that the award had never been fully implemented.

Friction with the Director of the HFC

But not everything was going as well during 2000. While working in the Adult Congenital Heart Disease (ACHD) clinic, Dr. Horne had experienced some interpersonal friction with the Director of the HFC, who also worked in the ACHD clinic. This friction arose from a mutual perception of lack of appropriate communication and a lack of appropriate professional respect. For example, both parties identified management decisions on patients being made without appropriate discussion or information being provided to the other. The Director of the ACHD clinic attempted to resolve these issues by separately speaking to both individuals, but was not successful in these efforts.

The ACHD clinic was held one afternoon a week, and there were also conferences involving staff and cardiologists from the ACHD and surgeons and pediatricians with an interest in particular cases. During 2000 and 2001, Dr. Horne saw approximately 40% of the patient visits to the ACHD clinic. The nature of the ACHD clinic and Dr. Horne's role in it were later to be issues in dispute.

In October, 2001, new policies were announced regarding scheduling and costs for research echocardiograms. Echocardiograms were central to Dr. Horne's research. Dr. Horne expressed concerns about the potential negative impact of these changes on her research. Because she was a Clinical Scholar, she was required to be productive in her echocardiography research, and she saw these changes as a threat to her ability to meet these expectations.

Also in October 2001, the Director of the HFC made a number of allegations about Dr. Horne to the Cardiology Division Chief, stating that he believed that Dr. Horne ought not to continue her involvement in the HFC. He went on to say that he would be compelled to resign his post as Director if the Cardiology Division Chief did not accept his view of the matter.

Concerns raised by the Chief of the Division of Cardiology

In November 2001, the Chief of Cardiology met with Dr. Horne and summarized that meeting in a follow-up letter. Concerns were expressed about the nature of interpersonal communications between Dr. Horne and some colleagues. Dr. Horne was told that the fundamental issue was her lack of collaboration with other cardiologists and that she was the source of tension because of her development of research protocols that did not involve the entire heart function group. The Cardiology Chief requested that Dr. Horne seek third-party professional assessment and counselling and that she agree to have that third party provide him with regular updates of her progress.

The letter also listed requirements to be met by Dr. Horne, including changes in her behaviour, refraining from communicating with other division members via email, and attending all clinical trials meetings unless she had provided the Cardiology Chief in advance with reasons for not attending.

The letter also required Dr. Horne to offer all members of the heart function group the chance to collaborate in any of her research protocols, including substantive cognitive contributions to her protocols and grant applications. Dr. Horne was also told that if she did not commit to this process, the Cardiology Chief would be unable to recommend that her privileges be renewed.

As discussed in Chapter 4 of this report, revoking privileges is an exceptionally serious matter for a physician, with the possibility of it being career-ending. Division Chiefs are not granted that power under the CDHA Bylaws. However, Division Chiefs do have the power to recommend that an individual's privileges not be renewed at the next regular CDHA review, and to recommend that that individual's CAPR appointment at Dalhousie not be renewed when it was next reviewed. Negative recommendations from her Division Chief in either of those processes could have been fatal to Dr. Horne's career at CDHA/Dalhousie. Dr. Horne's Division Chief had substantial power over Dr. Horne's career and was threatening to use it. As discussed in Chapters 2 and 4, the process of privileges review and the related CAPR processes for academic appointments as they are currently formulated at CDHA and Dalhousie University are a serious threat to academic freedom.

Dr. Horne was subsequently criticized for refusing third-party professional assessment and counselling. A similar issue arose in the cases of both Dr. Goodyear and Dr. Nassar. In all cases, their refusal to undergo professional assessments was considered both a fault, and an indication that they lacked insight into their actions and were not taking responsibility for them. In all cases they disagreed with the judgment made by others about their behaviour.

In December 2001, Dr. Horne asked the Associate Dean of the Faculty of Medicine for advice in preparation for a meeting she had planned with the Chief of Medicine concerning the issues raised in the letter from the Cardiology Chief. Dr. Horne was told that she first had to resolve her professional and clinical relationships with her CDHA Division Chief and Cardiology Division members before the Associate Dean could discuss Dr. Horne's research environment. This event demonstrates the artificial delineation of responsibilities between CDHA and Dalhousie, established in the Affiliation Agreement and discussed more fully in Chapter 3, when the office of the Dalhousie University Dean of Medicine is perceived to have no role in matters that are central to the mission of Dalhousie and that threaten the career of a member of that Faculty.

Throughout 2001 and 2002, Dr. Horne was criticized for not presenting her research protocols at the Clinical Trials Meetings and for observing that she and other researchers in cardiology did not recognize these meetings as the appropriate forum for discussing their research. The problem with such criticism is that the policies Dr. Horne was being admonished for not observing did not exist. At this time, there were no collegially derived policies in place for presenting research protocols. Dr. Horne continued to resist presenting her research protocols at the Clinical Trials Meetings. Ultimately, there was no valid criticism of the protocols when she did finally, under duress, present them at the Clinical Trials Meeting on October 24, 2002. This was a dispute about appropriate procedures, which first would have needed to be developed, not about the merits of Dr. Horne's protocols.

Dr. Horne perceived herself to be subjected to systematic professional harassment in the clinical workplace. There are a number of definitions of harassment in the literature, and it is not uncommon that harassment is understood differently by different individuals.

In particular, Dr. Horne perceived a major power imbalance between herself and those above her in the hierarchy at Capital Health. As the work environment appeared to deteriorate, Dr. Horne increasingly became concerned about her superiors taking actions that would negatively impact on her career, particularly on her ability to recruit research subjects for her studies. She was concerned that, if her ability to recruit research subjects were to cease, she would be unable to meet the expectations for her job as a Clinical Scholar. In the context, these were legitimate concerns.

On a number of occasions, allegations were made by an individual about the behaviour of another individual. When in receipt of such an allegation, an appropriate response from a Division or Department Chief would be either to determine that there was no merit to the allegations and dismiss the matter, or to conduct a full investigation in order to establish the facts and assess their import. A full investigation would have involved, among other things, requesting documentation about the allegations, taking statements from the individuals, and providing a full opportunity to understand the specific allegations and to respond to them.

On a number of occasions, Dr. Horne was involved in meetings with those above her in the hierarchy without prior notice of the topics to be discussed or without the opportunity, if she wished, to be accompanied by someone of her choosing. The recommendations in Chapter 9 will discuss an appropriate protocol to follow when holding meetings at which sensitive topics are to be discussed, particularly those in which there is possibility of disciplinary action being taken.

Also on a number of occasions, Dr. Horne was to state that other members of the Cardiology Division knew of the substance of the allegations against her. The problem with such a situation is that trust tends to deteriorate if matters thought to be confidential appear to be known beyond the immediate circle of legitimate participants. The handling of complaints by all participants is a delicate and perhaps even difficult process; thought needs to be given to proper procedures.

Early in 2002, Dr. Horne made a complaint to her Division Chief about what she perceived as a lack of professional respect for her on the part of the Directors of the HFC and the ACHD clinic. These matters involved ineffective interpersonal communications, and taking clinical decisions without consultation. Dr. Horne wanted the patterns of behaviour to stop, and expected her Division Chief to take actions that would cause that to happen.

New concerns raised by the Director of the HFC

Also early in January 2002, the Director of the HFC, in his capacity as a member of the ACHD clinic, made a number of allegations against Dr. Horne to the Director of the ACHD Clinic. The principal allegation was that Dr. Horne did not maintain appropriate professional interactions among colleagues and was not collegial and cooperative. He also listed five cases in which, in his opinion, Dr. Horne had made inappropriate clinical decisions. He said he would resign from the clinic if there were no redress for his concerns. The Director of the ACHD clinic discussed these matters with the Cardiology Division Chief. The Director of the ACHD clinic did not identify a problem with Dr. Horne's competence, care, diligence, or enthusiasm. However, she did identify that Dr. Horne did not work with her or the Director of the HFC in the manner that they expected, and in particular that Dr. Horne did not defer to them when making decisions. As discussed later in this Chapter, when the Peer Review Committee appointed by the Medical Staff Association considered these matters, they likened the expectation that Dr. Horne would consult her colleagues on all matters to be more appropriate for a junior physician in the process of training, than for a more experienced specialist physician such as Dr. Horne.

On a number of occasions, Dr. Horne had difficulty accessing the contents of her personnel file. According to Dr. Horne, because Cardiologists were not CDHA employees, the normal CDHA Human Resources policies did not apply. The Medical Staff Office had no policy other than those of the Department of Medicine, which was complex because of the different jurisdictions of the CDHA Department of Medicine and the Dalhousie Department of Medicine. Recommendations about access to personnel files are given in Chapter 9 of this report.

In late May 2002, Dr. Horne's application for promotion to Associate Professor was supported by the Cardiology Division Chief. The letter of support listed Dr. Horne's many achievements, including her teaching, her awards, her collaborations on research, and her grants. The letter also praised Dr. Horne's clinical skills. The letter said that regular meetings were being used to work through some difficulties with interpersonal relationships, but that these issues did not affect her ability to be recognized for promotion. A cardiology colleague also wrote in support of Dr. Horne's application, noting her many accomplishments and areas of strong performance, and her astute management of some of the most complex cardiology

patients. Taken together, these two recommendations are consistent with Dr. Horne displaying excellent academic performance and interaction with research colleagues and learners. What is interesting in the context of the growing acrimony between Dr. Horne and the Director of the HFC is that these two recommendations are silent about any problems in her clinical performance or interaction with clinical colleagues.

These letters of recommendation illustrate the crux of the problems with the underlying policy structures at CDHA/Dalhousie and the Affiliation Agreement that provides the foundation for those policies. Despite a modest record of publication, Dr. Horne was recognized by Dalhousie for her research excellence, which was considered to be a university issue. However, Dr. Horne was caught up in interpersonal conflict in a clinical setting, which was considered to be a CDHA issue. Actions taken by CDHA related to the issues in the clinical setting disrupted Dr. Horne's research and violated her academic freedom to pursue her research as she saw fit, and with co-investigators of her choice. Despite the implications of actions taken by CDHA for these central aspects of Dalhousie's mission, Dalhousie claimed to be powerless to resolve this matter that threatened the continued career of Dr. Horne. Such a situation is unacceptable.

It is surprising that throughout the entire period of involvement by the Cardiology Division Chief in the difficulties between Dr. Horne and her colleagues in the ACHD clinic, there is no evidence of an attempt at third-party counselling or mediation involving all parties. Such group mediation or conflict resolution procedures are common practice in complex organizations, and they could well have served a very useful purpose in this case. Dr. Horne did not deny that there were difficulties in her relationships. In fact she repeatedly highlighted issues that she wanted to be resolved. This is an example of when a mentor for Dr. Horne might have been helpful in insisting that the Division Chief take appropriate action.

A related matter is that the Division Chief and Department Chief seemed to expect that, had Dr. Horne sought counselling, they would not only be advised that she had done so, but they would also be informed about the results of that counselling. Many institutions have Employee Assistance Plans through which employees can voluntarily seek counselling on a confidential basis. That they sought assistance is confidential, not only to their academic superiors, but to everyone else.

In mid-September 2002, the Director of the HFC told one of Dr. Horne's research staff that he had not seen the protocol for the SMART-HF study and as the Attending Physician and HFC Director, he was therefore halting the study. The staff member felt somewhat intimidated and uncomfortable with the interaction. The Cardiology Chief discussed the matter with all parties and determined that the SMART-HF protocol should be presented at a Clinical Trials Meeting as soon as possible. He also reported the matter to the Department of Medicine Chief, and told the Chief that Dr. Horne had alleged that the HFC Director had seen the protocol and used it to propose a study of his own, and that she had been subjected to systematic professional harassment. He requested that the Department of Medicine Chief deal with these matters.

Variation of Dr. Horne's privileges

In early October 2002, the HFC Director made a number of additional allegations against Dr. Horne to the Cardiology Division Chief, including his concerns about Dr. Horne's SMART-HF research and other research projects. The Cardiology Division Chief met with Dr. Horne to advise Dr. Horne of these concerns, and to insist that Dr. Horne meet with the Director of the HFC to address them. One of the matters in dispute was who the Attending Physician for patients in the HFC was and what role the Attending Physician should play in recruitment of patients into research studies.

Subsequently, the Cardiology Division Chief wrote to Dr. Horne summarizing his view of events and providing formal notice of concerns about Dr. Horne's patterns of behaviour and interpersonal interactions. In particular he alleged that Dr. Horne had provided false and misleading information about the interaction of the HFC Director and the member of Dr. Horne's staff, about the lack of policies regarding presentation of research protocols at the Clinical Trials Meetings, and about the allegation that the HFC Director had made inappropriate use of the draft protocol for SMART-HF. There were no allegations of specific patient safety issues. The specific allegations against Dr. Horne in this letter all involved her research, not her clinical performance, and yet Dr. Horne had obtained all required approvals by the REB, which had a specific mandate to ensure that the research protocols were safe before approving them. The Cardiology Division Chief also expressed a concern that these alleged behaviours could potentially jeopardize patient care and safety and the collegial functioning of the group. He informed Dr. Horne that he was formally referring these matters to the Medicine Department Chief for advice and action. He also stated that any repetition of the alleged behaviours would lead him to recommend that Dr. Horne's privileges not be renewed.

Two days later, the HFC Director also wrote to Dr. Horne. He alleged that Dr. Horne's refusal to meet with him indicated that she did not recognize his role and responsibilities as Director. He also alleged that Dr. Horne did not act in a collegial manner, had initiated research studies that had not been properly approved by the Division of Cardiology, and had not appropriately respected the role of Attending Physicians regarding enrolment of patients in research studies. He then stated that, effective immediately, he had terminated her participation in HFC activities, that she would not have any official standing in the HFC, and that she could recruit HFC patients only with the permission of Attending Physicians in the HFC.

A week later, the Director of the ACHD Clinic answered a request from the Cardiology Division Chief to provide documentation about her perspective on Dr. Horne's performance in the ACHD clinic. After describing her perspective on events, she stated that she and Dr. Horne had agreed that they could no longer work together in a clinic environment where patients were cared for by a team. That same day, the Department of Medicine Chief made arrangements for Dr. Horne and her legal counsel to meet with the HFC Director and CDHA counsel on October 18, 2002, to discuss matters.

At that meeting, both the HFC Director and Dr. Horne described and debated their respective positions on the matters in dispute. Each of the issues identified by the HFC Director was discussed. Dr. Horne's legal counsel stated that the conditions proposed by the HFC

Director constituted a variation of Dr. Horne's privileges, and that no issue had been raised that implied a danger to patient care. All participants agreed that the HFC Director did not have authority to vary Dr. Horne's privileges, and counsel reached agreement on a process for Dr. Horne's continued involvement in the HFC

On October 21, 2002, the Cardiology Division Chief notified the CDHA VP Research of the ongoing disputes about Dr. Horne's research projects, and how he proposed to proceed. He had recommended that enrolment be temporarily suspended until Dr. Horne presented her protocols to the Clinical Trials meetings. On the same day, he also wrote to the HFC Director suggesting new procedures for reviewing clinical trials in which protocols would not come to him for approval until they had gone through review by a clinical trials process. He asked the Director of the HFC to work with the clinical trials group to formulate such a process and policy and present it to the Division for approval.

On October 21, 2002, the Department of Medicine Chief varied the privileges of Dr. Horne and stated her reasons for doing so. This variation is a core event in the case of Dr. Horne.

Enrolment of patients into Dr. Horne's research program was suspended until Dr. Horne met certain conditions. One condition was that she present her protocols at an extraordinary meeting of the clinical trials group. Dr. Horne did so on October 24, 2002. All four research protocols were approved and no safety issues were identified.

Regarding her 0.25 FTE clinical duties, Dr. Horne was removed from those clinical duties where team care was the existing model, specifically the HFC and the ACHD clinic. As a replacement, she was directed to work with her Division Chief to develop an ambulatory clinic to provide consultant cardiologist secondary care. Dr. Horne was told that this realignment of her clinical duties represented a variation in her privileges, and was informed of the provisions of Section 8 of the Medical Staff Disciplinary Bylaws.

On October 22, 2002, the Department of Medicine Chief wrote to the acting CEO of Capital Health to seek her approval for the variation of privileges that precluded Dr. Horne's participation in the HFC and ACHD Clinic. The action was stated to have been taken under sections 8.1.1 and 8.1.2 of the Medical Staff Disciplinary Bylaws. The reasons provided to the CEO were not the same as those provided to Dr. Horne the previous day. Specifically, the reason given to the CEO was concern by the Department of Medicine Chief about Dr. Horne's ability to maintain effective professional interaction in a team care model of service delivery so as to ensure delivery of optimal patient care and integrity of the care team. The acting CEO approved the variation of Dr. Horne's privileges and informed the Registrar of the College of Physicians and Surgeons of Nova Scotia, as was required under the Bylaws.

Also on October 22, 2002, the Dalhousie VP Research expressed concerns to the Dalhousie Dean of Medicine about the effect of the variation of privileges on Dr. Horne's peer-reviewed and ethics-approved research. He stated that halting that research was a serious decision that had a major impact on the academic rights and freedom of university faculty members. He asked the Dean to review the situation and ensure that due process was being followed.

The Dean of Medicine asked the Assistant Dean of Medicine for Research to review the situation in the light of the VP Research's concerns. She was informed that the immediate issue of clinical and professional relationships within the Division of Cardiology must first be resolved under the direction of the Capital Health VP Medicine. His opinion was that the anticipated timeline under the Bylaws of ten days for that process would not create an unreasonable hardship on Dr. Horne's research. He also told the Dean of Medicine that he would seek the advice of the VP Medicine on the role of the Faculty of Medicine in any review relating to research. In effect, clinical matters were to be dealt with exclusively by Capital Health before there was consideration of research matters. As it happened, it would take four years to deal with the clinical matters and there was a great deal of damage done to Dr. Horne's research during that long delay.

The Department of Medicine Chief had held a similar meeting with Dr. Goodyear on October 10, 2002, in which she had imposed a variation of his privileges and had written a similar letter to Dr. Goodyear summarizing the meeting. In both the case of Dr. Goodyear and that of Dr. Horne, the Department of Medicine Chief said she was acting under the provisions of sections 8.1.1 and 8.1.2 of the Disciplinary Bylaws then in effect.

Dr. Horne was later to tell the CDHA Board hearing that the variation of her privileges was all about her research. Dr. Horne stated that she was not working in the ACHD clinic when her privileges were varied, and that neither DMAC nor PRC had identified any complaints about her performance in the HFC. The Peer Review Committee later appointed by the District Medical Staff Association (DMSA) also found no fault with Dr. Horne's clinical performance. The CDHA Board subsequently found that there were insufficient grounds for varying Dr. Horne's privileges and ordered that she revert to the status she held on the morning of October 21, 2002.

As discussed in Chapter 4, under Section 8.2 of the Disciplinary Bylaws, Dr. Horne had ten days from the date of the variation of her privileges to make a written submission to DMAC and/or request the consent of DMAC to make an oral presentation. Under Section 8.5 of the Bylaws, DMAC then had ten days from receipt of the written submission or hearing the oral submission to make its report.

On October 30, 2002, all parties agreed to waive the timeframes set out in Section 8.2 of the Bylaws. This decision was to have serious consequences, because the time taken for review of the variation of Dr. Horne's privileges spread over years instead of the days provided for in the Bylaws. The variation of Dr. Horne's privileges had been done on a summary basis, without the normal process of investigation and review. The required review of that decision was not completed until the CDHA Board made its ruling in September 2007 that there was insufficient cause to vary Dr. Horne's privileges. In the meantime, the variation and all of its many consequences for Dr. Horne and her research program remained in place, and damage accumulated.

The DMAC process

On October 31, 2002, legal counsel for DMAC asked if Dr. Horne intended to make a submission to DMAC, and if so to provide her reasons for the request. Dr. Horne requested that she and her counsel be provided an opportunity to make an oral presentation. According to the Bylaws, Dr. Horne had no established right to make such a presentation or to be represented by counsel. The Bylaws specifically stated that the activities of DMAC and PRC were not judicial or quasi-judicial proceedings and hence were not conducted under the principles of natural justice. Under those principles, Dr. Horne would have the right to appear and make an oral presentation, without having prior approval of DMAC to do so. This provision of the Bylaws that the proceedings of DMAC and PRC were not judicial or quasi-judicial was to have serious consequences.

On November 5, 2002, legal counsel for Dr. Horne objected to the assignment of a half-day per week of general cardiology consulting as a replacement for the HFC clinic from which Dr. Horne had been removed by the variation of her privileges. The basis of his objection was that Dr. Horne was a Clinical Scholar with only 25% clinical duties. Dr. Horne considered the HFC duties to be research-related and the new assignment not research-related, so she would not have the required 75% of her duties assigned to research. Dr. Horne's counsel also requested that the reassignment of duties not occur until the Disciplinary Bylaws process was concluded.

Legal counsel for CDHA submitted that such a delay was in no one's interests. The Cardiology Division Chief told Dr. Horne that the reassignment of duties was to ensure that Dr. Horne maintained her competence as an academic tertiary care subspecialty cardiologist, which was the basis on which the clinical part of her remuneration was determined. This reassignment of duties was to become a major point of difference between Dr. Horne and the Cardiology Division Chief and Department of Medicine Chief, a point of contention which dragged on unresolved for several months. While this difference remained unresolved, Dr. Horne's revenue share was first frozen and later reduced. Dr. Horne was also told that, without a resolution of this matter, her privileges might not be renewed at the next scheduled review.

In late January 2003, Dr. Horne agreed that she would undertake whatever clinical duties the Department of Medicine Chief believed were necessary for Dr. Horne to maintain her clinical competence. Dr. Horne proposed that any additional clinical duties be related to her expertise and that it be understood that these duties were temporary while the review of the variation of her privileges was ongoing. Dr. Horne was told in February 2003 that newly assigned clinical duties would be for the long term and that even if the Disciplinary Bylaws process exonerated her, she might not be returned to the clinical duties in the HFC she held prior to the variation of her privileges. Dr. Horne was also told that, if she did not agree to the reassigned clinical duties, there would be a financial impact and the renewal of her privileges would be in jeopardy. Dr. Horne's revenue share was frozen at the previous year's level on January 17, 2003, was reduced by 2% on October 15, 2003, and was reduced by a further 4% effective January 1, 2004. By contrast, Dr. Goodyear's revenue share was reduced by 85% effective January 1, 2004.

In mid-November legal counsel for Dr. Horne requested an extension of the deadline for submission of a written statement from Dr. Horne because certain documents had not yet been made available from Division and Departmental files. The issue of access to documents in files

relating to Dr. Horne arose on several occasions and the inability of CDHA to respond to these requests in a timely manner provides strong evidence of the need for a policy that allows more immediate access to these files.

Under Section 8.1 of the Disciplinary Bylaws then in effect, the Department Chief may only vary privileges if (s)he finds, after due consideration, that the evidence establishes that the conduct exposes people to actual harm or injury, or adversely impacts the delivery of patient care, or is reasonably likely to do either or both of these. The Department Chief must also show that requesting a special review of privileges under the provisions of Section 9 of the Disciplinary Bylaws was precluded by the need for urgent action. Finally the Department Chief must show that a variation of privileges was the least intrusive action available to protect patients. These qualifications make clear that a variation of privileges is deemed a very serious matter, and is only to be invoked in the most serious of circumstances.

As discussed in Chapter 4, the variation of privileges has a severe impact on the career of the physician involved. A variation of privileges should be rare. As already noted, a summary variation of privileges should be extraordinary and adjudicated promptly. Given that variations of privileges should be extraordinary events, that two such variations (Drs. Horne and Goodyear) were deemed necessary within days of each other ought to have attracted immediate intense scrutiny by CDHA and Dalhousie, but apparently did not.

The DMAC process was lengthy, in part because of difficulties in assembling such a large group with their many other responsibilities. It was conducted without the protections of natural justice. The evidence considered was not fully vetted because neither Dr. Horne nor CDHA had the ability to cross-examine witnesses or even to know the evidence presented. Counsel for both CDHA and Dr. Horne expressed concerns that they were not able to respond to or rebut submissions made to DMAC. At one point Dr. Horne's counsel stated that the delay in concluding the DMAC process was causing increasing prejudice to Dr. Horne and suggested that if DMAC were to consider allowing rebuttals it should include all matters, including oral testimony, and should occur only after Dr. Horne's privileges had been temporarily reinstated under Section 8.4 of the Bylaws.

In mid-December 2002, legal counsel for Dr. Horne questioned whether DMAC had a mandate to consider and make rulings on what he described as interference with Dr. Horne's research resulting from the variation of her privileges in the HFC. He listed a number of limitations on Dr. Horne's ability to recruit patients for her research. The CDHA VP Medicine was a member of DMAC, which presented some obstacles to her addressing some of Dr. Horne's research-related concerns while the DMAC process was underway. When the CDHA VP Academic Affairs attempted to mediate Dr. Horne's research concerns with the Cardiology Division Chief, CDHA counsel asked if this intervention had been mandated by DMAC. Legal counsel for DMAC required Dr. Horne to refrain from any contact with members of DMAC, specifically the VP Medicine and the VP Academic Affairs, concerning matters that could potentially touch on the review being conducted by DMAC.

In January 2003, while the DMAC process was still underway, Dr. Horne's application for promotion to Associate Professor was considered by the Faculty of Medicine Clinical Promotion/Tenure/CAPR Committee. The Department Chief did not support Dr. Horne's

promotion, in part because of concerns about Dr. Horne's collegiality, which was required to be satisfactory in order to grant promotion. The Committee did not offer a recommendation because the collegiality matters were still under review. Dr. Horne's alleged shortcomings in collegiality were central to the DMAC review.

In February 2003, the CDHA VP Academic Affairs defined a process by which recruitment to Dr. Horne's research studies was to proceed. Dr. Horne declined to sign the document on the grounds that signing this document might be understood as meaning that the document had been negotiated, whereas, in Dr. Horne's view, it was a procedure mandated by CDHA. This process did not, in any case, prove to be effective, and recruitment to Dr. Horne's research projects did not meet Dr. Horne's requirements. This matter also dragged on unresolved for a substantial period.

On February 21, 2003, DMAC issued its report and recommendations, 122 days after the variation of privileges. The Disciplinary Bylaws called for the report to be issued within twenty-one days. The DMAC did not include any mention of research activities in the definition of privileges. Its definition stated "*The 'privileges' of a member of the Medical Staff in the category of active staff encompass the duties and responsibilities of a specialist physician working in a tertiary environment as an attending or active staff physician with the right to admit and discharge patients, the right to diagnose and treat disease, the right to perform certain technical, medical or surgical procedures of a diagnostic or therapeutic nature and to exercise overall responsibility and direction for the care of patients*…." Dr. Horne's research involved performing certain technical procedures, but those procedures were not diagnostic or therapeutic in nature. Rather they were basic research into the underlying physiology of disease. Clearly, the DMAC report and recommendations did not address at least one of the fundamental concerns underlying the conflict between Dr. Horne and her Division and Department Chiefs.

On February 24, 2003, Dr. Horne was informed of her right to make written submissions to the Privileges Review Committee (PRC), and to request an opportunity to make an oral submission. Dr. Horne was also told that any rebuttal of any of the material presented to DMAC should be made to PRC.

Section 8 of the Disciplinary Bylaws provided for the PRC Report to be issued within twenty days of receiving the DMAC Report. CDHA counsel requested that the time frames established in Section 8 of the Disciplinary Bylaws be waived because of the volume and complexity of the material provided with the DMAC report. This waiving of timelines was to have a major influence on the Disciplinary Bylaws proceedings. The PRC did not issue its report for over three years (March 17, 2006).

The mediated settlement

Soon after the release of the DMAC report, the VP Medicine offered to facilitate discussions among the parties to restore Dr. Horne's clinical practice activity on an interim basis. Dr. Horne also had discussions with the VP Academic Affairs concerning possible bridge funding to assist her in reestablishing her research. Dr. Horne also suggested direct discussions with the CEO and VP Medicine to resolve matters without further delay. CDHA counsel sought

clarification from PRC counsel about provisions in Section 8.9 of the Bylaws to negotiate a proposed agreement with Dr. Horne.

In February, 2003, CAUT appointed an Independent Committee of Inquiry (the 2003 Independent Committee of Inquiry) to investigate Dr. Horne's situation at Capital Health and Dalhousie and its impact on her research program. That Independent Committee of Inquiry was also tasked with considering how universities can protect the academic freedom and other rights and privileges of university faculty who hold positions at affiliated health care institutions. This first Independent Committee of Inquiry later resigned, as discussed in Chapter 1.

During March and April 2003, Dr. Horne continued to express concerns about the low rate of recruitment to her research studies based on the recruitment process put in place by the VP Academic Affairs.

In early April 2003, there were discussions about appointing an external mediator to assist the parties. One potential mediator met with Dr. Horne and the Cardiology Division Chief, and reported to the VP Medicine that the issues were complex, serious, and longstanding and that the parties remained far apart.

In late April 2003, counsel for the PRC asserted that use of a mediator could not usurp the role and authority of the PRC to recommend a proposed agreement to the CDHA Board. Counsel also asserted that the mediator would have no authority to make a binding agreement between Dr. Horne and the CDHA Administration regarding her privileges, but could only facilitate discussions. This position by PRC was to have major consequences for Dr. Horne and result in a lengthy delay in restoring her privileges. What is notable at this crux is the apparent indifference of the CDHA to the increasingly difficult position Dr. Horne found herself in as a result of the way the procedures operated and CDHA's unwillingness to assist in putting in place a mechanism that might help resolve some if not all of the issues in contention.

During May 2003, concerns continued that the mandated procedure for recruiting patients to Dr. Horne's research program was not effective, and, as a result, the CDHA VP Academic Affairs made efforts to find a method whereby Dr. Horne's research staff could exchange information with the staff of the HFC as they had before Dr. Horne's privileges were varied. These efforts proved unsuccessful. The VP Academic Affairs considered the recruitment issue as separate from the resolution of Dr. Horne's clinical status, whereas Dr. Horne considered that a restoration of her privileges, particularly privileges to the HFC, was required to resolve the recruitment issue.

In early June 2003, the Dalhousie Dean of Medicine requested an extension to September 2003 of the deadline for making a recommendation on Dr. Horne's promotion application, and that extension was granted by the Dalhousie VP Academic.

On June 6, 2003, one of Canada's best-known and experienced mediators led a mediation including Dr. Horne and officials from both CDHA and Dalhousie University. At the conclusion of the mediation, Dr. Horne, the CDHA CEO, and Dalhousie University legal counsel signed a document entitled "*Minutes of Settlement*," which included a statement that the parties agreed that it was a full and final settlement of the matter involving Dr. Horne's privileges.

This settlement provided that Dr. Horne was to return to the HFC as an Attending Physician, and accepted her responsibility to cooperate and collaborate with her colleagues. The expectations of Dr. Horne, and all other members of the Division of Cardiology and Department of Medicine, were set out in a separate letter from the Department of Medicine Chief. Capital Health agreed to a number of actions to facilitate Dr. Horne's return to the HFC, including appointing a clinical mentor and a clinical scientist mentor to work with Dr. Horne. Capital Health agreed that Dr. Horne could not be required to accept a co-investigator on her research, and Dr. Horne agreed that recruitment to her research would be in accordance with a document attached to the settlement. Dalhousie agreed to defer Dr. Horne's CAPR reappointment for a year, and Dalhousie and Capital Health agreed to assist Dr. Horne in obtaining extensions from research granting agencies. The Parties agreed that the "*Minutes of Settlement*" would remain confidential except as required to implement the agreement.

In the opinion of this Committee, these terms of settlement could all have been implemented by agreement between Dr. Horne and CDHA when difficulties started to arise. These terms are an example of other means that could have been available to the Department Chief as an alternative to a variation of Dr. Horne's privileges.

Legal counsel for CDHA presented this settlement to legal counsel for PRC for consideration as a proposed settlement under the terms of Section 8.9 of the Disciplinary Bylaws. There was also a request to proceed with an interim implementation of the terms of the settlement while PRC considered the matter.

Difficulties arise in implementing the mediated settlement

By late June, difficulties arose in implementing the settlement. There were disagreements about the choice and role of the clinical mentor and the clinical scientist mentor. Legal counsel for Dr. Horne expressed concerns that the settlement was being misconstrued from one of mentorship to one of supervision, including Dr. Horne's research, which violated Dr. Horne's academic freedom. Dr. Horne was told that she would not be reinstated to the HFC until she had completed a reintegration phase of at least four weeks and potentially longer if the clinical mentor deemed it necessary. Counsel for Dr. Horne expressed concern that Dr. Horne was expected to meet an unspecified standard of performance before the variation of Dr. Horne's privileges was lifted instead of the variation being immediately lifted as the signed agreement mandated.

Further difficulties arose in July, 2003. Legal counsel for PRC asserted that Dalhousie University, who had been a party to the settlement, could not be included in a proposed settlement of matters before the PRC because Dalhousie was not a party to proceedings under the Disciplinary Bylaws. Legal counsel for PRC also requested that the parties clarify a number of points regarding the settlement and expressed concerns about the confidentiality clause. Legal counsel for Dalhousie and Dr. Horne took the position that the settlement was a binding contract, including the confidentiality agreement. These actions by the PRC played a role in the ultimate failure by CDHA to implement the mediated settlement.

During August 2003, the CDHA CEO agreed to provide bridge funding to pay the salaries of Dr. Horne's research staff for a maximum of six months while the issues around Dr. Horne's privileges were resolved. Also during August, Dr. Horne's research sonographer/lab manager resigned.

In mid-September 2003, the new Dalhousie Dean of Medicine asked Dr. Horne to provide him with a written statement describing her progress as a Clinical Research Scholar, in the context of the difficulties she faced, so that he could decide whether it was appropriate to consider an extension of the deadline for the formal report required for an extension of the Clinical Research Scholar award. Dr. Horne responded that significant difficulties over the previous two years had impacted her ability to develop her research program and had led to her research program being effectively shut down on October 21, 2002. She also reported that there had been a settlement agreement to resolve those difficulties, which, she said, the parties were working hard to implement. The Dean agreed to extend the deadline until April 2004.

In mid-September 2003, additional difficulties in implementing the agreement arose when the former agreement regarding who would act as a clinical mentor for Dr. Horne unravelled amid allegations that confidentiality of the "*Minutes of Settlement*" had been breached to the former Independent Committee of Inquiry (the 2003 Independent Committee of Inquiry). Without a clinical mentor, the plan for reintegrating Dr. Horne into the HFC remained incomplete. Dr. Horne agreed, on an interim basis, to perform the additional half-day clinical duties assigned by the Cardiology Division Chief until the settlement could be implemented and she was back in the HFC. Dr. Horne considered those duties to conflict with the protected research time specified in the terms of the Clinical Scholar Award. The Cardiology Division Chief agreed that these new duties would be on an interim basis.

In early October 2003, there was a dispute about the terms of the bridge funding that had been provided by CDHA in August 2003 to support Dr. Horne's research. She had paid staff expenses from research accounts between March and September 2003 while the Disciplinary Bylaws process considering her privileges continued, on the understanding that these funds would be reimbursed by CDHA. Dr. Horne considered the bridge funding in August 2003 to be the expected reimbursement to her research grants. CDHA disagreed, and told Dr. Horne that the funds promised in August were only to be used to pay the salary of Dr. Horne's research nurse going forward. CDHA considered that the expenditures from research grants during the March to September period were Dr. Horne's responsibility. Dr. Horne considered this situation unacceptable. She stated that CDHA was aware that her research was not ongoing during the period when the privileges issue was being considered by the Disciplinary Bylaws process. In Dr. Horne's opinion, CDHA's failure to reimburse those funds would mean that the research grant funds had been expended outside the mandate for which they had been awarded.

In mid-October 2003, Dr. Horne was informed that the productivity adjustment to her revenue share for 2003 had been adjusted downward by 2%.

On October 23, 2003, legal counsel for CDHA told legal counsel for PRC that because of the inability to appoint a clinical mentor for Dr. Horne, CDHA was unable to implement the mediated settlement. After further discussion of other alternatives for a clinical mentor with counsel for Dr. Horne, counsel for CDHA, in mid-November 2003, confirmed to PRC that the

mediated settlement could not be implemented. Legal counsel for Dr. Horne stated that, in signing the "*Minutes of Settlement*," the CEO had agreed to the terms of the settlement, and that all matters were therefore resolved. Obviously, these two positions were irreconcilable.

In mid-November 2003, the Dean of Medicine informed the President of Dalhousie University that, in his opinion, Dr. Horne had not met the criteria for promotion to Associate Professor. Also in mid-November, counsel for PRC asked for clarification of what efforts had been made to appoint a suitable clinical mentor for Dr. Horne and warned the parties that in the absence of an agreement, PRC would require significant additional time and effort for its investigation. In late November, Dr. Horne was informed that one possible solution to the problem of appointing a clinical mentor was for Dr. Horne to inform the senior cardiologists in the HFC that Dr. Horne recognized that a problem existed of which ownership at least in part lay with her. She was also informed of a detailed set of requirements that she must meet in order for her status as an Attending Physician in the HFC to be restored. Dr. Horne agreed to meet with three potential clinical mentors to accept some responsibility for what had transpired. However, because CDHA officials became concerned that the meeting would not succeed in producing a clinical mentor for Dr. Horne, the meeting failed to materialize. It is worth noting that a hypothetical concern was used to obstruct efforts to reach a solution to Dr. Horne's situation.

In early December 2003, Dr. Horne was provided with an application form for reappointment to the Medical Staff at CDHA. Those parts which required Dr. Horne's input were blank. The part requiring input from the Cardiology Division Chief had been completed. The recommendation for reappointment was checked "No" and the Appointment Deferred box was checked "Yes." This situation made it appear that the Cardiology Division Chief held views about Dr. Horne that nothing she might say or write would alter. On the next day the Cardiology Division Chief apologized to Dr. Horne for erroneously completing his section of this form. Dr. Horne was later asked to return the form to the Division of Cardiology Chief.

In mid-December 2003, the Acting Director of the Dalhousie School of Biomedical Engineering informed the CDHA Department of Medicine Chief that the School had approved a renewal of the cross-appointment of Dr. Horne. He was informed that Dr. Horne's application for renewal of her appointment in the Department of Medicine had been deferred for a year and that consideration of the renewal of her cross-appointment in Biomedical Engineering would also be deferred for one year.

Early in January 2004, legal counsel for Dr. Horne told counsel for PRC that the proposed agreement had stalled and that any resolution of the matter of Dr. Horne's privileges would require the PRC completing its investigation and reporting to the CDHA Board. Counsel for CDHA informed counsel for PRC that she anticipated difficulties in coming to an agreement on the meaning of mentorship and the development of a mutually agreeable reintegration plan.

In late January 2004, Dr. Horne submitted an application for judicial review to the Supreme Court of Nova Scotia seeking to enforce the "*Minutes of Settlement*" that had been agreed in June 2003 to be a final and binding settlement of all matters in dispute. Dr. Horne sought a court order that would declare the "*Minutes of Settlement*" a legally binding agreement between the parties, declare that Capital Health had breached the agreement, reverse the variation of Dr. Horne's privileges, and make an order to set aside the proceedings regarding Dr.

Horne's privileges by the PRC "*… for the reason that the PRC lacks jurisdiction to consider any further action regarding Dr. Horne's privileges as that matter is now settled by the terms of the Minutes of Settlement …*"

Also in late January 2004, the Dalhousie Faculty of Medicine unanimously approved a definition of collegiality which read, "*Collegiality is broadly defined as the ability to function* professionally *within the academic community, and involves the demonstrated willingness to work with colleagues in contributing to the academic mission and governance of the department, the Faculty of Medicine, and Dalhousie University. As such, it is evaluated within the context of professional activities in the area of teaching, research and administration, and, where applicable, clinical service."*

In that same meeting one member sought assurance that if the clinical position of a Faculty Member were in jeopardy that the Member would not lose her/his associated position in the Faculty of Medicine. The Dean responded that Faculty members are hired with defined roles that relate to the specific areas of teaching, research, administration, and clinical service. If a problem relating to clinical privileges arises, the Faculty of Medicine deals only with the other specified areas of the Faculty member's position, not clinical matters. This statement by the Dean reflects one of the principal weaknesses in the Affiliation Agreement and suggests that the full implications of what was happening to Dr. Horne, and others, was not fully appreciated by the Dean of Medicine.

Also in late January 2004, this Independent Committee of Inquiry was established, as discussed in Chapter 1.

In early January, members of the Division of Cardiology were asked to access a draft document called *Cardiology Webpage 2004* on a shared network drive to review and update their profiles. That draft document was critical of Dr. Horne's publication record, and noted that her collegiality and her "*modus operandi*" were the basis of ongoing investigations under the Medical Staff Disciplinary Bylaws. Later the same day, the Dalhousie President and Vice-President Academic reported to the Dalhousie Senate that Dr. Horne's case was completely settled and that there were no outstanding issues. After objections from counsel for Dr. Horne about the prejudicial and defamatory nature of these entries in the draft Cardiology webpage, the document was removed and revised, with apologies from the Cardiology Division Chief.

In late February 2004, counsel for Dr. Horne informed the PRC that the intent of the court action was to request a court declaration that the "*Minutes of Settlement*" constituted a settlement regarding the variation of Dr. Horne's privileges, and that if it did, Dr. Horne's position was that the variation of privileges issue was settled and PRC had no jurisdiction to continue with its investigation. He also stated that Dr. Horne was entitled to natural justice and judicial review was permitted to ensure that CDHA had acted in compliance with the requirements of the Bylaws.

In early March 2004, the CDHA accounting office provided Dr. Horne with a review of the status of her research accounts. Dr. Horne was instructed on how to complete the financial reporting aspect of one of her externally funded research grants. Dr. Horne was also told that any

payroll obligations that would result in additional charges to her research grants must be terminated immediately.

Also in early March, Dr. Horne was informed that the Canadian Institutes of Health Research (CIHR) had placed her grant in abeyance from April 2003 until the end of March 2005 or until CIHR received confirmation that the serious problems Dr. Horne had reported were resolved.

In mid-March 2004, the School of Biomedical Engineering unanimously approved a renewal of Dr. Horne's cross-appointment with the Department of Medicine. The School was informed that Dr. Horne's cross-appointment had been extended to coincide with the extension of her Department of Medicine appointment until the end of June 2005. Dr. Horne informed the Dean of Medicine that in her opinion she had earned a renewal rather than an extension, and she wished the renewal to be granted.

In early April 2004, counsel for Dr. Horne informed counsel for PRC that Dr. Horne wished to pursue all avenues that could bring about a speedy resolution of the privileges matter, and, accordingly, PRC could proceed with its investigation even in the face of the application by Dr. Horne for judicial review. Counsel for CDHA also requested that PRC proceed at the very earliest opportunity. At the end of April, 2004, counsel for PRC confirmed that PRC would proceed with its investigation, and provided instructions for written submissions from CDHA and Dr. Horne.

Also in early April 2004, counsel for Dr. Horne requested clarification from CDHA counsel about the status of the application form for renewal of her appointment that the Cardiology Division Chief had requested she return. In particular, he asked if it was the intention of CDHA to proceed with a review of Dr. Horne's privileges with an intent to revoke her privileges.

In mid-May 2004, CDHA counsel provided a written submission to counsel for PRC. That submission requested that PRC affirm the variation of Dr. Horne's privileges, that Dr. Horne be required to undergo an assessment of her suitability to continue in her present role of a clinician scientist, and that Dr. Horne's maintenance of competence be reviewed to ensure that the variation of her privileges was sufficient from a patient safety perspective. Specifically, it was requested that Dr. Horne be required to undergo assessment at the Professional Renewal Centre and that the results of that assessment be made available to CDHA Administration. It was also requested that PRC investigate the steps taken by CDHA to reintegrate Dr. Horne to clinical practice and to support her research. In response, counsel for Dr. Horne stated that the Professional Renewal Centre was a centre for doctors with substance abuse problems and personality disorders and that Dr. Horne would not entertain any suggestion that she suffered from either of these problems. Counsel for Dr. Horne went so far as to characterize the proposal as *"offensive*." As discussed previously in this report, confidentiality is required for all who seek help from such external bodies. Maintaining patient confidentiality is an everyday practice for physicians, and it is ironic that full disclosure would be required in these circumstances.

In mid-May 2004, Dr. Horne was informed that her revenue share for her 2004 clinical duties had been reduced by 4%.

In mid-June 2004, Dr. Horne was informed that her research accounts were in an overdraft and that she was required to halt any activity that would increase that overdraft. Capital Health declined to provide additional funding, and Dr. Horne was required to terminate her research nurse/coordinator and a graduate student, all that remained of her research staff.

In late June 2004, CAUT requested that the government of Nova Scotia step in to resolve the ongoing variation of privileges of Dr. Horne and Dr. Goodyear. Before the end of June, the government announced a review of the Medical Staff (Disciplinary) Bylaws and invited participation from all district health authorities and Doctors Nova Scotia.

Unfortunately, even had the case been settled as the mediation had intended, Dr. Horne would have been unable to revert to the status she held on the morning of October 21, 2002 because too much damage, much of it irrevocable, had accumulated in the meantime. As discussed below, Dr. Horne later turned to the courts seeking damages from several parties involved in this dispute.

Dr. Horne's case seeking an order from the Nova Scotia Supreme Court to enforce the "*Minutes of Settlement*" was heard by The Honourable Justice Donald M. Hall on September 8, 2004. Justice Hall concluded that the CDHA Board did not have the power to delegate its authority over privileges to the CEO and that the Board had not authorized the CEO to negotiate a settlement on behalf of the Board. Justice Hall dismissed the application.

In late October 2004, the Dean of Medicine requested a progress report from Dr. Horne concerning her Clinical Research Scholar Award. He reminded Dr. Horne that her Department Chief also needed to write a letter for the Review Committee's consideration. Dr. Horne was denied a meeting with the Dean to discuss this matter. Dr. Horne stated that her working environment had not been modified for increased research as expected. She stated that the variation of her privileges had resulted in increased clinical activity, restricted her access to heart failure patients, and thrown her research program into chaos, which had a catastrophic effect on her ability to do research. Dr. Horne also stated that CDHA refused to implement the negotiated settlement and that Dalhousie had taken no meaningful action to have that agreement implemented, which had caused her research to shut down in June 2004. After describing her current research, Dr. Horne stated that she could not provide a progress report for her Clinical Scholar Award because the award had not yet been implemented.

The Canadian Medical Protective Association (CMPA) had assisted Dr. Horne with legal representation during the DMAC process. In mid-December 2004, the CMPA told Dr. Horne that the issues involved in further negotiations of settlement were outside the assistance available from the CMPA.

In mid-March 2005, the Dean of Medicine required Dr. Horne to provide a complete report by early April 2005 including papers published and letters from her external mentor for the Clinical Scholar Award and from her Department Chief. The Dean stated that since October 2001 financial support for the award had been provided to the Department of Medicine (presumably meaning the Alternate Funding Plan, which paid the remuneration of Dr. Horne), and therefore he could not agree that the award had not been implemented. Dr. Horne reminded the Dean of correspondence from him in October 2001 (when he was Associate Dean Research)

that he could not discuss her concerns about the research environment and the commitment of the Division and Department related to the Clinical Scholar Award until the issues related to her clinical activities had been resolved. She also referred to correspondence from the previous Dean of Medicine on these topics in October 2002, in which Dr. Horne was told the Dean's hands were tied until the privileges review had been completed. Dr. Horne also reviewed the failure of the interim protocol for recruitment of patients to Dr. Horne's research studies. She stated that funds had not flowed to her, nor could she conduct research, so, in her opinion, the award had not been implemented.

At the end of March 2005, the Chief of the CDHA Department of Medicine resigned and the physicians in the Department of Medicine adopted a fee-for-service system in the aftermath of a failure to reach agreement with the Nova Scotia Department of Health on a new Alternate Funding Plan contract.

In mid-May 2005, the Dean of Medicine responded that Dalhousie had no standing to participate in the CDHA privileging and discipline process and had no legal jurisdiction to change or influence that process. He stated that, like Dr. Horne, Dalhousie had no option but to let the CDHA privileges process unfold. He stated that Dalhousie had met its obligations under the settlement agreement but that the courts had determined that the settlement was not binding on CDHA. He stated that the Department of Medicine (again, presumably meaning the Alternate Funding Plan) had been receiving the Clinical Scholar Program funds since October 2001 and had been using them as a supplementary source of funding for Dr. Horne's remuneration. He stated that Dr. Horne had indicated that she could not report significant research activity or related publications. The Dean stated that he had concluded that to continue to support Dr. Horne's salary through the Clinical Research Scholar program was unsupportable and that Dr. Horne's Clinical Research Scholar award must be rescinded immediately.

One week later, Dr. Horne informed the Dean that she intended to seek redress through the Dalhousie Senate using a Senate regulation that allowed any faculty member who believed that (s)he had been given less than fair treatment in any matter for which settlement procedures were not expressly provided in any other regulation to carry the matter before Senate. At the end of May 2005, Dr. Horne filed her appeal with the Secretary of the Dalhousie Senate. Two members of Senate gave notice of motion that the Dean of Medicine retract his letter rescinding the award, and commit the Department of Medicine to implement fully the award for a five-year period to commence on the first day of the month after a resolution of the hospital privileges dispute in Dr. Horne's favour.

The Chair of the Dalhousie Senate considered this motion premature because there had been no meeting between Dr. Horne and the Dean to attempt to resolve the matter. Two Members of Senate objected on the grounds that a Dean should not be able to prevent a matter coming to Senate simply by refusing to meet with the individual submitting the grievance. The item was placed on the agenda of Senate for June 27, 2005, and both Dr. Horne and the Dean were given an opportunity to make a submission.

In mid-June 2005, the Dean of Medicine proposed to Dr. Horne that after her privileges were fully restored, under certain conditions, she would receive two years of the Clinical Scholar Award with 70% time protected for research and an additional three years of 50% or greater

protected time, to be funded entirely through Divisional and Departmental salary and resource arrangements. The condition was that in order to continue this arrangement after fifteen months, Dr. Horne would be expected to provide evidence of research grants to support ongoing work and substantial progress toward at least two publications in high-quality peer-reviewed journals. If Dr. Horne could not demonstrate these accomplishments, her clinical profile would be increased.

Dr. Horne informed the Dean that this proposal did not constitute a resolution of her grievance and opted to proceed to Senate. The Senate chose to establish a "*Special Committee of Inquiry*" to which Dr. Horne had the right to appoint two members of Senate, and she did so in early July 2005.

The DMSA-appointed Peer Review Committee

In mid-August 2005, Dr. Horne asked the President of the District Medical Staff Association (DMSA) for assistance in resolving the ongoing problem in her working environment. In mid-October, 2005, exactly three years after Dr. Horne's privileges had been varied summarily, the DMSA appointed a Peer Review Committee consisting of four highly regarded physicians, none of whom had any obvious prior involvement with Dr. Horne, or the other cardiologists involved in her case, and all of whom worked in different medical specialties. That committee asked Dr. Horne, the CDHA CEO, and the Acting Department of Medicine Chief to provide all documentation relevant to the case, including any documentation or information that had arisen since the DMAC proceedings. Dr. Horne provided the Committee with unaltered documentation from DMAC and PRC. Neither the CEO nor the Acting Department of Medicine Chief appears to have provided any documentation. The Report of the Peer Review Committee considered three allegations against Dr. Horne.

The first allegation was that Dr. Horne's research threatened the safety of patients. The Peer Review Committee found that there was no evidence that Dr. Horne's research threatened the safety of patients. Dr. Horne's research program functioned in a similar manner to others in the Division, and Dr. Horne was transparent with her colleagues and attempted to involve them in reviewing her studies. The Committee found that the more stringent review requirements put in place for research protocol review were not in place when Dr. Horne's privileges were varied and were not normative standards in the Division. Regarding the DMAC report, the Committee found that the central allegation was that the charts of patients enrolled in Dr. Horne's study were not identified and this constituted a safety issue, but an investigation by REB found that all the charts in this study were identified.

The second allegation was that Dr. Horne's research conduct breached research ethics. The Peer Review Committee did not identify any evidence that Dr. Horne's research conduct breached research ethics, and found that the REB had no ethical or safety concerns with her research. The Committee found that any research review policies of the Division were not in place at that time, and only became operational subsequently. The Committee noted that there were no safety concerns identified by any of the physicians attending the special meeting at which Dr. Horne presented her research protocols after her privileges were varied.

The third allegation was that Dr. Horne lacked collegiality in a clinical setting, which the Committee found nebulous and difficult to address. The Committee found no evidence that Dr. Horne lacked collegiality. The Committee found this allegation neither substantiated nor consistent with the documented history of Dr. Horne as a highly valued resident and Fellow; the high regard for her by the nursing staff and patients; the adulatory letters of reference; the large numbers of individuals who wrote letters corroborating Dr. Horne's collegiality; or the fact that Dr. Horne had developed multidisciplinary research collaborations requiring significant collegiality, transparency, and compromise. The Committee found that this allegation was made by only two of more than twenty Medical Staff cardiologists, and that the original allegation raised by the Director of the HFC was repeated either verbatim or paraphrased by others in administrative positions.

The Report also found that the HFC lacked procedures for developing consensus among independently functioning Attending Physicians. The Committee found that the insistence of the HFC Director and the Cardiology Division Chief that Dr. Horne consult with the HFC Director over patient management would have been a reasonable request of a trainee but would not be the norm for interactions between independent Attending Physicians. The Committee stated that this lack of procedures for developing consensus in the clinic structure exacerbated the differences among the respective Attending Physicians and contributed to the events that followed.

The Report also stated that Dr. Horne made the most overtures in an attempt to resolve problems, and that there did not seem to be documented evidence of attempts by senior department administrators to examine the basis for tensions between Dr. Horne and the two other cardiologists prior to the disciplinary action.

The Report found the Disciplinary Bylaws process worrisome because hearings were held that did not permit both sides of the dispute to hear the evidence presented, and other physicians who could have provided both an external perspective and more objective assessments of the collegiality issue did not appear to have been invited to provide oral or written testimony concerning the issues.

The Peer Review Committee Report contained the following conclusions "… *career altering changes in professional privileges imposed on Dr. Horne by CDHA administration … were based on three allegations. The Committee closely examined these and found no documentation to support the allegations that Dr. Horne's research conduct threatened the safety of patients or breached research ethics. As Dr. Horne defended herself against all three allegations, the frequency and amplitude of the accusatory 'lack of collegiality' increased while those of the other two allegations diminished in the face of contradictory documentation. This, in the Committee's view, makes the allegations and thus the reason for the variation of privileges subjective and unsupported … Dr. Horne had developed a unique, externally funded research program that has been irreparably altered. Her ability to continue an academic research career has been halted by the prolonged process utilized by CDHA to examine these allegations. In the interests of all parties including CDHA this committee recommends that CDHA expeditiously re-examine these issues and re-instate Dr. Horne's full privileges*."

CAUT threatens censure of Dalhousie University

In the fall of 2005, the President of Dalhousie was told that CAUT intended to begin censure proceedings against Dalhousie University in the spring of 2006 unless the University acted to restore natural justice to Drs. Horne and Goodyear and took action to mitigate the damage to their academic careers.

In early January 2006, the President of Dalhousie wrote to the Chair of the CDHA Board expressing concerns about the ongoing CDHA Privileges Review process for Drs. Horne and Goodyear and urging that immediate steps be taken to bring the process to a conclusion. The President of Dalhousie also stated that in the event a conclusion was not forthcoming in the very near future, the intervention of the Minister of Health would be warranted.

In parallel with these events, the Nova Scotia Department of Health was conducting a review of the Disciplinary Bylaws, and the CDHA CEO and Chiefs of Staff were told in mid-January 2006 that there would be a redraft of the Bylaws available for discussion in the near future.

In mid-January 2006, Dr. Horne wrote to Nova Scotia Premier John Hamm to explain her situation, inform him of the findings of the Peer Review Committee, and request that the Government of Nova Scotia acknowledge that the Disciplinary Bylaws process had not been followed by CDHA in her case. Premier Hamm's office responded that the Minister of Health had been asked to look into Dr. Horne's concerns.

Also in mid-January 2006, Dr. Horne met with the CDHA Board Chair to propose that the CDHA CEO withdraw the allegations against her, and that the CDHA Board then move to restore her full privileges because the Board could not proceed to a hearing in the absence of a dispute. Dr. Horne stated that the only resolution of the privileges matter that she would accept would be withdrawal of the allegations, exoneration by the Board, and restoration of her full privileges. Dr. Horne indicated she was prepared then to discuss an out-of-court settlement with respect to damages.

One week after Dr. Horne's meeting with the CDHA Board Chair, the CDHA CEO offered "*without prejudice*" to meet Dr. Horne in the presence of their respective counsel with a view to starting a process to accomplish a resolution. Dr. Horne requested that neither lawyers nor PRC be involved. The CEO stated that it was not possible for CDHA to resolve these Disciplinary Bylaw matters without involvement of the PRC. The CEO stated it might be possible to request that PRC review any proposed settlement without detailed investigation, analysis, and report, but that CDHA could not guarantee that PRC would accommodate such a request in light of the active role contemplated in the Disciplinary Bylaws for PRC. The CEO stated that to resolve effectively this matter, it must be done pursuant to currently existing and legally mandated requirements.

In early February 2006, legal counsel for the CDHA Board informed the PRC that the HFC ceased to operate on a shared-care model effective January 1, 2006, and that Dr. Horne had made a longstanding decision to withdraw from the ACHD clinic. Counsel stated that in these circumstances there might be no practical utility in maintaining an ongoing variation of Dr.

Horne's privileges and the CDHA Administration did not object to Dr. Horne's privileges being restored in full. Counsel suggested it would be appropriate for the PRC to make that recommendation because the change in the underlying facts made the variation not operationally useful or necessary. Counsel also stated that this action did not constitute an acknowledgement by CDHA that the variation ought not to have been imposed in the first instance.

Counsel for Dr. Horne responded to the PRC that Dr. Horne wanted a full and unqualified reinstatement of her privileges in the HFC and ACHD and a statement that her privileges should never have been varied. Counsel also asked for clarity on the other issues raised by the CDHA Administration in submissions to PRC, in the form of a retraction of those allegations regarding Dr. Horne's clinical competence, safety of her research projects and procedures, and related matters. Counsel also asked for clarity on whether the CDHA Administration agreed that it was not necessary for Dr. Horne to have clinical and research mentors. Counsel also stated Dr. Horne had expended considerable money and time in defending herself, and had lost her research program and career advancement, but had received no indication from the CDHA Administration of how those losses were to be compensated.

On March 13, 2006, the Dalhousie University Senate unanimously passed a motion "… *to express its profound concern about the extended delay in reaching a conclusion to the review of clinical privileges involving two faculty members at Dalhousie University, Dr. Gabrielle Horne and Dr. Michael Goodyear … the inordinate delay in bringing closure to these matters raises serious concerns about the process itself. Insofar as the Board of the Capital District Health Authority seems unable to bring this matter to closure, we ask Premier Rodney MacDonald to review the matter and take the necessary steps, with the appropriate officials, to ensure that justice is done …*" During discussion of the motion, the Dalhousie Vice-President Academic stated that members of the academic community were well aware that this variation of privileges could have enormous consequences for the ability of colleagues to conduct medical research and carry out their full professorial duties. The VP Academic also stated that Dalhousie had taken remedial action to the extent of its abilities and could not deal with the matter further until the CDHA review process was completed.

Three days later, the President of Dalhousie informed the Premier of Nova Scotia of the motion from Senate. The President said that the ongoing problem had undermined the operation of the university and the hospital and their ability to serve the people of Nova Scotia. The President also stated that, in his opinion, "*justice delayed is justice denied*," a view that appears highly relevant in this instance. He said Dalhousie had fully cooperated with the CDHA Board in the hope that these matters could be brought to a conclusion, but had been frustrated by the lack of progress. The President said that CDHA claimed it lacked authority to ensure a reasonably speedy process, and also observed that, although all responsible parties acknowledged a problem, they also claimed an inability to act. This Committee of Inquiry notes that the President might also have observed that responsible parties at Dalhousie were aware of the problems and had also claimed an inability to act.

In mid-March 2006, the Director of the Ethics Office of the Canadian Institutes of Health Research reported to Dr. Horne on the investigation of a complaint she had filed about noncompliance with CIHR research policies. Dr. Horne was informed that Dalhousie had determined that decisions regarding Dr. Horne's practice privileges at CDHA were governed by

the CDHA Bylaws which precluded Dalhousie from participating. Dr. Horne was told that CIHR had done all it could to assist in resolving her dispute with CDHA over practice privileges. Regarding the length of time this matter had taken, Dr. Horne was told that Dalhousie had indicated she had not submitted an allegation under Dalhousie's Policy on Integrity in Scholarly Activity, an action which would be required to trigger the response timelines under that policy. Dr. Horne was told that the CIHR file on her complaint was closed.

In mid-April 2006, the President of Dalhousie committed to render a decision on Dr. Horne's application for promotion by June 1, 2006, in the event that CDHA did not dispose of her case satisfactorily by that time. The President also stated that most of the issues in the cases of Drs. Horne and Goodyear lay beyond the authority of the University and were beyond its control. At the end of May, 2006, the President recommended to the Dalhousie Board that Dr. Horne be promoted to Associate Professor retroactive to 2003, the date on which her promotion would have become effective if it had not been put into abeyance by the variation of Dr. Horne's privileges. Among other things, the criteria for promotion required Dr. Horne to demonstrate collegiality in clinical care, research, and teaching. In promoting Dr. Horne, the Dalhousie President accepted that Dr. Horne had done so.

The hearing by the CDHA Board

The Privileges Review Committee finally issued its report to the CDHA Board on March 17, 2006, more than three years after the receipt by PRC of the DMAC Report, instead of the twenty days specified in the Disciplinary Bylaws. The report was approximately five hundred pages long and included discussion of many issues that were unrelated to the question of whether CDHA had just and sufficient grounds on October 21, 2002, to vary summarily the privileges of Dr. Horne.

In early April 2006, Dr. Horne was informed that the Board would hold a hearing on May 16, 2006. The hearing was to consist of an oral presentation by Dr. Horne or her counsel, with questions from the Board, followed by an oral presentation by the CEO or his counsel, with questions from the Board, and finally a rebuttal by Dr. Horne. There were also to be written submissions by both Dr. Horne and the CDHA CEO. Counsel for Dr. Horne objected that the proposed hearing was inadequate and would continue to deny natural justice to Dr. Horne. Counsel for Dr. Horne stated that natural justice guaranteed Dr. Horne the right to present evidence and to cross-examine witnesses, which neither DMAC nor PRC provided. Counsel for Dr. Horne also stated that the burden in the hearing rested with the CDHA CEO and that evidence from the CEO should be presented first. After substantial discussions among counsel, it was agreed to schedule a Board hearing in September 2006, with the full protections of natural justice. As part of the preparation for that hearing, the Administration and Dr. Horne produced lengthy and detailed prehearing briefs.

In late August 2006, counsel for Dr. Horne submitted that the variation of Dr. Horne's privileges were specifically in the HFC and ACHD and did not make reference to the terms "*team care*" or "*shared care*," neither of which were terms generally understood in cardiology. He also submitted that because there had been no protections of natural justice in the hearings of DMAC or PRC, it would be a denial of natural justice to adopt as factual the findings of DMAC

and PRC. Counsel also submitted that Dr. Horne still held privileges in the ACHD when her privileges were varied even though she was not actively working in the ACHD at that time, and she had never resigned those privileges. The PRC report and its attached documents were sealed by the Board and played no role in the Board hearing, although both Dr. Horne and CDHA Administration made extensive use of the PRC materials in their prehearing briefs.

At the beginning of the Board hearing, counsel for Dr. Horne raised a preliminary question of whether there was sufficient evidence on October 21, 2002, to invoke Article 8.1 of the Disciplinary Bylaws and vary Dr. Horne's privileges. The Board accepted the characterization of Article 8.1 as "*an emergency variation*."

On September 8, 2006, the Board ruled "… *the evidence supports that corrective action was needed with respect to Dr. Horne's interactions with her colleagues, specifically her lack of collegiality. The Panel finds, however that Dr. Horne's lack of collegiality was not sufficiently problematic to invoke the 'emergency variation' pursuant to Article 8.1, on October 21, 2002 … the Panel's* decision *is that Dr. Horne revert to the status she held on the morning of October 21, 2002. The Panel notes that Dr. Horne had voluntarily withdrawn from the Adult Congenital Heart Clinic (the 'ACHC') in March 2002. Accordingly, whether or not she is permitted to return to the ACHA is a matter for Administration and not for this panel …*"

On October 24, 2006, an article in the News section of the Canadian Medical Association Journal reported on Dr. Horne's case and the decision of the CDHA Board. The article stated that the Board had reinstated all Dr. Horne's privileges. It also quoted the acting CDHA CEO as saying that the reinstatement turned solely on a procedural issue. The article then quoted other statements in the Board ruling concerning Dr. Horne's alleged behaviour, including that the Board accepted that the Administration had reason to try to correct that behaviour. Counsel for Dr. Horne was quoted as objecting that the Board had no basis for these statements, which he called "*gratuitous comments*," because there had been no hearing in which Dr. Horne could rebut evidence and present evidence in her defense. The article also quoted Dr. Horne as saying she would take the CDHA to court for damages.

Events following the Board Ruling

At the beginning of November 2006, Dr. Horne requested that she be scheduled to resume work in the ACHD clinic and to read ACHD echocardiograms, and that this clinical work replace the general ambulatory clinic in which she had worked on an interim basis while her privileges case was subject to the Disciplinary Bylaws process. Dr. Horne also stated that all those responsible for what had happened should focus on restoring her research program to where it would have been if the summary variation of privileges had not occurred. The Cardiology Division Chief refused this request on the grounds that the Board ruling had stated that CDHA Administration was responsible for deciding whether she would return to the ACHD from which she had voluntarily withdrawn prior to the variation of her privileges. He stated that the current physician resource requirements were all met by the current complement of physicians working in that area, that practice in the ACHD clinic would detract from Dr. Horne's ability to reactivate her research and meet the deliverables as a clinical scholar, and that her presence in the same clinic as the two cardiologists who had brought forward the allegations against Dr. Horne was

not in the interests of the patients in that clinic. The Cardiology Division Chief provided a list of things that were imperative for Dr. Horne, including, among others, that Dr. Horne should seek mechanisms for divisional colleagues to collaborate with her with a view to enhancing her research and the research interests of the Division. It appears that even at this late date the understanding that Dr. Horne's academic freedom protected her right to choose her research collaborators remained incomplete.

In late November 2006, the Dean of Medicine asked the Department of Medicine Chief to assist with Dr. Horne's resumption of her Clinical Research Scholar Award by not later than January 1, 2007.

At the end of November 2006, Dr. Horne wrote the Dean of Medicine to request that he intervene in the refusal of the Cardiology Division Chief to reinstate Dr. Horne to her previous ACHD duties. The Dean stated that Dr. Horne's clinical activities in cardiology fell under the purview of the Cardiology Division Chief, that the Dean was guided by recommendations of the Division Chief, and that he accepted the decision of the Division Chief.

As previously mentioned, Dr. Horne turned to the courts seeking damages. At the end of November, 2006, Dr. Horne filed a Statement of Claim in the Supreme Court of Nova Scotia. The Defendants in the case were the QEII Health Sciences Centre; CDHA; the Department of Medicine (DOM), an unincorporated association of physicians in the Department of Medicine that operated the Alternate Funding Plan and determined the revenue share of physicians including Dr. Horne; the Cardiology Division Chief; and the Interim CEO of CDHA who had stated that the CDHA Board decision had turned solely on procedural matters. At the time of final editing of this report, that court proceeding had not been concluded.

In early January 2007, Dr. Horne discussed her concerns about working in the ACHD Clinic with the CDHA Vice-President, Clinical Care (Acute Care Services). The VP Clinical Care told Dr. Horne these issues would be best addressed through the Cardiology Division Chief, the Department of Medicine Chief, or the VP Medicine.

In early February 2007, Dr. Horne brought to the attention of the newly appointed CDHA CEO that when the CEO had been Acting VP Medicine in October 2002 Dr. Horne had made to her a complaint of bullying and escalating harassment, just days before the variation of Dr. Horne's privileges. That complaint had not been investigated. Dr. Horne stated that the VP Academic Affairs at that time had promised that these matters would be dealt with once the privileges matter had been resolved. Dr. Horne stated that since her privileges had been restored there had been no process to remediate her work environment, and asked if the CEO was prepared to take action to deal with the working environment faced by Dr. Horne.

The CDHA CEO responded that she and the Chief of Medicine would consider any cases that arose after the decision of the CDHA Board in September of 2006, and that were not part of Dr. Horne's civil action against Capital Health. She stated that she had reviewed the Board decision and the materials submitted in the civil lawsuit and that Dr. Horne's allegations of bullying and lack of collegiality had been fully canvassed at a senior level. In her view, there was no further benefit to pursuing another internal review.

In early March 2007, Dr. Horne responded to the CEO. She stated that the fact she was suing CDHA for its conduct did not release CDHA from its responsibilities to her, and that the lawsuit underscored the gravity of the situation and the consequences of ignoring it. Dr. Horne pointed out that the processes under the Disciplinary Bylaws do not provide for investigation of harassment allegations and were solely concerned with patient safety allegations. Dr. Horne stated that the only legally legitimate finding was the Board's decision that the allegations that Dr. Horne had compromised patient safety were unfounded, based on documents that had been available to all parties for almost four years. In Dr. Horne's opinion, that finding was a *de facto* finding of harassment, and spoke to the severity of the underlying harassment and to the need for the Administration to deal with it. Dr. Horne stated that harassment in her work environment was preventing her from reestablishing her research program.

The Statement of Claim set out Dr. Horne's credentials and the requirements of her contract, including that success in research was a condition for renewal of Dr. Horne's appointment. Dr. Horne claimed that Dalhousie and CDHA had an obligation to investigate allegations of research misconduct using impartial and accountable procedures within an established time frame through mechanisms consistent with due process and natural justice. They also had an obligation to protect or restore the reputation of people falsely accused. Dr. Horne claimed that CDHA owed a duty of care to Dr. Horne to provide a supportive work environment, to protect her academic freedom, to ensure that she received her protected research time, and to protect her reputation. The Statement of Claim alleged that Dr. Horne had been subject to harassing behaviour, interference with her research, and violations of her academic freedom, which unlawfully interfered with Dr. Horne's contractual obligations, damaged her research career, and damaged her reputation. The Statement of Claim also alleged that actions had been taken against Dr. Horne on the basis of false allegations that her research was unsafe, that she potentially endangered patients, that she was uncollegial, and that she failed properly to follow ethical research procedures. The Statement of Claim alleged that DMAC and PRC purported to make findings of fact against Dr. Horne, which they were not entitled to do, and that the Board did not hold a hearing with the rights of natural justice and had no basis to make remarks in its decision that harmed Dr. Horne's reputation. The Statement of Claim stated that Dr. Horne had been denied the right to natural justice. Dr. Horne sought damages and legal costs. The Defendants denied all of Dr. Horne's claims. The matter remains before the Court at the time of final editing of this report.

Lessons from the case history

Like Dr. Nassar, Dr. Horne came to CDHA and Dalhousie with strong preparation, and a positive record as a resident. The Sobey Fellowship Dr. Horne was granted for postgraduate studies was intended to provide further research opportunities to promising physicians with the hope that they would return to CDHA/Dalhousie and make significant contributions to research. When Dr. Horne was appointed to a full-time permanent position as Medical Staff in the Division of Cardiology, from the beginning there were a number of positive signs and promising research was begun. At that time, Dr. Horne was the only PhD trained female cardiologist in Canada, and the only cardiologist at CDHA to also hold a PhD. Dr. Horne was successful in attracting external grants in support of her research. The problems began with some interpersonal

conflicts with the Director of the HFC, and to a somewhat lesser extent with the Director of the ACHD. These conflicts were not resolved, and many additional issues arose.

Lessons from other cases were also apparent in this case

There were a number of lessons from the case of Dr. Nassar that were also apparent in the case of Dr. Horne. The extraordinary powers of the Department Chief and the authority-based model of leadership were readily apparent. The decision by the Chief of Medicine to vary summarily Dr. Horne's privileges put in place a series of events over more than four years that resulted in considerable damage to Dr. Horne and her career.

The inordinate power of the Alternate Funding Plan was also demonstrated when Dr. Horne's remuneration was reduced both in real terms and relative to that of her cardiology colleagues. As previously discussed, the same person acted as Chief of Medicine to vary Dr. Horne's privileges and then acted as Chief of the Alternate Funding Plan to reduce Dr. Horne's remuneration before the case against Dr. Horne had been heard, let alone decided.

The imbalance of resources between individual members of the Medical Staff and CDHA was as apparent in the case of Dr. Horne as it was in the case of Dr. Nassar. On many issues, over a number of years, Dr. Horne retained legal counsel at her own expense. On a number of occasions, Dr. Horne met on her own with her Division and Department Chiefs, and with other CDHA officials, without assistance from counsel or an advisor or representative. In the opinion of this Committee, Dr. Horne was at a distinct disadvantage on too many occasions.

Taken together, the extraordinary power of the Department Chief and the AFP, and the imbalance of resources available to Dr. Horne to defend her interests, pose an unacceptable threat to the academic freedom of Medical Staff.

Many of the same lessons discussed in the other cases about shortcomings in CDHA policies and procedures applied in the case of Dr. Horne. In addition, the lessons learned by analyzing the problems that arose in using the Disciplinary Bylaws in the cases of Drs. Horne and Goodyear are discussed in Chapter 4.

Allegations of workplace harassment must be promptly and fully investigated

In the case of Dr. Nassar, there was a longstanding complaint that he faced a hostile work environment, which was not promptly and fully investigated. Dr. Nassar's complaint was combined with a number of other unrelated issues into the mandate of the external Reviewer. In the case of Dr. Horne, her allegation that she faced bullying and escalating harassment in her workplace was also not promptly and fully investigated. Dr. Horne was told that the CDHA Board decision, and the various materials submitted in the civil lawsuit filed by Dr. Horne, had fully canvassed Dr. Horne's complaint of harassment. Dr. Horne responded that the Disciplinary Bylaws process was limited to allegations that Dr. Horne had compromised patient safety, and specifically excluded other matters such as the effect of the variation of Dr. Horne's privileges on her research program. Dr. Horne suggested that the inordinately lengthy Disciplinary Bylaws

process was a *de facto* instance of harassment. By contrast, this apparent reluctance of CDHA to address complaints of harassment laid by Dr. Horne was not apparent when the harassment complaint was laid against Dr. Nassar.

Standard policies and procedures are required

As in the case of Dr. Nassar, appropriate policies and procedures were lacking on a number of occasions. One example was the lack of policies and procedures in the Division of Cardiology for approving research protocols and reporting the results of research. In the case of Dr. Horne, this lack of policy led to allegations that Dr. Horne's research protocols had not been approved, and that they were in some way unsafe and unethical despite having all the required approvals by the Research Ethics Board. The Division Chief attempted to impose unilaterally a policy on approval of research protocols that had not been discussed or approved by the Division.

The Director of the HFC, with support from the Division Chief, attempted to impose unilaterally a policy that the selection of research subjects from patients of the HFC be done exclusively by him. Dr. Horne was concerned that such a policy would have a negative impact on her research program and was inconsistent with her rights as an Attending Physician in the HFC. After Dr. Horne's privileges were varied to remove her from the HFC, the Director also insisted that only Attending Physicians from the HFC could approve participation in Dr. Horne's research. These policies and procedures were not standard, approved policies, and their creation not only undermined Dr. Horne's ability to continue with her research, but caused a sharp increase in distrust.

Dr. Horne faced an imbalance in the power relationship with the HFC Director

There is an inherent imbalance in the power relationship between a relatively new female member of the Medical Staff and a well-established senior male who held a position as Director of a major clinic, and threatened to resign as Director unless his view of matters was supported by the Division Chief and the Department Chief. There need to be resources to mitigate this imbalance. This is one of the important ways in which mentors can support relatively inexperienced members of the Medical Staff like Dr. Horne. It is also one of the important ways in which a suitable organization with the power to represent an individual member of the Medical Staff would have been useful.

Interpersonal conflicts must be resolved promptly

Much of what happened in the case of Dr. Horne had origins in interpersonal conflict between Dr. Horne and the Director of the HFC. Dr. Horne believed the behaviour of the HFC Director was disrespectful and amounted to bullying and harassment. Dr. Horne made attempts to resolve the conflict but was unsuccessful. She asked for assistance from senior administrators, which was not forthcoming. Instead, it was alleged that Dr. Horne lacked collegiality and insight into her actions. This Committee is not aware of any attempt to engage advisors, mentors, mediators, or conflict resolution consultants to assist prior to the mediation leading to the

"*Minutes of Settlement*" discussed earlier in this report. That settlement was not accepted by the PRC.

While Dr. Horne was involved in the HFC, the clinic operated on a "*shared care*" model, in which a patient might be assigned to see a different physician on each visit and the team of physicians worked together to provide consistently appropriate care. Open and transparent sharing of information among the physicians is essential to ensure quality care, which in turn requires professional and respectful communication. One of the principal allegations that was to be directed against Dr. Horne was that interpersonal conflict in a clinic operating on a "*shared care*" model posed a serious risk to patients. From that perspective, it is surprising that the CDHA administration did not take more steps to resolve the conflicts in a timely manner despite repeated requests by Dr. Horne for assistance in resolving this matter.

Too few resources were applied to prevention of disputes

One of the features shared by the cases considered in this Inquiry is the striking imbalance between the resources applied to preventing disputes from arising or attempting to resolve them in a timely manner when they did arise, and the resources used to carry out investigations and disciplinary actions against those who were alleged to be the origin of the problems. The former resources were rare, whereas the latter resources seemed to be nearly unlimited in scope, as the thousands of pages of documents produced during these cases attest. There should be a focus on means of preventing disputes arising by having clear, collegially developed and approved, policies in place on important matters likely to result in disagreements. There should also be a focus on reaching a timely, fair, final, and binding resolution of disputes that do arise. Applying resources to problem-solving is likely to be more efficient and certainly less costly than using resources in disciplinary proceedings. A focus on preventive measures rather than disciplinary actions is to be preferred. Recommendations for accomplishing these objectives are contained in Chapter 9.

Clear misunderstandings of academic freedom were not corrected

The Division Chief attempted to require that Dr. Horne make active participation in her research projects available to every cardiologist in the Division, and expressed disapproval that she had not included the Director of the HFC as a co-investigator. The Division Chief also told Dr. Horne that if she did not commit to do so, he would be unable to recommend that her privileges be renewed. Academic freedom provides Dr. Horne with the right to choose to collaborate, or not to collaborate, with anyone of her choice, and to suffer no negative consequences for those choices. Similarly, academic freedom protects Dr. Horne's right not to share her intellectual property with others. This clear misunderstanding of one of the basic tenets of academic freedom should have been recognized and quickly corrected by senior administrators.

Professional counselling is a personal and confidential choice

Concerns were expressed about the nature of the interpersonal communications between Dr. Horne and certain colleagues. She was told that the fundamental issue was her choice not to collaborate with some other cardiologists, and that she was therefore the source of the tension. Dr. Horne was requested to seek external professional assessment and to agree to have the counsellor provide her Division Chief with regular updates of her progress. In effect she was being told that she was responsible for the tension with others because she insisted on her academic freedom to choose her collaborators, and that she needed counselling to correct the matter. The choice to work with a counsellor was Dr. Horne's alone to make, and both the fact that she was doing so and the results of the counselling are strictly confidential. Many large institutions have Employee Assistance Plans to provide such counselling on a strictly confidential basis.

Meetings on disciplinary matters should include observers or advocates

On a number of occasions Dr. Horne met alone with her Division Chief and/or her Department Chief on matters that were clearly of a disciplinary nature. In such circumstances, members of the Medical Staff should have the right to be accompanied by a person of their choice as a supporter, advisor, or advocate. The meeting between Dr. Horne and the HFC Director to discuss the Director's concerns also involved legal counsel for both parties. An appropriate organization with the power to represent individual members of the Medical Staff could play an important role in such circumstances.

Expressed concerns about patient safety and quality of care must be bona fide

Patient safety and quality of care will always be a prime concern in a tertiary care teaching hospital such as CDHA. However, safety concerns must be *bona fide* and not a convenient framing for events with a different core. In the disputes over Dr. Horne's research protocols, it was alleged that the protocols presented a safety risk. The protocols all had peer review and REB approval, and no safety concerns were identified when Dr. Horne presented her protocols at a special Division meeting. Because the Disciplinary Bylaws require that privileges may only be varied summarily when there is an actual or reasonably likely risk to patient safety, many of the allegations against Dr. Horne were framed as safety issues when they were actually related to research matters that had been shown not to involve risk to patients. Such use of the term "*patient safety*" risks debasing the term.

The division of responsibilities between CDHA and Dalhousie was ineffective

The Dalhousie VP Research quickly identified that the decision to vary Dr. Horne's privileges was a serious decision that could have a major impact on academic rights and freedoms. He was told that the issues of clinical and professional relationships needed to be dealt with by CDHA alone through the CDHA Disciplinary Bylaws. Only after that matter was settled could the research issues be addressed. In Dr. Horne's case, her clinical status in the HFC was integrally connected with her ability to recruit appropriate patients as research subjects. Had the Disciplinary Bylaws process been resolved in the ten days anticipated by the Associate Dean of Medicine for Research in accordance with the timelines in the Bylaws there might have been no harm done, but the process took four years and a promising research program was shut down. Dalhousie had no effective influence on matters that were at the core of Dalhousie's mandate.

The agreement to waive time deadlines had unacceptable repercussions

Dr. Horne and CDHA Administration mutually agreed to waive the timelimits specified in the Disciplinary Bylaws. It could not have been foreseen at the time of the agreement that a decision to waive a ten-day deadline would result in the case not being decided for over four years. In the meantime, all of the consequences of the variation of Dr. Horne's privileges remained in place and the damage accumulated.

VP Medicine's DMAC role inhibited her involvement in achieving a resolution

The VP Medicine and VP Academic Affairs were members of DMAC, engaged in judging the case for the variation of Dr. Horne's privileges. The VPs considered their DMAC role to be incompatible with working with Dr. Horne to resolve the issues in dispute. Shortly after DMAC issued its report, the VP Medicine offered to facilitate an interim restoration of Dr. Horne's duties. These discussions led to an agreement to retain an external mediator to assist the parties in resolving the disputes. The VP Academic Affairs assisted Dr. Horne by arranging for bridge funding for her research, which helped to reduce the damage. Had these interventions occurred at an earlier stage, much of the damage might have been avoided.

The mediated settlement included terms that could have been implemented as soon as Dr. Horne began to experience difficulties

All of the major parties involved in the dispute, including the Chief of the Department of Medicine, the CEO of CDHA, and representatives of Dalhousie University, participated in the mediation. The parties made an agreement on a no-fault, going-forward basis. That meant that there was no agreement on whatever fault may or may not lie with any individuals, but rather, the parties had agreed to move forward on the basis of a clearly stated set of expectations that would hopefully avoid a repetition of the problems that had arisen in the past. It called for two

mentors to assist Dr. Horne, one with her clinical duties and one with her research role as a clinician scientist. It returned Dr. Horne to her duties in the HFC under a reintegration plan, which was to be proposed by Dr. Horne in consultation with the mentors. It also provided Dr. Horne with a clear statement from the Department Chief of expectations to be met by all Medical Staff in the Department. In the opinion of this Committee, these mentor arrangements and clear statement of expectations could have been put in place as soon as, or even before, Dr. Horne began to experience difficulties. Doing so in a timely manner, instead of proceeding with disciplinary action, might have avoided the subsequent events that consumed so many resources and did so much damage. But for reasons discussed previously, the agreement was never implemented.

Some basic principles of the choice and role of mentors were misunderstood

There is extensive literature on the role of mentors in clinical and research environments.[25] There is a consensus that a successful mentor/mentee relationship is based on a high level of trust between the mentee and the mentor. Mentors must not only be acceptable to the mentee, but must also be trusted to offer confidential advice and guidance to the mentee and to hold in strict confidence matters discussed between them. A mentor is a confidante, sounding board, advisor, and sometimes advocate or defender, not a monitor, judge, assessor, or supervisor. Mentors cannot be imposed. Failure to understand these principles led to disagreements on the choice and role of mentors for Dr. Horne, which were not resolved. No mentors were appointed, the mediated agreement was not implemented, and the damage continued to accumulate.

Dalhousie lacked the tools to intervene to protect fundamental rights of faculty

On several occasions, Dalhousie officials claimed that they lacked the means to intervene to ensure fair treatment in a reasonable time for Dr. Horne and Dr. Goodyear. The Dean of Medicine reported that Dalhousie had no standing to participate in the Disciplinary Bylaws process and no jurisdiction to change it or to intervene. Despite Dalhousie's full involvement in the mediated settlement, the PRC made it clear that Dalhousie had no role in the Bylaws process and could not be a party to a recommendation of a proposed solution to the CDHA Board. The President of Dalhousie asked the CDHA Board Chair to take steps to bring the matter to a conclusion shortly after receiving notice that CAUT intended to initiate censure proceedings against Dalhousie. In the event that a conclusion was not forthcoming quickly, the President indicated that the intervention of the Minister of Health would be warranted. When the Dalhousie Senate passed a motion asking the Nova Scotia Premier to take the necessary steps to ensure that justice was done, the Dalhousie VP Academic stated that Dalhousie had taken action to the extent of its abilities and could not deal with the matter until the CDHA Disciplinary Bylaws process was complete. When the President of Dalhousie wrote to inform the Premier of the motion of Senate, he indicated that CDHA claimed it lacked authority to ensure a reasonably speedy process, and he observed that all responsible parties at CDHA claimed an inability to act.

[25] See *Mentorship in Academic Medicine*, Sharon E. Strauss and David L. Sackett, Wiley, 2014

Recommendations for a new Cooperative Partnership between CDHA and Dalhousie are discussed in Chapter 9.

The DMSA-appointed Peer Review Committee demonstrated the usefulness of independent external reviews

Within two months of their appointment, the Peer Review Committee found no evidence for the allegations that Dr. Horne's research threatened the safety of patients or for the allegation that Dr. Horne's research breached research ethics. The Peer Review Committee found there was no evidence that Dr. Horne lacked collegiality, that the allegation was made by only two of more than twenty cardiologists, and that the original allegation had been raised by the Director of the HFC and had been repeated either verbatim or paraphrased by CDHA administrators. The Peer Review Committee found that the HFC lacked procedures to develop consensus among the independently functioning Attending Physicians, a deficiency that contributed to the problems that arose. They also remarked that the insistence that Dr. Horne consult the HFC Director over patient management decisions would have been appropriate for a trainee, but was not to be expected for interactions among independent attending physicians. They also stated that Dr. Horne had made the most overtures in an attempt to resolve the disputes, and that there did not seem to be documented evidence of attempts by senior administrators to examine the basis of the tensions between Dr. Horne and her two colleagues. This Committee is at a loss to understand why, if the Peer Review Committee could conclude an investigation in two months, PRC required four years to deal with the same matters.

Summary

This Inquiry found that the basic cause of the serious damage done to the career of Dr. Horne was not the specific actions of individuals but the deficient framework of policies, procedures, and foundational documents in place, and in some cases not in place, at CDHA and Dalhousie.

These deficiencies included, among others, an Affiliation Agreement that failed even to mention, let alone to protect, academic freedom; an Affiliation Agreement that was interpreted to preclude any influence by Dalhousie University on matters that threatened the careers of Dalhousie faculty members and were manifestly denying them justice; Disciplinary Bylaws that were seriously deficient; the lack of appropriate procedures for investigating complaints fairly, promptly, and with appropriate protections for the rights of all concerned; the lack of adequate procedures to reach a final and binding resolution of disputes in a fair and timely manner; an apparently broadly held misunderstanding of some basic concepts such as academic freedom, collegiality, and harassment; an appointment and remuneration system for medical faculty that posed a serious threat to academic freedom and basic rights; a reliance on a rigid hierarchical authority structure that faulted colleagues who vigorously defended their rights for not showing sufficient deference to the authority of the Administration and its various officers and agents; and a lack of clearly established Divisional policies on important matters such as procedures for approving clinical research protocols and appropriately informing physicians about the conduct of that research.

Many of the lessons learned in the case of Dr. Horne are similar to those demonstrated by the case of Dr. Nassar. Although the principal parties involved were different from those in the case of Dr. Nassar, many of the same systemic weaknesses in policies, procedures, and medical academic culture were as apparent in the case of Dr. Horne as they were in the case of Dr. Nassar.

A major difference in these cases was the use of the CDHA Disciplinary Bylaws in the case of Dr. Horne. Those Bylaws were triggered when the Chief of the Department of Medicine varied the privileges of Dr. Horne and the Acting CEO of CDHA approved the variation. A process that was designed to take a number of days dragged on for nearly four years. The many problems that arose during the Bylaws process are discussed in other sections of this report.

Chapter 7 will discuss the case of Dr. Goodyear, which also involved the CDHA Disciplinary Bylaws. Some of the lessons learned in the cases of Drs. Nassar and Horne were also demonstrated in an even more exaggerated form in the case of Dr. Goodyear.

Chapter 7 | Case of Dr. Michael Goodyear

Academic Background

Dr. Michael Goodyear's *Curriculum Vitae* lists extensive training and experience in a broad range of institutions and environments before he came to the QEII HSC and the Dalhousie Medical School. Dr. Goodyear was a graduate of Monash University Medical School, Melbourne Australia (1972). In the period between 1970 and 1983, Dr. Goodyear held several internships and residencies in Australia, the UK, and Canada. In 1980–81, Dr. Goodyear became Senior Resident in Medicine and Acting Chief Resident at the Princess Margaret Hospital and Ontario Cancer Institute, University of Toronto. Between 1981and 1983, Dr. Goodyear was a Fellow of Clinical Oncology at the Princess Margaret Hospital and Ontario Cancer Institute, University of Toronto, and a Visiting Consultant Medical Oncologist at the Thunder Bay Regional Cancer Centre. From 1983 to 1985, he also served as a medical oncologist at the Port Arthur, St. Joseph's, and McKellar General Hospitals, Thunder Bay. In 1985, Dr. Goodyear became a Fellow of the Royal College of Physicians and Surgeons of Canada for Internal Medicine. From 1983 to 1997, Dr. Goodyear served as a clinical associate at the Hamilton Regional Cancer Centre at the Henderson and Hamilton General Hospitals and St. Joseph's Hospital, of the McMaster University Medical Centre, McMaster University in Hamilton, Ontario.

Dr. Goodyear's departure from McMaster

On December 2, 1997, Dr. Goodyear's appointment as a Clinical Associate in the Department of Medical Oncology at McMaster was terminated. Although the termination was initiated by the employer, and Dr. Goodyear denied the substance of the allegations, the terms of the termination were mutually agreed to by both Dr. Goodyear and his employer and did not include any admission of wrongdoing by either party. Such separation agreements are commonly used when both parties have an interest in moving forward without the stress, expense, and delay of legal proceedings and fault-finding. One of the disadvantages of this approach was displayed in this case. There was neither hearing nor adjudication of the issues involved in the termination, which had the unfortunate effect of allowing suspicion of wrongdoing to linger without a factual base. It is not surprising, therefore, that this termination was to cast a long shadow over Dr. Goodyear's later career at CDHA (Capital District Health Authority)/Dalhousie. Notwithstanding this termination, a number of Dr. Goodyear's Hamilton colleagues subsequently recorded their positive opinions of Dr. Goodyear's performance in Hamilton.

Dr. Goodyear's initial appointment to QEII/Dalhousie and extensions

In 1998, Dr. Goodyear sought a position at the Nova Scotia Cancer Centre at the QEII Health Sciences Centre in Halifax. There was some hesitation about employing Dr. Goodyear based on what was inferred about his termination at McMaster. Nevertheless, on November 9, 1998, Dr. Goodyear was offered and accepted a *locum tenens* appointment as a medical oncologist at QEII HSC, a position that was to run from November 30, 1998, to February 26, 1999. Dr. Goodyear was also granted temporary privileges as a member of the Active Staff in the

Department of Medicine. Dr. Goodyear was also appointed to a position as Assistant Professor in the Department of Medicine at Dalhousie University.

In January 1999, Dr. Goodyear's *locum tenens* appointment was extended to June 30, 1999. Under the terms of this extension, Dr. Goodyear's remuneration was paid by the newly established Department of Medicine Alternate Funding Plan. This arrangement for Dr. Goodyear's remuneration was to have serious negative consequences for Dr. Goodyear at a later stage in this case.

Dr. Goodyear appears to have performed his duties satisfactorily because his positions and privileges were extended several times. For example, a letter offering an extension of Dr. Goodyear's *locum tenens* appointment to September 1999, jointly signed by the Chief of Medicine and the Head of the Cancer Care Services, who was also the Acting Chief of the Division of Medical Oncology, described Dr. Goodyear's services as "*invaluable*" and told him they had received many complimentary remarks about Dr. Goodyear's commitment to the Cancer Program and about his compassionate and attentive patient care.

This sequence of short-term contracts allowed Dr. Goodyear's performance to be monitored closely. It seems reasonable to infer from these extensions that there was a decrease in the initial uneasiness about Dr. Goodyear's appointment, and an increased interest in keeping Dr. Goodyear in Halifax. There was also some consideration given to the possibility of offering him a more permanent appointment. Dr. Goodyear had himself broached the issue of a more permanent appointment.

Nevertheless, there was still residual uneasiness about Dr. Goodyear's performance. Some of this unease was based on Dr. Goodyear's past history; some, on more current observations. One concern involved Dr. Goodyear's prescription of treatment regimens reported at academic meetings but not sanctioned by his Halifax colleagues. Another involved perceptions by some nurses that his clinical decisions were not always appropriate for the circumstances of his patients. These concerns were not, however, sufficient to prevent extensions of Dr. Goodyear's contract.

As administrative efforts to keep Dr. Goodyear simultaneously employed and supervised continued, there was a shift in administration. A new Chief of the Division of Medical Oncology was appointed, one who had come from Hamilton and was more familiar with Dr. Goodyear's difficulties at McMaster than were the administrators who had offered Dr. Goodyear his first Dalhousie contracts. When the CDHA Board ultimately held hearings on the Goodyear case, two witnesses testified to the effect that the new Division of Oncology Chief had formed a negative opinion of Dr. Goodyear while both were employed in Hamilton. The Board found that while there was tension between Dr. Goodyear and the Chief of the Division of Oncology, there was no evidence that the Division Chief, or anyone else, acted with malice toward Dr. Goodyear.

Despite the unease about Dr. Goodyear's past history, a compromise about Dr. Goodyear's continuing employment was reached. Dr. Goodyear was offered and accepted a one-year contract for 2000, the longest contract he had received thus far, but one that mandated continued supervision and a formal review of his performance. This review would become part of Dr. Goodyear's application for a full-time position should one be offered in the near future and

should Dr. Goodyear apply. On its face, however, this review was prejudicial to Dr. Goodyear because it treated Dr. Goodyear differently from other candidates for a full-time permanent position in oncology by requiring Dr. Goodyear to meet additional criteria. The letter offering the position contained an Appendix, which, among other matters, required Dr. Goodyear to accept and uphold the direction offered by the Division of Oncology Chief and the Department of Medicine Chief. Such a provision is inappropriate if the direction offered to Dr. Goodyear conflicts with his academic freedom. Dr. Goodyear's academic freedom also allows him to be critical of the Division Chief and Department Chief.

In the summer of 2000, Dr. Goodyear's Division Chief advised Dr. Goodyear in writing of a variety of ongoing concerns. The Division Chief indicated that, in his opinion, some of Dr. Goodyear's clinical judgments were faulty, that there were problems with collegiality, and that there were issues arising over Dr. Goodyear's availability when he was on call. Moreover, the Division Chief stated that Dr. Goodyear had failed to modify his behaviour after these matters were pointed out. As a result of these continuing problems, the Division Chief limited Dr. Goodyear's new patient activities. From later comments by the Chief of the Department of Medicine, it would appear that this letter from the Division Chief to Dr. Goodyear was intended to constitute the formal review referred to above.

If so, there were problems with this assessment. Among them, (1) there was no notice to Dr. Goodyear about a review; (2) there was no request for Dr. Goodyear to provide a statement or other evidence that he wished to have considered; (3) there was no request for a list of people who could provide a range of opinion about Dr. Goodyear's performance; (4) there was no Committee formed to conduct a peer evaluation; and (5) there was no opportunity for Dr. Goodyear to comment on the evidence. The Oncology Division Chief's letter apparently was not based on these procedures required for a formal performance review.

Dr. Goodyear responded to the criticism offered by the Division Chief by taking the matter up with the Chief of the Department of Medicine. Dr. Goodyear wrote an extended refutation of the Division Chief's criticisms, pointing out that various allegations made by the Division Chief had never been investigated or previously brought to Dr. Goodyear's attention. The Chief of the Department of Medicine proved unsympathetic, dismissing all aspects of Dr. Goodyear's response to the criticism of the Division Chief without any apparent concern about the procedures used by the Division Chief in reaching his assessments, or any independent investigation by the Department Chief of the allegations made by the Division Chief. Indeed, in the written response of the Chief of the Department of Medicine to Dr. Goodyear, all the allegations made by Dr. Goodyear's Division Chief were reiterated. Dr. Goodyear was told that by refuting the Division Chief's criticisms, he had given the Department Chief concerns about Dr. Goodyear's insight and ownership of these deficiencies.

The upshot of the purported review was that an "*action plan*" was formulated, the most salient features of which were that Dr. Goodyear and his Division Chief would meet weekly and that all concerns about Dr. Goodyear's performance would be brought to his attention in a timely manner. In late fall 2000, the Chief of the Department of Medicine wrote to Dr. Goodyear noting improvement in Dr. Goodyear's performance while pointing out some concerns.

Despite the expressed concerns of the Division of Oncology Chief and continued unease about Dr. Goodyear's performance, Dr. Goodyear's contract was extended for a further six months, to end in June 2001. The offer was similar to the previous one, but contained an Appendix with specific conditions that involved continued supervision of Dr. Goodyear's performance. By this point, Dr. Goodyear had held a total of six *locum tenens* appointments of various durations.

At the same time as Dr. Goodyear was being renewed, the Division advertised a permanent position as Staff Medical Oncologist. Dr. Goodyear was advised that, as part of this extension offer, the criticism of his performance within the Division and the Department would be taken into account should he choose to apply for the permanent position.

Dr. Goodyear's appointment to a regular staff position

Dr. Goodyear applied for the permanent position in January, 2001. As his application was being processed, complaints regarding Dr. Goodyear's booking practices were brought to Dr. Goodyear's attention by the Division Chief, an action consistent with the previously formulated "*action plan*." Despite the criticism, in June 2001 Dr. Goodyear was offered a regular full-time appointment, which he accepted.

At this point in Dr. Goodyear's work relationship with the Hospital and the Department of Medicine, his appointment and privileges had been considered six times by each of the Division of Medical Oncology, the Department of Medicine, the Privileges Review Committee, the District Medical Advisory Committee, and the QEII Board. Those making these assessments had a great deal of information available to them about Dr. Goodyear and his performance, and in each case they chose to appoint him and grant him privileges in medical oncology. After a national search, Dr. Goodyear was offered a regular appointment and hospital privileges in medical oncology after yet another round of assessments. In total, then, by the time of his appointment to a regular staff position, there had been a total of seven assessment rounds, each round involving assessment by five different bodies. There can be few physicians who had received as much scrutiny as Dr. Goodyear during that two and a half year period. It appears reasonable to conclude that Dr. Goodyear's credentials, experience, and performance were repeatedly judged to meet an appropriate standard for appointment.

Dr. Goodyear's experience as a regular staff Medical Oncologist

From the beginning of his appointment, Dr. Goodyear expressed concern about certain types of cancer treatments then in use in the Division of Medical Oncology at CDHA, especially since several patients had died of toxicity using the then-current Saltz regimen. Dr. Goodyear also attended professional conferences and meetings in which new cancer treatments were discussed and advocated. Dr. Goodyear found these experiences enlightening, and sought to engage his colleagues in a general discussion of cancer treatments that included concerns about current practice and standard protocols.

In February 2002, Dr. Goodyear drafted and circulated a discussion paper on alternate treatments for gastro-oesophageal cancer. Informal discussion of appropriate treatment proceeded, but no consensus among the physicians tasked with treating oesophageal cancer was reached. The discussion about appropriate treatments involved consideration of the medical efficacy of the treatments, but also the various costs involved in the different treatments. The discussion of appropriate treatments soon became strained.

Dr. Goodyear nevertheless continued to advocate for new treatments for his patients and attempted to bring these concerns forward despite obstacles such as cost, absence of local guidelines, worries about consistency in treatment, and the apparent reluctance of the Division Chief. At the heart of this ongoing discussion was Dr. Goodyear's belief, oft reiterated, that treatment needed to be suited to the individual needs of the patient. Implicit in Dr. Goodyear's advocacy for new approaches was his resistance to the apparent desire of the Division Chief to achieve consensus about treatment norms or protocols, from which there was to be little deviation.

One of the central issues that was to appear in the case later made against Dr. Goodyear was his implementation of infusional techniques (the "*Douillard protocol*") to replace the Saltz regimen in some cases during the summer of 2002. Dr. Goodyear had strongly advocated adopting the Douillard Protocol as a standard protocol in CDHA, but there had been no consensus agreement among his colleagues, other than to discuss this potential new protocol in the fall of 2002. It was later alleged that this change of treatment protocols by Dr. Goodyear put patients at risk because there had not been appropriate training of nurses and involvement of the pharmacy in the delivery of this new treatment. Dr. Goodyear refuted these allegations and pointed to a list of actual deaths from toxicity in patients who had been prescribed the Saltz regimen. Much later, in the final stage of the Disciplinary Bylaws process against Dr. Goodyear, after hearing expert testimony, the CDHA Board ruled that Dr. Goodyear's use of the Douillard protocol had not exposed patients to harm.

The variation and then the suspension of Dr. Goodyear's hospital privileges

The Division Chief's criticism of Dr. Goodyear's performance

In October 2002, the Division Chief wrote to Dr. Goodyear about problems he had with Dr. Goodyear's performance. The Division Chief focused on Dr. Goodyear's desire to use new therapies, which, according to the Division Chief, led Dr. Goodyear to bypass due process and thereby subject patients to risk. The Division Chief also faulted Dr. Goodyear for disrupting group consensus. Another complaint was that Dr. Goodyear had neglected to bill in a timely manner.

The Division Chief then took up three of Dr. Goodyear's cases about which he had concerns. These cases were to become part of the cases cited in the Administration's evidence against Dr. Goodyear. Later, when all of these cases were considered by the CDHA Board and subject to expert scrutiny, the Board found that none of these cases ought to have been cause for

varying or suspending Dr. Goodyear's hospital privileges. However, those Board findings were a long way in the future.

The Division Chief noted that the problems he was raising were not new, but were throwbacks to matters raised earlier with Dr. Goodyear, and which the Division Chief thought had been satisfactorily resolved. The Division Chief found their recurrence worrying, and he warned Dr. Goodyear that failure to resolve these matters might lead to the nonrenewal of Dr. Goodyear's hospital privileges.

Response of Dr. Goodyear to criticisms by the Division Chief

Several days later, Dr. Goodyear responded at length to the points raised by the Division Chief. Dr. Goodyear expressed surprise at the criticism, noting that the Division Chief had instituted a series of regular meetings to address any issues that might arise, but these meetings were discontinued because, according to Dr. Goodyear, the Division Chief did not deem them necessary. Moreover, no criticism of Dr. Goodyear's performance was raised during the course of the first year of his current appointment.

Dr. Goodyear then explained his reasons for the decisions he made regarding the three patients whose treatment was of concern to the Division Chief. With regard to the Division Chief's concern about due process, Dr. Goodyear noted that he found the pace of implementation of changes in cancer treatments frustratingly slow, but he had advised the Division Chief of his substitution of alternatives to the Saltz regimen, and these alternate treatments were always approved by the Division Chief. Dr. Goodyear concluded by rejecting the assessment of his performance by the Division Chief as unbalanced, limited as it was to the negative.

Dr. Goodyear then proposed that more opportunities be provided for the medical oncologists to meet together in a nonthreatening environment, express their concerns, and thus clear the air. In the event that the group was unable to undertake this clearing of the air on their own, Dr. Goodyear suggested the possibility of external intervention by someone with expertise in conflict resolution. Dr. Goodyear acknowledged that there were issues in dispute, but he did not accept that it was up to him alone to resolve them by changing his practice. He believed that these issues needed to be addressed by the group as a whole.

Variation of Dr. Goodyear's privileges by Department Chief

On October 10, 2002, Dr. Goodyear's privileges were varied summarily, restricting his practice to the provision of ongoing care to those patients for whom he was presently responsible. In a letter to Dr. Goodyear, the Department Chief explained the reasons for this action. Among them, in the view of the Department Chief, Dr. Goodyear showed little understanding of the problems with his performance despite many efforts to bring those problems to his attention. The Department Chief went on to state her concerns for patient safety and care and the collegial functioning of the Division and the care teams, which were underlying the restriction being placed on Dr. Goodyear's privileges. As described in Chapter 4, the CDHA CEO must approve any action to vary privileges of a member of the Medical Staff. The CEO did not ask for an explanation of how Dr. Goodyear's continued care for his present patients was

consistent with the requirement in the Disciplinary Bylaws that a variation of privileges must be based on a threat to the safety of patients.

The external clinical experts who ultimately examined Dr. Goodyear's practice at the CDHA Board hearing, however, did not consider it unusual that colleagues might disagree on the treatment to be offered in complex cases. Those clinical experts advised that the appropriate question to ask was not whether the Division Chief, or the other members of the Division, agreed with Dr. Goodyear's decisions in these cases, but whether Dr. Goodyear's performance fell within the bounds of a reasonable standard of care defined by the profession as a whole, and they concluded that it did. The Board ultimately ruled that none of the cases presented by CDHA to justify the Department Chief's actions ought to have been cause for variation or suspension of Dr. Goodyear's privileges.

Further Investigation by Department Chief subsequent to variation

The Department Chief then undertook to seek further written documentation to support the variation. A more reasonable and fairer process would have been one in which the investigation of all allegations took place before the imposition of penalties, rather than after. Indeed, the Bylaws require that the Department Chief make a finding that Dr. Goodyear's actions expose, or are reasonably likely to expose, patients to harm or injury or are adversely impacting, or are reasonably likely to impact, the delivery of patient care. To meet the requirements of the Bylaws, there must be an investigation leading to such a finding before the variation of privileges can be imposed.

As the Department Chief sought further documentation, a number of written assessments by other members of the medical and nursing staff, largely critical of Dr. Goodyear, were received by the Division Chief, apparently at his request. In particular, some of Dr. Goodyear's colleagues in the Division of Medical Oncology provided examples of cases in which they had concerns about Dr. Goodyear's performance. Some of these cases were among those later considered by the Board and found not to justify the variation of Dr. Goodyear's privileges.

Letter from Department Chief about Dr. Goodyear's performance

On October 30, 2002, Dr. Goodyear met with the Department Chief. In the letter sent to Dr. Goodyear that same day, the discussion was summarized and a response was requested. The concerns raised included (1) failure to abide by the restrictions put on Dr. Goodyear's privileges; (2) problems related to the management and delivery of the Douillard protocol, including failure to provide adequate information to nursing staff and pharmacists; (3) failure adequately to advise patients about toxicities involved in their plan of care; (4) failure to accept feedback from colleagues; and (5) failure to deal appropriately with several patients.

Also recorded in the letter is the agreement of both Dr. Goodyear and the Department Chief to waive the timelines outlined in Section 8.2.2 of the Disciplinary Bylaws. That provision would have required Dr. Goodyear to make a written submission to DMAC within ten days. This waiver was clearly to Dr. Goodyear's advantage at this juncture. However, the practice of waiving the timelines in the Disciplinary Bylaws ultimately resulted in the extremely long delay

in reaching a conclusion to the charges against Dr. Goodyear, a situation that would seriously disadvantage Dr. Goodyear.

Dr. Goodyear's response to letter of Department Chief

On November 11, 2002, Dr. Goodyear addressed in writing the concerns raised by the Department Chief. Dr. Goodyear began by providing an explanation of what had happened with regard to the patient whose circumstances had prompted the Department Chief to complain that Dr. Goodyear had breached the variance of his privileges. In the view of Dr. Goodyear, no breach had occurred because he had merely proceeded to implement a treatment plan that had been established before Dr. Goodyear's privileges had been restricted.

Dr. Goodyear then took up the other points raised by the Department Chief. With regard to the delivery of the Douillard regimen, Dr. Goodyear stated that he had provided a great deal of background material to the GI medical oncology group, the nursing staff, and pharmacists. Dr. Goodyear further stated that he believed he had been scrupulous in providing patients and their families with the necessary information on toxicities, and went on to make the point that it would be difficult to create an objective standard by which to judge whether or not this information has been effectively transmitted.

With regard to feedback, Dr. Goodyear explained that, although he had differences of opinion about cancer treatment with his colleagues, he was always respectful of their opinions, sought to advance discussion by circulating relevant literature, and indicated that his academic freedom allowed him to engage with his colleagues in this manner. With regard to patient care, Dr. Goodyear provided detailed accounts of his treatment of the patients in question to indicate that he had not placed them at risk. Dr. Goodyear ended his lengthy reply hoping that the problems raised might be resolved in a nonconfrontational manner. Unfortunately, the proceedings under the Disciplinary Bylaws proved to be adversarial in nature.

It is amply clear from Dr. Goodyear's letter responding to the Department Chief that his understanding of team participation and consensus differed from the understanding held by his Division Chief, some of his other colleagues, and his Department Chief. Eventually, at the CDHA Board hearing, medical experts testified to the Board that the appropriate standard was whether Dr. Goodyear practiced within the bounds of generally accepted standards in the profession, professional standards that may not be the same as the opinion held by the majority of Dr. Goodyear's colleagues. Judged from this perspective, the Board concluded that Dr. Goodyear did indeed practice within the bounds of the generally accepted standards in the profession. That vindicating assessment was, however, years away.

Further Investigation of Dr. Goodyear's practice by Division Chief

On November 15, 2002, the Division Chief sent the Department Chief a summary of his review of the charts brought to his and the Department Chief's attention as examples of Dr. Goodyear's performance deficiencies. He concluded that Dr. Goodyear was unable safely to treat patients suffering from advanced stages of cancer.

Response of Department Chief to Dr. Goodyear's letter

On November 20, 2002, the Department Chief wrote to Dr. Goodyear summarizing a meeting of the same day and referencing Dr. Goodyear's letter of November 11. The Department Chief took the view that Dr. Goodyear's letter failed to address the Chief's concern about patient safety and care, and the other matters raised.

This judgment failed to take into account that Dr. Goodyear had written an extensive, point by point response to the issues raised by the Division Chief. There is, moreover, no evidence of which this Committee is aware that the Department Chief undertook an independent assessment of the criticisms made of Dr. Goodyear's performance by the Division Chief or of the validity of the explanations offered in response to those criticisms by Dr. Goodyear. Instead, the Department Chief advised Dr. Goodyear that, without further information from Dr. Goodyear, there was no other option but to proceed with Sections 8 (the variation of privileges) and 9 (a special review with a view to terminate) of the Disciplinary Bylaws.

The Department Chief then proposed an alternative approach in which Dr. Goodyear would attend a professional renewal centre in Kansas at his own expense in order to obtain an independent assessment of his fitness to practice medicine. At the end of the process, the Department Chief required access to the results. The recommended centre dealt primarily with disruptive behaviours, sexual misconduct, burnout, substance abuse, and mental illness. It is not surprising that Dr. Goodyear did not find the Department Chief's proposal that he enrol at this centre likely to resolve matters since his difficulties did not arise from the issues this centre was set up to address.

Responses to the proposals of the Department Chief by Dr. Goodyear and his legal counsel

In his response, Dr. Goodyear concluded that when the Department Chief stated that Dr. Goodyear did not adequately address the concerns raised, what the Chief meant was that Dr. Goodyear had not agreed that he had indeed committed the errors of judgment that the Chief attributed to him. Dr. Goodyear said he was unable to make that admission. He did, however, want the conflict resolved in a nonadversarial way, perhaps by an independent mediator who might facilitate a resolution to the problems raised not only for himself, but for everyone involved. Several days after Dr. Goodyear responded to the Department Chief, Dr. Goodyear's legal counsel wrote to the CDHA legal counsel reaffirming that Dr. Goodyear would not agree to attend the renewal centre.

Having rejected the professional renewal centre option, Dr. Goodyear proposed to have an independent external review of his patient care and other related matters as long as the independent review also included the practices of other members of Dr. Goodyear's Division.

The rejection of the proposals of Dr. Goodyear and his legal counsel

In response to the letter from Dr. Goodyear's legal counsel, the CDHA legal counsel reiterated the two possibilities presented by the Department Chief, with a further possibility, that Dr. Goodyear might consider replacing his clinical care practice for one that would involve no direct patient care. This third option involved more than either the variation or the suspension of Dr. Goodyear's privileges; it mandated that he agree to leave the field in which he was trained, qualified, and licensed. This third option would have been punitive in the absence of any finding that Dr. Goodyear's practice did not meet the generally accepted standards for the field as a whole.

Dr. Goodyear's proposal of an external review having been rejected, and he being unwilling to accept either the professional renewal centre option or the termination of his ability to continue his practice in oncology, Dr. Goodyear had no other option but to proceed pursuant to the Disciplinary Bylaws.

Timelines — what proceeding pursuant to the Disciplinary Bylaws meant

It is useful to review the requirements of the Disciplinary Bylaws then in place, as discussed in detail in Chapter 4.

The Department Chief could request a review under Section 9 of the Bylaws and inform DMAC and Dr. Goodyear within twenty-four hours, giving the grounds and the remedy sought. Dr. Goodyear would then have ten days in which to provide a written and/or oral response to the charges.

DMAC then would have ten days from the time it received the written response or heard the oral response in which to investigate and submit its recommendations to the Privileges Review Committee (PRC). The CEO, District Chief of Staff, and the member concerned all had ten days in which to make a submission to PRC. The PRC then might either negotiate a settlement or conduct any investigation it thought necessary.

The PRC then made a recommendation to the Board within ten days of receiving the submissions of the CEO, District Chief of Staff, or the member. The CEO or the member would have ten days to give notice of their intention to proceed to a hearing before the CDHA Board.

The Board was then required to hold a hearing and make a decision, subject to the right of the member (but not the CEO) to appeal to the Provincial Appeals Board. There is no maximum time by which the Board must hold the hearing and reach a decision.

It would appear that, in adding these maximum times together, there is a maximum period of fifty-one days from the time the decision to vary privileges was made by the Department Chief until the CDHA Board receives notice of the need for a hearing.

The decision by the Department Chief to vary the privileges of Dr. Goodyear was made on October 10, 2002. The first hearing of the Board was held June 25, 2008, almost six years later. The Board's decision, issued on January 26, 2009, six years after the suspension of Dr. Goodyear's privileges in January 2003, ruled that there was no basis to vary or suspend Dr. Goodyear's privileges, and ordered that Dr. Goodyear be returned to the status he had on October 9, 2002.

This extraordinary delay in reaching a decision that exonerated Dr. Goodyear did grievous harm to Dr. Goodyear. Indeed, as discussed below, this extraordinary delay resulted in Dr. Goodyear being effectively removed from practicing his profession despite the Board finding that there was no basis for the original variation and suspension of his privileges.

Suspension of Dr. Goodyear's privileges

On December 21, 2002, despite the variation of his privileges that disallowed him from treating new patients, Dr. Goodyear wrote a consultation report concerning a patient at the Dartmouth General Hospital who was the wife of a long-time patient of Dr. Goodyear, a woman who was not, however, a patient of Dr. Goodyear's. It was this action that precipitated the suspension of his privileges on January 9, 2003.

Dr. Goodyear disputed that he had breached the restrictions on his privileges, noting that he had not initiated any new treatments for this patient. The Department Chief remained unpersuaded, and the suspension remained. When the CDHA Board ultimately ruled on this matter, it stated " *strictly speaking, Dr. Goodyear breached the variation on his privileges … from a humane desire to provide support to a family member of a patient … as such … the breach was not sufficient to fully suspend Dr. Goodyear's privileges*."

The Board ruling was six years away. In the meantime, Dr. Goodyear was prevented from carrying out all his clinical and teaching duties.

Further investigation of Dr. Goodyear's clinical practices after suspension

Soon after the suspension of Dr. Goodyear's privileges, the Department Chief launched a review of Dr. Goodyear's clinical practices. The review the Department Chief proposed to carry out following Dr. Goodyear's suspension should, under the Disciplinary Bylaws then in effect, have been carried out prior to any decision to vary Dr. Goodyear`s privileges, not after.

To allow documentation to be gathered for presentation to DMAC, the CEO of Capital Health and Dr. Goodyear both agreed to waive the timelines embedded in the Disciplinary Bylaws process.

Report to the CDHA Administration regarding six cases of Dr. Goodyear

In January, 2003, legal counsel for CDHA requested an assessment of six of Dr. Goodyear's cases by a medical oncologist practicing in Toronto. Dr. Goodyear was not consulted about the selection of the medical oncologist, nor was he consulted about the cases that were selected for assessment or the terms of reference. The legal counsel for Dr. Goodyear suggested an alternative approach, proposing instead that an independent medical oncologist review the files of Dr. Goodyear and other members of the Division. This suggestion was not accepted.

The report of the external medical oncologist employed by CDHA supported the contention of the Department Chief that Dr. Goodyear showed poor clinical judgment. Dr. Goodyear's legal counsel disputed the findings and provided a critique of that report.

Biases in external report

The deployment of this medical oncologist and the terms of reference provided by CDHA were not consistent with best practices to reduce potential bias in the assessment. For example, the review was not blind. The medical oncologist knew that Dr. Goodyear was the physician and that CDHA was the institution, and appears, as well, to have had substantial knowledge of Dr. Goodyear's career. Only six files were to be reviewed, and these were presented as examples of the perceived problems with the care provided by Dr. Goodyear. The investigator knew the end result of the treatment. The investigator was encouraged to pay particular attention to specific features of the charts and was not asked whether the care was within the generally accepted boundaries of appropriate care established by the profession as a whole.

Recommendations for how to conduct an appropriate external review with a minimum of bias are provided in Chapter 9.

The District Medical Advisory Committee (DMAC) hearings

In February 2003, legal counsel for CDHA sent to the legal counsel for DMAC the submission of the case against Dr. Goodyear. Here Dr. Goodyear was, for the first time, provided with a complete statement of the allegations against him. However, the Administration continued to introduce additional allegations throughout the Disciplinary Bylaws process, up to and including the Administration's post-hearing brief to the CDHA Board in late 2008. The central charge against Dr. Goodyear was that his patients had been and might in the future be exposed to harm. Included in the CDHA submission was the review of the six patients submitted to the Toronto-based medical oncologist discussed above.

In May 2003, legal counsel for Dr. Goodyear provided the written submission of Dr. Goodyear to DMAC. The submissions of both legal counsels were copious.

In preparation for the DMAC hearings, fourteen colleagues wrote letters describing their impressions of Dr. Goodyear. These attest to the high regard in which Dr. Goodyear was held by some colleagues outside the Division of Medical Oncology. Taken together, the letters describe

many positive characteristics of Dr. Goodyear and paint a far different picture from that provided by Dr. Goodyear's Division Chief and Department Chief.

Further review of Dr. Goodyear's cases

In the autumn of 2003, DMAC sought their own independent review of the six cases of Dr. Goodyear that CDHA had previously had examined by a medical oncologist from Toronto. These six were packaged with another four cases and submitted to four medical oncologists from the London (Ontario) Regional Cancer Care Centre for their individual assessments. Each oncologist was asked to provide a summary of the relevant factual and/or clinical aspects of the patient's file, a statement of the perceived problem or area of concern, and a brief description of the applicable range of acceptable conduct. In those cases in which no issues of concern were identified, DMAC requested that such a finding be noted.

The terms of reference for these external reviews contained bias despite some effort made to minimize it. The four examiners were advised that the cases they were asked to examine were cases about which concerns had been raised. It appears that the cases provided for review did not contain a sample of cases in which Dr. Goodyear's care was considered appropriate or even exemplary, nor did the sample include cases from other oncologists. The four reviewers knew they were considering Dr. Goodyear, and they knew the institution at which he worked.

The responses of the four reviewers varied one from the other, and varied considerably from the findings of the Toronto medical oncologist employed by CDHA. The second examination of Dr. Goodyear's practice found less of concern than had the Toronto oncologist's first examination. Despite the four reviewers having examined ten cases, the only cases later submitted to the CDHA Board were the six original cases relied on by the Division Chief and the Department Chief at the time Dr. Goodyear's privileges were varied and then suspended.

Dr. Goodyear provided an extensive commentary on the report of the external reviewers and the interpretation placed on that report by the CDHA Administration. Dr. Goodyear concluded that commentary by noting that, in the view of Dr. Goodyear, these patients were people who made difficult choices and were supported in their choices. Some benefited; others did not. But, whatever their choices, in the view of Dr. Goodyear, all had received a high level of physical, emotional and spiritual care.

Procedures used by DMAC

DMAC heard oral testimony from Dr. Goodyear on December 9, 2003, more than a year after the Department Chief had varied Dr. Goodyear's privileges. DMAC also conducted interviews of others on December 9, 11, and 12, 2003, January 13, 14, 15, 16, and 18, 2004, and March 29, 2004, approximately a year after the Department Chief had suspended Dr. Goodyear's privileges. The final report and recommendations of DMAC was not issued until September 3, 2004, only one month shy of two years from the date on which Dr. Goodyear's privileges were varied. As discussed in Chapter 4, the Disciplinary Bylaws required DMAC to issue its report and recommendations within twenty-one days of the variation of privileges.

DMAC provided transcripts of the interviews DMAC conducted both to Dr. Goodyear and to the Department Chief, but neither was allowed to be present for any testimony other than his/her own. Consistent with the Disciplinary Bylaws, which deemed the proceedings nonjudicial in nature, there was no cross-examination of any of the witnesses that appeared at the DMAC hearings. There was no right to be represented by legal counsel, to know all of the evidence considered, to present evidence, or to cross-examine witnesses. It would be fair to say that the provisions of natural justice did not apply to the investigation of the DMAC (or, for that matter, to the later hearings before the PRC).

Reduction of Dr. Goodyear's income

On November 12, 2003, the Chief of the Department of Medicine Alternate Funding Plan notified Dr. Goodyear that, as of January 1, 2004, his annual income would be reduced to 15% of its previous value despite the still ongoing deliberations of DMAC and the fact that there had been no determination of any wrongdoing by Dr. Goodyear. This action was premature. Its effect was to apply a financial penalty to Dr. Goodyear not only prior to any judgment being made but even prior to any hearings of the evidence.

As discussed in Chapter 2, there were no appropriate means for Dr. Goodyear to appeal this drastic reduction in his income. In summary, the same person, first acting as the CDHA Chief of Medicine, suspended Dr. Goodyear's privileges preventing him from performing clinical duties and teaching; then, acting as the Chief of the Department of Medicine AFP, reduced Dr. Goodyear's income on the basis that he was not performing the required clinical duties and teaching; and, finally, was a member of the bodies to which Dr. Goodyear might direct an appeal of the reduction. This decision-making structure was mandated by the Affiliation Agreement and by the foundational documents of the Alternate Funding Plan. In the opinion of this Committee, the process does not meet a reasonable standard of fairness, and, when applied to Dr. Goodyear, resulted in grave consequences for Dr. Goodyear. It is recommended in Chapter 9 that reductions in remuneration not take place until the suspension of privileges that is used as a justification has been upheld.

Needless to say, this reduction of his annual income had severe consequences for Dr. Goodyear, as the process under the Disciplinary Bylaws continued until the final report of the CDHA Board was issued in January 2009, five years later. After some time, the economic realities of this income reduction forced Dr. Goodyear to choose between the needs of his family and paying the cost of continuing to maintain his medical licence. Dr. Goodyear relinquished his medical licence, reluctantly, in 2007, a choice whose negative implications for Dr. Goodyear's medical career continue to reverberate. Dr. Goodyear also filed for bankruptcy before the CDHA Board finally made its ruling exonerating him of the charges that had been used to justify the reduction in Dr. Goodyear's remuneration.

DMAC report

On September 3, 2004, DMAC submitted its Report and Recommendations concerning Dr. Goodyear's privileges to the CEO, the District Chief of Staff, Dr. Goodyear, and the PRC.

The DMAC report accepted almost all of the submissions presented to it by the CDHA Administration supporting the actions of both the Division Chief and the Department Chief. It accepted that Dr. Goodyear's care was faulty in the six cases examined by the Toronto medical oncologist, and that Dr. Goodyear's pattern of practice exposed patients to potential harm. It also concluded that Dr. Goodyear was a disruptive influence in the cancer care team environment. Then, after outlining the significant strengths of Dr. Goodyear, DMAC recommended that his privileges be revoked by the CDHA Board. DMAC went on to comment that although there was insufficient evidence to conclude that Dr. Goodyear was incompetent as a medical oncologist, he had nevertheless failed to function appropriately within the CDHA Division of Medical Oncology.

Psychological assessment of Dr. Goodyear

In December 2004, Dr. Goodyear's legal counsel received a psychological report about Dr. Goodyear. This report had been requested on November 2, 2004, in response to a DMAC recommendation that Dr. Goodyear undergo such an assessment. The findings were positive, even glowing.

It was noted that Dr. Goodyear was not suffering from any clinical psychiatric disorders. Overall, Dr. Goodyear handled his work-related stress pragmatically and focused on the upbeat and the positive. The report took up directly the DMAC claim that Dr. Goodyear was disruptive and unable to function in a team environment. According to this report, Dr. Goodyear was well-adjusted, alert to his surroundings, and aware of the emotional cues of those with whom he interacted. In counterdistinction to the DMAC findings, this assessment stated that Dr. Goodyear's difficulties were not explained by character flaws, personality traits, or lack of insight.

The Privileges Review Committee

CDHA submission to PRC

On February 25, 2005, legal counsel for CDHA provided the Privileges Review Committee with the CDHA Administration's submission. CDHA was, for the most part, in agreement with the report and recommendations of the DMAC. Added to the submission was a further allegation that Dr. Goodyear had breached the restrictions imposed on his privileges, and CDHA requested that PRC investigate this new matter. Evidence for this allegation arose after the DMAC hearings were complete as a result of a search made on Dr. Goodyear's computer hard drive. A series of emails between Dr. Goodyear and a former patient were uncovered. Although Dr. Goodyear clearly stated that he could only offer advice as a friend and not as a doctor, it was the view of

CDHA that Dr. Goodyear had in fact provided a consultation, which constituted a breach of his suspension.

Re-review of the six cases by an expert medical oncologist on behalf of Dr. Goodyear

In early 2005, the six cases that had been assessed on behalf of CDHA by the Toronto oncologist (and became part of their submission to DMAC in support of the suspension of Dr. Goodyear's privileges) were submitted, by legal counsel on behalf of Dr. Goodyear, to an expert medical oncologist at the Juravinski Cancer Centre in Hamilton, Ontario. This medical oncologist's review of the cases came to different conclusions from the ones provided to CDHA by their expert medical oncologist from Toronto. In the view of this new expert, there were no concerns raised about Dr. Goodyear's diagnostic or therapeutic management of any of the six cases.

PRC process

According to legal counsel for the PRC in correspondence with legal counsel for Dr. Goodyear, the PRC process was fluid and ongoing as it determined its needs. As a result there was no preset list of witnesses. Dr. Goodyear was assured that he would receive transcripts of witness testimony, and he would have an opportunity to be interviewed by the PRC. Neither direct examination nor cross-examination of witnesses was allowed. The PRC also proposed to examine the charts of a further five of Dr. Goodyear's patients.

Despite the assurances, the process was unfair to Dr. Goodyear. The Bylaws specifically stated that the PRC stage of the Disciplinary Bylaws process did not provide the protections of natural justice. Nevertheless, Dr. Goodyear should have had advance notice of who was to be interviewed and the nature of the evidence to be provided, and he should have had the right to be present with legal counsel, to cross-examine, and to call witnesses in rebuttal. The fact that PRC reserved for themselves the right to decide whether any particular witness was to be called prevented Dr. Goodyear from providing evidence he deemed relevant. Having interview transcripts after the fact and being able to comment was not an adequate substitute. Furthermore, the request by PRC for five additional patient charts was another example of the shifting ground on which the case against Dr. Goodyear was based.

PRC time frame

The fluidity of the PRC process created a time frame that was excessively leisurely, and worked to the disadvantage of Dr. Goodyear. The DMAC report had been submitted on September 3, 2004, but the PRC did not make recommendations to the CDHA Board until November 1, 2007. By that time, PRC had had the matter of the suspension of Dr. Goodyear's privileges before it for a total of thirty-eight months instead of the ten days provided by the Disciplinary Bylaws. For reasons described in the next section, the Board never saw those PRC recommendations.

Counsel for Dr. Goodyear eventually sought ways to bypass or terminate the PRC deliberations and proceed to a hearing before the CDHA Board. Indeed, it transpired that, without receiving a report from PRC, the CDHA Board appointed a committee on November 1, 2007, to hear the matter.

CDHA Board Hearing under New Bylaws

Revised Medical Staff Disciplinary Bylaws became effective May 1, 2007. Those 2007 Bylaws were used to govern the CDHA Board hearings conducted in Dr. Goodyear's case. These 2007 Bylaws greatly modify the role of the PRC. Under the former Disciplinary Bylaws, one aspect of the work of the PRC was to conduct an investigation and make a recommendation. That role is not provided in the 2007 Bylaws. On that basis, the Board considered it inappropriate to consider any materials forwarded to it by the PRC under the terms of the former Bylaws, and did not do so. Moreover, under the new Disciplinary Bylaws, if DMAC has recommended a suspension of privileges, it forwards its recommendation, not to the PRC as in the former Bylaws, but directly to the CDHA Board, which makes a final determination within sixty days.

Request from Dr. Goodyear that the activities of the Independent Committee of Inquiry cease

On December 5, 2005, Dr. Goodyear emailed the Canadian Association of University Teachers and the Independent Committee of Inquiry that, because of confidentiality concerns raised by CDHA, he believed that continuing with the independent inquiry might put him in further jeopardy. Based on legal advice, Dr. Goodyear requested that all investigation activity cease until further notice.

Although this request was based on a misunderstanding of the role of the Independent Committee of Inquiry, the Committee did not wish to put Dr. Goodyear at any greater risk than he already faced, however inadvertently. The Committee therefore reluctantly decided to honour Dr. Goodyear's request, and to revisit this decision at a later date when any threat to Dr. Goodyear's safety had abated. By the time this Inquiry returned to the case of Dr. Goodyear, there was, in our opinion, no further threat to Dr. Goodyear's career possible since his career had been terminated.

The CDHA Board decision and subsequent events

The decision

On September 25, 2007, legal counsel for Dr. Goodyear wrote to the Head of the CDHA Board, stating that Dr. Goodyear wished to proceed with a hearing before the CDHA Board under the new Bylaws. On November 1, 2007, the CDHA Board appointed a committee of four Board members to deal with the matter of Dr. Goodyear's privileges in accordance with the requirements of the Disciplinary Bylaws. The Board hearing was the first time that Dr. Goodyear was accorded the rights to a fair hearing, including the protections of natural justice, the ability to

present evidence in his defence, and the ability to cross-examine witnesses. The Board ultimately conducted twenty-three days of hearings. In December of 2008, the legal counsel for both the CDHA Administration and Dr. Goodyear submitted Post-Hearing Briefs and Closing Arguments to the Board.

On January 26, 2009, the CDHA Board issued its decision. The conclusion of the Board was that there was no basis to vary or suspend the privileges of Dr. Goodyear. With regard to the six patients that the Administration had claimed were endangered by Dr. Goodyear, the Board found that Dr. Goodyear's care did not jeopardize their safety. As to Dr. Goodyear's use of the Douillard protocol, the Board did not condone the unilateral adoption of a protocol. However, the Board ruled that Dr. Goodyear's use of the Douillard protocol was not grounds for variation or suspension of his privileges. The Board commented as well on the recurring theme in the evidence of the desire for collegiality among the CDHA medical oncologists. In the view of the Board, the term "*collegiality*" was used as a stand-in for the term "*conformity*," and it noted that an undue emphasis was placed on conformity. The Board also took up the absence of complaints against Dr. Goodyear by any of his patients, their families, and medical specialists other than medical oncologists. That absence, in the opinion of the Board, eroded any claim that Dr. Goodyear's practice exposed his patients to harm. The Board then ordered that Dr. Goodyear be returned to the status he held on October 9, 2002, subject to any credentialling, licensing, or professional requirements. The Board did not, however, explicitly retain jurisdiction to deal with disputes arising from the implementation of its decision.

The implications of "subject to any credentialing, licensing or professional requirements"

The CDHA Board did not set out a process by which the "*credentialing, licensing or professional requirements*" were to be met. Of particular importance in this regard were the negative opinions of Dr. Goodyear expressed by several of his colleagues in medical oncology at CDHA. These negative opinions were well known by the Board. They were stated in the testimony of Dr. Goodyear's colleagues, were stressed by the Administration in its submissions to the Board, and the Board acknowledged them in its ruling. It was therefore important for the Board to address how the reintegration of Dr. Goodyear could be accomplished in the face of those negative opinions of his colleagues at CDHA. In hindsight, it might have been helpful for the Board to retain jurisdiction over this final phase of its ruling. Without such oversight by the Board, the reintegration plan for Dr. Goodyear that was subsequently implemented effectively gave two of Dr. Goodyear's colleagues in medical oncology at CDHA a veto over his return to his position in the Division of Medical Oncology.

Thus, despite the vindication of Dr. Goodyear in this decision, Dr. Goodyear did not return to the position he held on October 9, 2002. It is important to remember that, had the CDHA Board reached the same conclusion within the time limits specified in the Disciplinary Bylaws, there would have been no credentialling, licensing, or professional requirements to be met by Dr. Goodyear. These requirements arose because of the inordinately lengthy Disciplinary Bylaws process to which Dr. Goodyear was subjected.

The failure of the reintegration plan

On February 26, 2009, Dr. Goodyear applied to the College of Physicians and Surgeons of Nova Scotia for a full licence to practice medicine in Nova Scotia. On March 9, 2009, Dr. Goodyear was informed that the College required him to demonstrate his clinical competence in the specialty of Medical Oncology by way of a clinical assessment.

Organizing an appropriate reintegration plan for a physician who has been out of clinical practice for six and a half years is not a routine matter. The reintegration plan required the approval of Dr. Goodyear and had to meet the guidelines of the College. It also required identifying willing mentors with appropriate qualifications. On July 20, 2009, a reintegration plan was submitted to the College. It had taken four and a half months to work out. The start date for the plan was to be August 4, 2009, and the anticipated end date, on or before February 28, 2010. In the opinion of this Committee, given the context in which Dr. Goodyear was required to approve the plan, it appears that he had no real choice, and his agreement must be suspected of being under duress.

Unfortunately, there was a reasonable apprehension of bias in the plan proposed. The two CDHA medical oncologists appointed to mentor Dr. Goodyear had written about their concerns with his clinical practice, and these concerns were part of the testimony before the Board. The integrity of this plan rested on the ability of these two medical oncologists to set aside their long-held negative assessments of Dr. Goodyear and judge him in light of the findings of the Board. It is difficult to understand how any decision against the interests of Dr. Goodyear could escape the apprehension of bias in these circumstances.

The final release

On September 16, 2009, Dr. Goodyear signed a "*Final Release*," in which Dr. Goodyear agreed not to pursue any financial compensation from CDHA and QEII Health Sciences Centre Department of Medicine as a result of his suspension. In exchange, Dr. Goodyear received a financial settlement. During the negotiation of this settlement, Dr. Goodyear was assisted by legal counsel provided by CAUT. The terms of the settlement were confidential.

The denial of Dr. Goodyear's application for full licence

On July 2, 2010, Dr. Goodyear received from the College of Physicians and Surgeons a summary of the results of the various components of the reintegration plan. With regard to internal medicine, Dr. Goodyear's performance was judged to be adequate although some concerns were expressed regarding patient history-taking, physical examinations, decision-making, emergency care, and relationships with the hospital team as well as overall knowledge base. When assessed by an oncologist whose practice was unrelated to CDHA, Dr. Goodyear's performance in general oncology was found adequate or better in all categories, and he was judged able to practice without supervision. However, when Dr. Goodyear's performance was assessed by two medical oncologists from CDHA, Dr. Goodyear was judged unfit to practice without supervision. As a result of these negative evaluations by the two medical oncologists from CDHA, Dr. Goodyear was deemed not to have the required level of medical skill and

knowledge necessary to re-enter the practice of medical oncology and was, therefore, denied the full licence to practice medicine for which he had applied in February 2009.

Thus, despite the decision of the CDHA Board exonerating Dr. Goodyear of the allegations against him, Dr. Goodyear has been unable to take up his medical oncology practice to this day. Dr. Goodyear's medical oncology career was ended as a result of the unwarranted suspension of his privileges and the unconscionably long time taken to provide a fair hearing based on procedural fairness and natural justice and to reach a final decision.

Lessons from the case history

Many of the same lessons discussed in the other cases about shortcomings in CDHA policies and procedures applied in the case of Dr. Goodyear.

Lessons from other cases were also apparent in this case

There were a number of lessons from the case of Dr. Nassar that were also apparent in the case of Dr. Goodyear. The extraordinary powers of the Department Chief, and the authority-based model of leadership, were readily apparent. The decision by the Chief of Medicine to vary summarily Dr. Goodyear's privileges put in place a series of events over more than six years that resulted in Dr. Goodyear being removed from CDHA and Dalhousie.

The inordinate power of the Alternate Funding Plan was most clearly demonstrated when Dr. Goodyear's remuneration was cut to 15% of its value prior to the suspension of his privileges. As previously discussed, the same person acted as Chief of Medicine to suspend Dr. Goodyear's privileges and then acted as Head of the Alternate Funding Plan to reduce Dr. Goodyear's remuneration because he was no longer able to meet his clinical practice plan. There was no appeal of that decision to reduce Dr. Goodyear's income except to bodies that included the same person who had made the previous decisions. The danger of a single individual exercising this much power is best displayed in the case of Dr. Goodyear.

The imbalance of resources between individual members of the Medical Staff and CDHA was also most apparent in the case of Dr. Goodyear. Dr. Goodyear was ably represented on many matters directly related to the Disciplinary Bylaws process by counsel provided by the Canadian Medical Protective Association, but their role was limited to supporting direct challenges to Dr. Goodyear's privileges. CAUT provided Dr. Goodyear with legal counsel during the negotiation of the settlement discussed above. On more general matters, Dr. Goodyear had no access to legal counsel, in part because of the financial hardships he faced because of the large reduction in his remuneration. On a number of occasions, Dr. Goodyear met on his own with his Division and Department Chiefs without assistance from counsel or an advisor or representative. In the opinion of this Committee, Dr. Goodyear was at a distinct disadvantage on too many occasions.

Taken together, the extraordinary power of the Department Chief and the AFP, and the serious imbalance of resources available to Dr. Goodyear to defend his interests, pose an unacceptable threat to the academic freedom of any member of the Medical Staff of CDHA.

Hearings under protections of natural justice and procedural fairness

The decision by the Department Chief to suspend the privileges of Dr. Goodyear was made on October 10, 2002. The first hearing of the Board was held June 25, 2008, nearly six years later. The Board's decision, issued on January 26, 2009, exonerated Dr. Goodyear of the allegations and ordered that his status be restored to what it was prior to the variation of his privileges, "… *subject to any credentialing, licensing or professional requirements* …". The Board also ruled that there had been no malice directed against Dr. Goodyear.

The Board held a full hearing of the allegations against Dr. Goodyear with the protections of natural justice and procedural fairness. The Board heard expert medical testimony that it was not unusual that colleagues might disagree on treatment to be offered in complex cases, and that the appropriate standard was whether Dr. Goodyear practiced within the bounds of generally accepted standards in the profession, professional standards that may not be the same as the opinion held by the majority of Dr. Goodyear's CDHA colleagues in Medical Oncology. After examining the evidence concerning each of the allegations against Dr. Goodyear, the Board made its ruling.

The Board hearing demonstrates the power of a case being fully adjudicated using the protections of natural justice and procedural fairness. The evidence was fully presented and tested during twenty-three days of hearings, and exchanges of briefs by the parties. A clear decision was reached. The proceedings of DMAC and PRC, which lacked the protections of natural justice and procedural fairness, took a vastly longer time and were not effective at reaching a fair and final decision on the merits of the case.

Established guidelines

The expert medical testimony established two important guidelines: it is not unusual for opinions to differ among colleagues on treatment offered in complex cases; and, the professional standard to be applied is whether Dr. Goodyear practiced within the bounds of generally accepted standards in the profession, professional standards that may not be the same as the opinion held by the majority of his colleagues in the Division of Medical Oncology.

Grievous harm from extraordinary delays

By the time of the Board's ruling, Dr. Goodyear had been removed from clinical practice as a Medical Oncologist for over six years. This extraordinary delay in reaching a decision that exonerated Dr. Goodyear did grievous harm to Dr. Goodyear, resulting in his being effectively removed from practicing his profession. There would have been no credentialling, licensing, or professional requirements to be met if the decision had been reached within the timelines specified in the Disciplinary Bylaws.

The implications of this result for policy at CDHA and elsewhere is profound. The Board found that there was not just and sufficient cause to vary Dr. Goodyear's privileges, and yet the perverse result of the process under the Disciplinary Bylaws was that he was, nevertheless, removed from practice. Dr. Goodyear was exonerated, but suffered the same result as if he had

been found guilty of the allegations against him. Justice was denied because of the unconscionable delays.

The normal standard required in dismissal proceedings is for the employer to show that dismissal is an appropriate penalty for an offence for which it was proven that there were just and sufficient grounds for disciplinary action. In analogy with the case of Dr. Goodyear, the Board found that there were not just and sufficient grounds for the action taken against Dr. Goodyear, and by inference no penalty should be applied. Nevertheless, the end result of that action was that Dr. Goodyear's career was terminated.

Risks inherent in a separation agreement

The circumstances surrounding Dr. Goodyear's departure from Hamilton played a background role in the events at CDHA. Dr. Goodyear and his employer in Hamilton concluded a mutual separation agreement with no admission of wrongdoing by either party. Consequently, there was no independent hearing or adjudication of the issues involved in the termination of Dr. Goodyear's appointment in Hamilton. The consequence was lingering suspicion of wrongdoing without a proven factual base, which proved to be disadvantageous to Dr. Goodyear.

The role of the separation agreement in the case of Dr. Goodyear's departure from Hamilton is similar to the situation faced by Dr. Nassar after the Court quashed the letter of discipline and counselling arising from the harassment complaint and the records of the proceeding were destroyed. Dr. Nassar also faced a lingering suspicion of wrongdoing despite there being no valid finding against him in this case. That lingering suspicion also proved to be disadvantageous to Dr. Nassar.

Particular features of Dr. Goodyear's appointment letters were unusual

As discussed previously, by the time of his appointment to a regular staff position, Dr. Goodyear had been assessed a total of seven times, each assessment involving five different bodies, during a two and a half year period of *locum tenens* appointments. There can be few physicians who had received as much scrutiny, which, in itself, is unusual.

The performance review specified during the last *locum tenens* appointment was also unusual. The statement that this review would form part of the evidence considered if Dr. Goodyear applied for a full-time position is even more so. On its face, that requirement was prejudicial because it meant that Dr. Goodyear would be required to meet criteria that did not apply to other candidates.

The requirement that Dr. Goodyear accept and uphold the direction offered by the Division of Oncology Chief and the Department of Medicine Chief is also unusual. It is reasonable to direct Dr. Goodyear to follow established protocols and procedures, but the context suggests the intent might have been to keep Dr. Goodyear under a form of supervision by the Division Chief. To the extent that the direction offered conflicted with Dr. Goodyear's academic freedom, it was

inappropriate. Dr. Goodyear's academic freedom allowed him to be critical of both the Division and Department Chiefs.

Procedures for performance reviews were inadequate

Performance reviews must be considerably more formal and rigorous than a critical letter from the Division Chief.

There must be notice that a review will be conducted and a request that the member of the Medical Staff provide a statement or other evidence (s)he considers relevant. It is best practice to consult the member of the Medical Staff concerning a number of individuals who could provide an assessment from different relevant perspectives. It is also normal to engage a peer review Assessment Committee to conduct a peer evaluation and make a recommendation.

Prior to the peer review Assessment Committee making a recommendation, the member of the Medical Staff should have an opportunity to review and comment upon the accuracy, meaning, and significance of any evidence considered. If the Committee has tentatively reached a recommendation that is disadvantageous to the member of the Medical Staff, (s)he should have an opportunity to comment and to submit additional evidence to be considered before a final recommendation is made.

Fair external reviews of Dr. Goodyear's practice could have been done sooner

Many of the lengthy delays that characterized the case of Dr. Goodyear might have been avoided if a fair external review of Dr. Goodyear's practice by independent third party experts in medical oncology had been conducted at an early stage. A better procedure would have been to have Dr. Goodyear and CDHA jointly agree on a single external expert reviewer, or a panel of such reviewers, to conduct an assessment of Dr. Goodyear's practice, with procedures that were as free of bias as possible.

When its hearings finally took place, the CDHA Board considered in detail each of the six cases presented by CDHA Administration as evidence that Dr. Goodyear's practice exposed patients to risk and justified the suspension of his privileges. Expert testimony by external medical oncologists concerning Dr. Goodyear's care for these six patients was a significant part of the basis on which the Board found that there was not sufficient cause to vary the privileges of Dr. Goodyear. The problem was that it took over six years to obtain that evidence, and a great deal of damage had occurred as a result. Had that evidence been available within weeks of the variation of Dr. Goodyear's privileges as was prescribed by the Disciplinary Bylaws, the entire case likely would have proceeded very differently.

A set of procedures for establishing a clinical practice audit with a minimum of bias are recommended in Chapter 9.

An investigation of charges is required before privileges are varied

As discussed in Chapter 4 of this report, the Disciplinary Bylaws require that the Department Chief who decides to vary privileges must have made a finding, meaning that the Chief must have diligently examined the evidence, that the conduct of a member of the Medical Staff exposes relevant people to actual harm or injury, or adversely impacts the delivery of patient care, or is reasonably likely to do one or both of these. The Department Chief is not entitled simply to take the advice of the Division Chief on these matters, and must fairly and diligent consider any response to the evidence that the member wishes to make. This strongly suggests that there must be an investigation before the decision to vary privileges is made.

After the decision was made to vary the privileges of Dr. Goodyear, the Chief of the Division of Medical Oncology continued to gather additional written documentation to support the variation. One of the ways in which evidence was gathered was to ask a Toronto medical oncologist for comments on some of Dr. Goodyear's cases. Another was to ask members of the Division of Medical Oncology to provide examples of cases in which they had concerns about Dr. Goodyear's practice. This collection of additional evidence did not meet the requirements of an investigation because it did not seek evidence that might counter the evidence for the allegations against Dr. Goodyear. It also happened after the variation of Dr. Goodyear's privileges, whereas an investigation would have occurred before the action was taken.

Bias is to be expected when a Division Chief asks members to provide evidence

A Division Chief who has demonstrated that (s)he has the backing of the Department Chief who has the power to vary or suspend the privileges of a member of the Medical Staff should not expect to receive unbiased responses when (s)he requests members of the Division to provide examples of cases in which they have concerns about the performance of a colleague. The Division Chief is asking for evidence of wrongdoing, not a full performance assessment. A better approach is to conduct a full formal performance review, and/or an independent external clinical practice assessment, as discussed above.

Other means of dealing with group disagreements were possible

Dr. Goodyear did not deny that there were disagreements among his colleagues. In his opinion it was up to the group as a whole to resolve those matters, not solely up to him to change his practice to conform to the opinions of his colleagues. Dr. Goodyear proposed more opportunities for group discussion in a nonthreatening environment, possibly with the assistance of external experts in conflict management. This Committee has seen no indication that group facilitators or experts in conflict management were used. There is no guarantee that such processes would succeed, but they might have been significantly faster and cheaper than a proceeding under the Disciplinary Bylaws proved to be.

Counselling is a private matter between the counsellor and the client

A suggested alternative was that Dr. Goodyear attend, at his expense, an independent assessment and treatment centre for an assessment of his fitness to practice medicine, with the understanding that the results would be made available to CDHA. This is an example of the extent to which Dr. Goodyear was deemed to be responsible for the disagreements with his colleagues. Strict confidentiality is the expectation between counsellor and client.

The agreement to waive time deadlines had unacceptable repercussions

Undoubtedly, the case of Dr. Goodyear was complex. To allow sufficient time for Dr. Goodyear and the CDHA Administration to gather the documentation to be presented to the DMAC, there was mutual agreement to waive the ten-day time limit for a presentation to DMAC specified in the Disciplinary Bylaws. It could not have been foreseen at the time of the agreement that a decision to waive a ten-day deadline would result in the case not being decided for over six years. That unacceptable result had grave consequences for Dr. Goodyear.

Summary

On October 10, 2002, Dr. Goodyear's privileges were varied summarily without a proper investigation. His privileges were subsequently suspended for what the CDHA Board described as a humane desire to provide support to a family member of a patient, and, as such, not sufficient grounds to fully suspend his privileges.

As a result of the suspension of his privileges, Dr. Goodyear was not able to carry out clinical or teaching duties, which resulted in the reduction of his income to 15% of its original value. Dr. Goodyear had no fair means of appealing that decision, and was therefore deprived of 85% of his income for the duration of the process under the Disciplinary Bylaws, which did not conclude for a further five years.

The disciplinary process, which the Bylaws conceived as taking approximately two months to reach the CDHA Board for a decision, did not conclude until January 26, 2009, more than six years after the original variation of privileges.

The Board ruled that there were not sufficient grounds to vary or suspend the privileges of Dr. Goodyear and ordered that he be returned to the status he enjoyed before the variation of his privileges, "… *subject to any credentialing, licensing or professional requirements* …"

By the time of the Board ruling, Dr. Goodyear had been removed from his clinical practice of medical oncology for over six years. Even for considerably shorter periods of clinical inactivity, it is well known that substantial periods of supervised practice are often needed to return individuals to the high levels of skill required for clinical practice in a specialty. Successful reintegration after more than six years removed from clinical practice is uncommon. Indeed, in the case of Dr. Horne, the Chief of Medicine expressed concern that the absence for a few months of one half-day clinic per week from Dr. Horne's clinical profile was a risk to her

maintaining her clinical competence as a specialist cardiologist. This Committee is not aware of any concern being expressed by the Chief of Medicine or any other CDHA official about the impact that the lengthy removal from all clinical activities would have on the ability of Dr. Goodyear to maintain his competence as a specialist medical oncologist and be reintegrated in the event that the suspension of his privileges was not upheld. It appears that no account was taken of the potential need to mitigate the damage to Dr. Goodyear if the suspension of privileges was subsequently, as it was, overturned by the CDHA Board at the conclusion of the Disciplinary Bylaws process.

The reintegration plan, which was required to meet the "… *credentialing, licensing and professional requirements* …", granted an effective veto on Dr. Goodyear's return to his practice as a medical oncologist to two CDHA oncologists whose testimony against Dr. Goodyear was a significant part of the case the CDHA Administration made to support the decision of suspending Dr. Goodyear's privileges. The apprehension of bias is clear and irreconcilable with any basic standard of justice.

All parties agreed that Dr. Goodyear was a dedicated, knowledgeable, caring, and compassionate oncologist. His career was ended, after what could only have been a nightmarish six years, as a result of his privileges being suspended without adequate grounds for doing so.

Since 1998, there have been seven physicians whose licences have been revoked by the Nova Scotia College of Physicians and Surgeons after complaints were filed about their conduct: four for sexual misconduct, two for drug addiction and substance abuse, and one for incompetence and failure to abide by agreements that had been made with the College. All of these cases involve professional misconduct far beyond the allegations made against Dr. Goodyear, yet the end result — termination of a medical career — was the same.

There could be few comparable examples in the history of Canadian academe of the truth of the legal maxim "*Justice delayed is justice denied*." Indeed, the lengthy delay in holding a hearing based on procedural fairness and the principles of natural justice was itself the greatest injustice to Dr. Goodyear.

Chapter 8 | Summary

Case studies

The case study and lessons learned from each of the cases considered are presented for Dr. Nassar in Chapter 5, for Dr. Horne in Chapter 6, and for Dr. Goodyear in Chapter 7.

The Committee found that many of the events in dispute derived from, or were enhanced by, a much smaller number of underlying events and issues that brought certain individuals into conflict. Each of the cases of Drs. Nassar, Horne, and Goodyear began with some interpersonal disagreements over matters that appear to be within the bounds of what might reasonably be expected to arise from time to time in an academic tertiary care environment.

What sets apart the three cases considered by this Inquiry is the extent to which the available policies and procedures proved incapable of resolving these disputes, and in many ways served to initiate, and broaden the disputes. The disputes escalated in both scope and intensity and dragged on for an unconscionably long time, spawning a range of other disputes and a cascade of documents on ever-widening matters.

The failure to resolve the disputes arising from those conflicts in a fair, final, and binding manner, within a reasonable time frame, resulted in a major diversion of talent and resources, and caused a great deal of damage to all participants, principally, but not solely, Drs. Nassar, Horne, and Goodyear.

Rulings made during the three cases considered

To the best knowledge of this Committee, to date there have been no hearings under the protections of procedural fairness and natural justice that have made findings of fault against any of the participants in these many lengthy disputes. In the case of Dr. Nassar some disputes have been ongoing since the early 1990s.

The competence of Dr. Nassar was never questioned. The case of Dr. Horne was based on disputes over her research and the concern by her Division Chief and Department Chief that the interpersonal friction between Dr. Horne and a small subset of the cardiologists at CDHA might compromise patient care for which they were jointly responsible. The clinical competence of Dr. Horne was not at issue during the Disciplinary Bylaws process. Some of Dr. Goodyear's colleagues in medical oncology disagreed with Dr. Goodyear's judgment and the care he provided in a small subset of cases in his practice. Concerns were raised during the CDHA Board hearings about six cases from four years of Dr. Goodyear's very busy practice. Expert external medical oncologists testified that Dr. Goodyear's practice was within the bounds of what would be considered appropriate care in the profession as a whole.

In the case of Dr. Horne, the only issue adjudicated through a full hearing with the protections of procedural fairness and natural justice was a hearing by the CDHA Board, which ruled that there were not sufficient grounds to invoke an emergency variation of Dr. Horne's privileges. The Board ordered that Dr. Horne be reinstated to the status she held prior to the variation.

Also in that Board ruling, the Board made statements critical of Dr. Horne on two matters, one to the effect that Dr. Horne had a considerable history of difficult relationships with doctors in a supervisory position to her, and the other to the effect that the Administration had reason to take some action to try to correct Dr. Horne's behaviour. The Board did not conduct any hearing under the protections of natural justice and procedural fairness on which to base those judgments. In the opinion of this Committee, the documentary evidence available to this Inquiry could equally well be interpreted to the effect that some doctors in a supervisory position at CDHA had a considerable history of difficult relationships with certain strong-minded, capable, and independent doctors who insisted on their right to exercise their academic freedom, to disagree with the majority opinion of their colleagues, and to be treated with due respect.

These comments by the CDHA Board were interpreted publicly by the then Acting CEO of CDHA as indicating that the Board ruling in Dr. Horne's favour was based on a technicality and that there had been cause to take corrective action against Dr. Horne. Similar interpretations were made in the case of Dr. Nassar. In both cases, an incorrect perception circulated that rulings in favour of Drs. Nassar and Horne had been based on a procedural technicality, rather than on the merits of the evidence. Such incorrect perceptions can do damage to the reputations of the individuals, as was most clearly demonstrated in the case of Dr. Nassar.

In the case of Dr. Goodyear, after a full hearing under the protections of procedural fairness and natural justice, the CDHA Board ruled that there were not sufficient grounds to vary Dr. Goodyear's privileges and ordered him reinstated to the status he held prior to the variation. The Board also found that there was no malice toward Dr. Goodyear on the part of any of the other individuals involved.

The lack of negative findings against the three doctors whose cases are at the heart of this Inquiry has not ended matters. Rather, there continue to be spinoffs from these investigations and other matters that are not resolved to this day.

Both Dr. Horne and Dr. Nassar have filed claims for damages before the Supreme Court of Nova Scotia that remain unresolved at the time of final editing of this report. It is expected that the Court has available a more complete record than was available to this Inquiry and that the merits of the various allegations by plaintiffs will be fully adjudicated upon by the Court at trial.

Consequences for Drs. Nassar, Horne, and Goodyear

In the opinion of this Committee, in any proceeding in which allegations of wrongdoing are made, care must be taken to minimize damage to the accused. In the event that the allegations are not upheld, careful attention must be given to means of mitigating what damage has occurred.

For much of two decades, Dr. Nassar was repeatedly the subject of investigations and assessments that threatened his career and were not conducted in accordance with the requirements of natural justice and procedural fairness. Dr. Nassar's complaint of a hostile work environment was not adequately investigated or resolved, and he remained in that same work environment for many years. The harassment investigation and the resulting reprimand, which

was quashed by the courts, introduced a cloud of suspicion over Dr. Nassar that lingered and had serious consequences for his planned career advancement. The career and personal life of Dr. Nassar suffered extensive damage and he was involved in legal action of one form or another, at his own expense, for a lengthy period. Dr. Nassar experienced these consequences despite the fact that his professional performance was repeatedly found to be strong, and no misconduct on his part was ever proven.

In the cases of Drs. Horne and Goodyear, the damage rapidly accumulated as the Disciplinary Bylaws process dragged on for years instead of the few weeks specified in the Disciplinary Bylaws. That damage occurred before the merits of the cases against Drs. Horne and Goodyear were even heard in a process including the protections of procedural fairness and natural justice, let alone decided. Officials at both Dalhousie and CDHA claimed not to have the means to ensure a rapid conclusion. There were no apparent steps taken by CDHA to prevent or to mitigate the damage. The most effective means to achieve a conclusion appeared to be intervention by outside parties, the threat of censure of Dalhousie by CAUT, and the resulting intervention of the government of Nova Scotia. The cumulative damage was so great that means to appropriately mitigate the damage were severely constrained, and, in some cases, impossible.

For nearly four years, Dr. Horne was unable to carry out clinical work as an attending physician in the Heart Function Clinic, she was unable to recruit patients directly into her research studies from the Heart Function Clinic, she could not continue with her original research plan, her ability to compete for grants to support her research was impaired, and she was deprived of a portion of her income. What should have been a time of blossoming research for Dr. Horne became, instead, a protracted struggle to defend her rights and reputation and to protect her research. Dr. Horne lived under a cloud of suspicion because the summary variation of her hospital privileges suggested that her research put her patients at risk despite her research having all required approvals by the Research Ethics Board. The career and personal life of Dr. Horne suffered extensive damage, and a promising research program ceased. In addition, the patients already enrolled in her studies did not see their participation and sacrifice lead to valid and useful medical knowledge, a situation that violates research ethics. Dr. Horne was also involved in lengthy legal actions at considerable personal expense. These consequences were experienced by Dr. Horne despite the fact that none of the concerns raised by CDHA about her performance or research were proven, and the CDHA Board ultimately determined that there were not sufficient grounds to invoke an emergency variation of Dr. Horne's privileges.

For over six years, Dr. Goodyear suffered a ban on clinical practice at CDHA and restrictions on his appointment as an Assistant Professor in the Dalhousie Faculty of Medicine. For over five of those years, his income was only 15% of normal. The career and personal life of Dr. Goodyear suffered grievous damage, including personal bankruptcy and a related decision that he could not afford to maintain his medical licence. He lived under a cloud of suspicion that the summary variation of his hospital privileges suggested that his clinical performance posed a risk to his patients. These consequences were experienced by Dr. Goodyear despite the fact that none of the allegations raised by CDHA about Dr. Goodyear's performance was proven, and the CDHA Board ultimately determined that "… *there was no basis to vary or suspend the privileges of Dr. Michael Goodyear*" and ordered that "… *Dr. Goodyear be returned to the status he enjoyed on October 9, 2002*." Despite this ruling, for reasons discussed in Chapter 7,

Dr. Goodyear was refused reinstatement to the CDHA Division of Medical Oncology and his medical oncology career at CDHA was terminated.

Aside from the case of Dr. Horne discussed below, this Committee observed that there was little apparent consideration given to how to prevent damage to the careers and reputations of Drs. Nassar, Horne, and Goodyear while the merits of the allegations were being adjudicated, or how to mitigate damage in the event that the cases against them were not sustained.

After Dr. Horne had been absent from her former duties in the HFC for a few months following the variation of her privileges, her Division Chief and Department Chief expressed concerns that Dr. Horne's clinical profile might not allow her to maintain her clinical competence if she did not agree to undertake an addition half-day-a-week clinic. This Committee has no knowledge of the Department Chief, or any other senior administrator at CDHA, expressing similar concerns about the potential impact on Dr. Goodyear's clinical competence of being removed completely from practice for what turned out to be more than six years.

Committee focus and systemic findings

This Report focuses on what the Committee believes to be the foundations of the dispute, the damage done by failure to reach final resolutions of those matters in a timely manner, and the lessons that can be learned from these cases. In the experience of this Committee, having three such major cases active at the same time and extending over such a lengthy period without resolution is rare in Canada, if not unique.

The Committee concluded that at the heart of these cases are a number of fundamental flaws in the foundational policies and procedures of Capital Health and Dalhousie University, in the Medical Staff Disciplinary Bylaws, and in the failure appropriately to understand and apply the concepts of academic freedom, collegiality, procedural fairness, and natural justice. The academic medicine culture that insists that members of the CDHA Medical Staff are private contractors, and places extraordinary power over members of the Medical Staff in the hands of CDHA Division and Department Chiefs and the various group practice plans, also contributed to the problems that arose.

The damage created by these unresolved disputes resulted from a collective and systemic failure of policy, process, and academic administrative culture at CDHA/Dalhousie. Where errors were identified, they reasonably could be attributed to inexperience; a lack of sufficient training, support, and guidance from others; deficiencies in the policy and procedural framework; a seemingly broadly held misunderstanding of basic concepts of academic freedom, collegiality, procedural fairness, and natural justice; undue reliance on a governance model at CDHA that was authoritarian rather than collegial; and remuneration arrangements that place members of the Medical Staff at great risk. The identified problems are systemic, and systemic solutions are required.

Accordingly, the Committee has chosen not to make any materially adverse findings of fault on the part of any individuals.

Nothing in this report should be interpreted as a judgment by this Inquiry about the medical competence of any of the highly skilled individuals at the centre of this Inquiry.

The Committee believes that the most useful contribution the Inquiry could make would be to identify what the Committee considers to be crucial weaknesses in policy, process, and culture and make recommendations about how these matters can be addressed to help prevent a repetition of these unfortunate events, either at CDHA/Dalhousie or elsewhere. The Recommendations are discussed in Chapter 9.

Academic freedom

The cases considered by this Committee demonstrated some clear misunderstandings of the principles of academic freedom discussed in Chapter 2. Appropriate reference to those principles must be included in the foundational documents, policies, and procedures and be a recognized part of the academic culture at CDHA, as at any other university affiliated teaching hospital.

As discussed in Chapter 2, the fundamental requirements that must be met to guarantee the right to academic freedom are: a clear commitment to academic freedom in official policies; employment security; an independent adjudication procedure ensuring procedural fairness, natural justice, and timely binding decisions; income security during any dispute; opportunity for representation by an independent professional organization or union; and means of addressing the inherent imbalance of resources that commonly exists between individual members of the Medical Staff and the institution in which (s)he works. None of these essential requirements was met in the cases investigated by this Committee. As a consequence, academic freedom was, and remains, under unacceptable threat.

As discussed in Chapter 3, academic freedom is not included in the Affiliation Agreement between CDHA and Dalhousie. Consequently, academic freedom had no formal role in the relationship between Dalhousie and CDHA, the rights of clinical faculty were not adequately protected, and the parties lacked an important tool to make their relationship more effective.

As discussed in Chapter 3, to continue unimpeded in their work, faculty members were required to maintain their academic appointment at Dalhousie, their clinical appointment and privileges as Medical Staff at CDHA, and their income through the Alternate Funding Plan or similar group practice plans. Each of these three domains is governed by different policies. Similar arrangements are found at most Canadian medical schools and their affiliated teaching hospitals. To guarantee the academic freedom of Dalhousie clinical faculty and CDHA Medical Staff, and that of clinical faculty and medical staff at other Canadian medical schools and their affiliated teaching hospitals, all three of these sets of policies must meet the standards discussed above. The investigation by this Committee demonstrates that there are serious deficiencies in all three policy domains that place academic freedom in great peril. This risk is amplified by the absence of an explicit provision for reaching a fair and final resolution of conflicts, by mediation, negotiation, arbitration, or other means.

As discussed in Chapter 2, the CAPR appointments used at Dalhousie clearly do not provide the security of employment that is essential to the protection of academic freedom. The

standard protection for academic freedom is tenure, which guarantees that an appointment can be terminated only for just and sufficient cause.

As discussed in Chapter 3, group practice plans such as the Alternate Funding Plan of the Department of Medicine and UALMA related to the Department of Pathology and Laboratory Medicine, determine the majority of the remuneration to be paid to most of the clinical faculty, with usually only a small (or no) contribution from Dalhousie. Consequently, group practice plans hold extraordinary power outside of the control of either Dalhousie University or CDHA. That extraordinary power is a grave threat to academic freedom.

Collegiality

As discussed in Chapter 2, in the cases considered, there is no apparent consistency in the understanding of collegiality, other than a general sense that collegiality is viewed as an important attribute of Faculty Members and Active Medical Staff. There appears to have been no general agreement in practice about its meaning, other than that it relates to professional interactions with other faculty members leading to effective functioning of the department. Unfortunately, the combination of the undefined "*collegiality*" with the equally undefined "*effective functioning*," allowed both "*collegiality*" and "*effective functioning*" to be applied to Drs. Horne, Goodyear, and Nassar in broad, unspecific, but negative ways that related to perceptions of personality rather than to professional competence.

Indeed, it would appear that "*collegiality*" was commonly misunderstood as a personal characteristic, rather than a professional one. A weakness of the CDHA/Dalhousie environment is the vague and flexible way in which the term "*collegiality*" appears to be used. Those weaknesses must be corrected.

Dispute resolution

There appeared to be no dispute resolution procedures at CDHA other than the seriously flawed Disciplinary Bylaws, or, in any event, such procedures as might exist were not deployed in any of the cases considered by this Committee. The result, particularly evident in the case of Dr. Nassar, was that disputes dragged on without resolution for inordinate periods of time. In some cases an unresolved dispute actually became the basis or cause for new disputes, as occurred a number of times in the case of Dr. Nassar.

This Committee is not aware of any attempt to engage advisors, mentors, or conflict resolution experts to assist in resolving interpersonal tension and disputes in the early stages of the cases considered. Drs. Goodyear and Horne specifically requested such assistance, and Drs. Nassar and Horne sought assistance from senior administrators.

As discussed in Chapter 6, after the disputes had gone on for a lengthy period, Dr. Horne engaged in mediation to reach a settlement of all matters in dispute, which CDHA did not implement. In the opinion of this Committee, the mediated settlement contained elements that could have been implemented as soon as Dr. Horne began to experience difficulties. Had that proactive action been taken before the difficulties expanded and action was taken under the

Disciplinary Bylaws, most of the subsequent events and the resulting damage might have been avoided.

In the cases considered, there was little use made of a formal grievance procedure to allow individual members of the Medical Staff to seek redress if a dispute arose. As discussed in Chapter 6, Dr. Horne appealed to the Dalhousie Senate when the Dean of Medicine revoked her Dalhousie Clinical Scholar Award. Otherwise, the only mechanism seemed to be an appeal to a Division Chief, Department Chief, or VP. In most cases, one of those individuals was involved in the dispute. It is important to have robust grievance procedures defined, formally approved using collegial processes, and enshrined in published policies that are known to all. Those grievance procedures must provide ultimately for a hearing before an independent external arbitrator, or arbitration panel, with all the protections of procedural fairness and natural justice, and empowered to make a final and binding ruling on the substance of the matters in dispute.

An important resource could have been the VP Medicine, who has clearly defined responsibilities to deal with performance-related problems. The VP Medicine also has a formally defined role as a member of DMAC. That role on DMAC created a clear conflict of interest during the Disciplinary Bylaw proceedings of Drs. Horne and Goodyear, which extended for a lengthy interval. At various times, Drs. Nassar, Horne, and Goodyear were all required to abstain from corresponding with the VP Medicine because of a perceived conflict of those communications with other duties of the VP Medicine, particularly her role on DMAC.

The DMSA

As discussed in Chapter 3, a professional organization such as the DMSA with the authority to represent the individual members and the financial resources to provide a level playing field is an essential requirement if academic freedom is to be properly protected and the rights of individuals to fair and timely resolution of disputes is to be enforced. Nevertheless, the role of DMSA appeared to be limited in the cases considered.

As discussed in Chapter 6, the DMSA appointed a Peer Review Committee to examine the allegations against Dr. Horne. That review by independent peers provided useful findings and recommendations. It demonstrated that an agreement to establish an independent review panel could have provided a rapid and comprehensive examination of the allegations against Dr. Horne without embarking on a variation of privileges and incurring all of the expense and damage that resulted from the Disciplinary Bylaws process.

In the case of Dr. Goodyear, the DMSA began a similar investigation of the concerns expressed by Dr. Goodyear's Division and Department Chiefs about the patient care provided by Dr. Goodyear. That investigation was terminated, and all materials destroyed, under legal threat from lawyers acting on behalf of CDHA. In the opinion of this Committee, a body specifically granted the right to speak on behalf of individual members of the Medical Staff must also have the right to information to which that member has legitimate access.

Ethics

As discussed in Chapter 3, the professional conduct of the Medical Staff is governed by the Code of Ethics of the Nova Scotia College of Physicians and Surgeons. That code states that respect for persons and justice is a fundamental ethical principle of medicine. In the opinion of this Committee, the egregiously long Disciplinary Bylaws process to which Drs. Horne and Goodyear were subjected was inconsistent with that fundamental ethical principle. Justice was denied by being so long delayed, and there was little evidence of respect for Drs. Horne and Goodyear and their personal well-being as the damage accumulated as a result of those delays. Similarly, the lengthy delay in investigating Dr. Nassar's complaint of a hostile work environment is inconsistent with this principle.

Colleagues have a responsibility to report immediately any conduct that they consider to be unprofessional or unsafe. As discussed in Chapter 7, in Dr. Goodyear's case none of his colleagues did so until they were requested to do so by the Division Chief in order to provide examples of cases in which they had concerns about the care provided by Dr. Goodyear. The lack of complaints against Dr. Goodyear by colleagues, patients, or families of patients was a significant factor in the CDHA Board ruling in Dr. Goodyear's case.

As discussed in Chapter 3, much of the research in which Dr. Horne was engaged was funded by an external granting agency and therefore had undergone thorough scientific peer review. It also had received all the required approvals by the Research Ethics Board. In approving the research protocols, the Research Ethics Board judged that Dr. Horne had taken all required steps to meet the ethical requirements for research. These steps included establishing appropriate safeguards to meet the requirements that: subjects were unlikely to suffer disproportionate harm from participating in the research; all subjects were provided with appropriate information about the purpose of the study, the funding source, the nature of Dr. Horne's role, and the nature and relative probability of harms and benefits; informed consent was obtained from subjects; and it was made clear to subjects that their participation, or refusal to participate, would not prejudice their ongoing care.

Bylaws

There were serious defects in the CDHA Medical Staff Disciplinary Bylaws in place at the time[26] the privileges of Dr. Goodyear and Dr. Horne were varied. Those defects are discussed in Chapter 4.

As also discussed in Chapter 4, this Committee found that the Disciplinary Bylaws are, in many ways, unsuited to productive solutions to disputes about the performance of physicians. Variation of privileges is an extremely serious matter for a physician, requiring a very high standard of procedural fairness and proof. A summary variation of privileges carries the stigma that some form of egregious behaviour has taken place, and should therefore be reserved for those egregious cases.

[26] These Bylaws are referred to as the "*Former Bylaws."* They were replaced by the "*New Bylaws*" in 2007.

The Disciplinary Bylaws do not provide for procedural fairness and natural justice until the final internal stage, the hearing by the CDHA Board. Consequently, a great deal of the evidence in the cases of Drs. Horne and Goodyear had not been properly tested prior to the hearing of the Board. Failure to test the evidence was a disservice, not only to Drs. Horne and Goodyear, but to CDHA as well. Procedural fairness and natural justice were denied for almost four years in the case of Dr. Horne, and for nearly six years in the case of Dr. Goodyear. The allegations made against Drs. Horne and Goodyear were ultimately found not to be grounds for variation of privileges. Furthermore, those allegations did not approach the level of seriousness required for a summary variation of privileges.

In the cases of Dr. Horne and Goodyear, a number of alternatives to variation of privileges could have been used. In addition, the CEO did not invoke certain powers, such as temporarily reinstating privileges, which might have avoided or mitigated the damage to Drs. Horne and Goodyear.

Mutual agreements to waive the time limits for Drs. Horne and Goodyear to make a submission to DMAC resulted in there being no time limits for the Disciplinary Bylaws process. A waiver of a ten-day time limit led to an extension of the process over several years. Surely, this unintended result demanded corrective action, which was not forthcoming.

As discussed in Chapter 6, a settlement of all matters in dispute involving Dr. Horne was achieved using a mediator. PRC did not honour the agreement and asserted that only PRC had the power to conclude an agreement. Dr. Horne's attempt to enforce the agreement through the Court failed when the Court ruled that the CDHA CEO did not have authority to bind the CDHA Board on a matter involving privileges. The Disciplinary Bylaws in effect prior to 2007 prevented the Board from ratifying the mediated agreement signed by the CDHA CEO because the PRC asserted power to make a recommendation to the Board on any proposed settlement. The agreement was not implemented by CDHA, amid disagreements about the choice and role of two mentors for Dr. Horne, among other matters.

The provision in the CDHA Bylaws that privileges be renewed every three years does not provide the secure appointment that is needed for proper protection of academic freedom. It leaves individual members of the Medical Staff vulnerable to termination without the expected procedural safeguards against unjust terminations. Drs. Nassar, Horne, and Goodyear all faced threats that their privileges would not be renewed.

The Bylaws are silent on the effect that any suspension of privileges may have on the income of the affected member of the Medical Staff. Dr. Goodyear's remuneration was reduced to 15% of its normal value for five years until the Disciplinary Bylaws process was concluded. The effect was punitive, and exacerbated an already major imbalance of resources between Dr. Goodyear and CDHA.

Individuals should be removed from the workplace only if their presence can be shown, on sound and reasonable grounds, to present a real and current danger to patients, staff, or the public.

The Bylaws should provide for a binding process to settle any disputes about whether or not the ruling of the CDHA Board has been implemented.

Affiliation Agreement

The Affiliation Agreement between Dalhousie University and CDHA is deficient in a number of important ways, discussed in Chapter 3. Among other matters, the Affiliation Agreement does not provide protection for academic freedom; allows for confusion regarding decision-making, particularly during Disciplinary Bylaws proceedings; takes no account of the important role of group practice plans; allows for potentially inconsistent or conflicting policies between the CDHA and Dalhousie University domains; and is not a true partnership of equals. Recommendations for a new cooperative partnership are made in Chapter 9.

Recommendations

Although the cases studied by this Committee took place at CDHA and Dalhousie University, many of the features of foundational documents, policies, procedures, and academic medical culture are not unique to CDHA and Dalhousie. In the opinion of this Committee, similar disputes might arise, for similar reasons, in other medical schools and their affiliated teaching hospitals. The recommendations provided in Chapter 9 are aimed at dealing with the specific circumstances that were studied by this Committee. However, the Committee anticipates that some or all of these recommendations may be useful in similar situations elsewhere.

Chapter 9 | Recommendations

Overview of Recommendations

This Inquiry concluded that the fundamental cause of the problems that arose in the three cases considered was a deeply flawed set of foundational documents, Bylaws, policies, and regulations. The grave injustices that occurred were not ultimately the fault of individuals, but of a broken system which needs to be rethought and replaced. The recent establishment of the Nova Scotia Health Authority (NSHA) provides an excellent opportunity to correct these deficiencies.

The recommendations set out below are based on:

- a full commitment to a culture built around Evidence-Based Practice, as discussed below, by all parties;
- a new Cooperative Partnership between NSHA and Dalhousie University in which both are equal partners in all aspects of clinical care, medical research, and medical teaching, and the planning, administration, and funding of those activities;
- a new commitment by all parties to Quality Assurance and Clinical Management, emphasizing mutual responsibility and support for implementing the principles of Evidence-Based Practice;
- new contractual safeguards for Medical Staff/Dalhousie Faculty, including robust protection for academic freedom;
- making mentorship a core resource available to all faculty and academic/clinical administrators, recognizing the valuable role mentors can play in reducing misunderstanding and both avoiding and resolving disputes, and building personal support through mentoring into the academic clinical culture;
- a new set of policies for dealing with performance issues when they arise, including a new and clearly defined Policy Concerning Variation or Suspension of Privileges, a Discipline Policy for issues that do not directly impact clinical care, and a Grievance Policy for prompt, final, and binding resolution of disputes that arise concerning the application, administration, or interpretation of the Bylaws, policies, rules, and regulations;
- a new means for providing more effective representation for members of the Medical Staff/Dalhousie Faculty through a mutually recognized and well-funded representative agency chosen by the Medical Staff/Dalhousie Faculty;
- a new means of obtaining expert external independent assessments of members of the Medical Staff/Dalhousie Faculty, and principles to be applied when requesting external independent assessments in order to reduce the impact of potential biases;
- new national resources to assist with defining and assessing clinical practice standards, to provide active support and training to assist individuals and groups to achieve and maintain these standards, to assist with performing practice audits or establishing appropriate panels to perform effective external independent reviews and assessments of clinical practice, and to help with the management and investigation of cases in which there are disputes about practice standards;
- new procedures regarding the Official Files of members of the Medical Staff/Dalhousie Faculty;
- action to reach a final resolution of the remaining issues in dispute.

Adopt a culture centred on Evidence-Based Practice:

Evidence-Based Practice describes an overall clinical approach in which research provides new evidence and understanding that is incorporated into the care of individual patients, resulting in treatments that evolve and improve over time. Through the implementation of Evidence-Based Practice, patients benefit from research advances, and the critical connection between research and improved patient care is emphasized.

Evidence-Based Practice (EBP) requires[27] "*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating* individual *clinical expertise with the best available external clinical evidence from systematic research*." EBP is the integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care. "Clinical expertise" refers to the clinician's cumulative experience, education and clinical skills. The patient brings to the encounter his or her own personal preferences and unique concerns, expectations, and values. The best research evidence is usually found in clinically relevant research that has been conducted using sound methodology.

Society has a crucial interest in encouraging a commitment to Evidence-Based Practice, and one of the main instruments for doing so is through tertiary and quaternary care teaching and research hospitals associated with medical schools, such as CDHA and Dalhousie University.

The *de facto* standard at tertiary and quaternary care teaching and research hospitals should be Evidence-Based Practice. All of the foundational documents defining the relationship between NSHA and Dalhousie should support and enhance a culture of Evidence-Based Practice. An important component of doing so is for leadership to create a culture of understanding, valuing, and respecting academic freedom. Academic freedom provides essential protection for those engaged in such transformative practice and its research foundations, where strongly held differences of opinion and practice are likely, if not inevitable, and powerful interests can resist changes proposed by individual members of the Medical Staff/Dalhousie Faculty devoted to implementing Evidence-Based Practice.

Replace the Affiliation Agreement with a Cooperative Partnership:

A new Affiliation Agreement between Dalhousie University and NSHA should be negotiated to establish a new and more appropriate foundation for their joint activities. The particular changes required in the current Affiliation Agreement between Dalhousie University and Capital Health are described in this section.

The current Affiliation Agreement is structured so that each of the parties has exclusive jurisdiction and responsibility for certain aspects of the relationship, arising from their separate legal identities established by distinctly different statutes. Two separate organizations recognize

[27] See, for example, Sackett et al BMJ 1996;312:71–72 (13 January)

the interests and expertise that each has, and these separate organizations agree to support each other in accomplishing their objectives.

The separate missions of Dalhousie University and Capital Health, as expressed in the Affiliation Agreement, are mutually consistent, and also consistent with Evidence-Based Practice. For example, the Dalhousie University "… *Faculty of Medicine's aim is an equal commitment to the provision of exemplary patient care, the education of students, the discovery and advancement of knowledge and, through education and community work, to service society in the Maritimes, Canada, and world-wide …*" and the Capital Health mission is "… *to provide care, educate, conduct research and advocate in the pursuit of healthy people in healthy communities. The values that guide Capital Health's decisions and behaviour are collaboration, accountability, respect and excellence …*"

Notwithstanding the mutual consistency of these missions and objectives, the Affiliation Agreement specifies an elaborate set of parallel structures with split responsibilities. This bifurcation of structure and responsibility undermines the consistency of missions the Affiliation Agreement is supposed to uphold. For example, there is a Department of Medicine at Capital Health with a major focus on clinical care and a Department of Medicine at Dalhousie, with a major focus on research and teaching. There are requirements that Dalhousie Faculty Members normally have joint appointments with privileges as Medical Staff at Capital Health. Similarly, there are requirements that the Chief of Medicine at Capital Health also normally be the Head of Medicine at the Dalhousie Faculty of Medicine. In addition, the majority of the compensation of most members of the Medical Staff and Faculty Members is derived from the various group practice plans such as the CDHA Department of Medicine Alternate Funding Plan, which are separate from either Dalhousie or Capital Health.

The parallel structure of the Affiliation Agreement is an artificial construct that denies the inherent unity of leading-edge clinical care, medical research, and teaching. Medical faculty, residents, interns, and students cannot do their job without access to the Capital Health facilities and patients. Similarly, Capital Health cannot provide the high-quality tertiary and quaternary medical care that is their mandate without the participation of the Dalhousie faculty, residents, interns, and students. This basic reality demands a new Cooperative Partnership between Dalhousie and Capital Health covering all of the activities in which they have joint interests.

The premise that each organization acts on its own within a certain sphere and that an Affiliation Agreement can bridge the inherent contradictions in this model is tenuous at best and was shown to be badly flawed in the cases under investigation. For example, this flawed premise allowed Capital Health to vary the privileges of both Dr. Horne and Dr. Goodyear, with all the negative consequences that arose from those actions, without Dalhousie University having any effective input into the decision, being given formal reasons for the action, or even being able to prevent an exceptionally long process to determine if the variation of privileges was justified (which in neither case it was). The Alternate Funding Plan of the Department of Medicine at Capital Health unilaterally reduced Dr. Goodyear's compensation to 15% of its value before his privileges were suspended, without any consultation with Dalhousie or Capital Health other than the trivial "consultation" — and the obvious related conflict of interest — arising from one individual being Chief of all three organizations.

The missions of the Dalhousie Faculty of Medicine and NSHA are each compatible with a Cooperative Partnership in which each party shares responsibility equally with the other in all aspects of their joint work. Sharing responsibility equally in a Cooperative Partnership would have avoided much of the dysfunction that this Inquiry found in the current Affiliation Agreement. Therefore, the current Affiliation Agreement should be replaced by a new Cooperative Partnership negotiated between the parties.

That Cooperative Partnership should be based on an active commitment by NSHA and Dalhousie University to meet the overall objective of the partnership jointly. That overall objective should include a commitment to Evidence-Based Practice that recognizes the essential unity of the three aspects of clinical care, research, and teaching and requires every participant to integrate all three aspects into a coherent whole. This integration is in the best interests of both Dalhousie and NSHA, and is essential to each attaining its separate objectives as currently defined. The Cooperative Partnership should clearly recognize this unity and be structured to encourage it.

The Cooperative Partnership should be based on the sound foundation of co-fiduciary responsibility, which is a well-established concept in medical ethics. It should recognize the important role that medical education and research play in promoting the best possible evidence-based care for patients, making education and research synergistic, rather than separate and distinct from, or even competitive with, patient care. From that sound foundation, leaders at Dalhousie and NSHA should build an organizational culture of co-fiduciary responsibility both in writing and in practice, and become models for the reform and improvement of the relationships between Dalhousie and NSHA to the benefit of the patients, students, interns, residents, faculty, and staff.

The Cooperative Partnership should recognize the critical role played by academic freedom in medical education, research, and even administration. It should make explicit commitments to openness, transparency, and shared decision-making by NSHA and Dalhousie in all joint activities. It should provide explicit terms for sharing revenue and costs between Dalhousie and NSHA. The current practice of arrogating many of the cost issues — notably the major cost of paying the Medical Staff/Dalhousie Faculty who are responsible for patient care, medical research, and teaching — to third parties such as the various Alternate Funding Plans requires reform.

Under a Cooperative Partnership, the distinct Departments at NSHA, focused on patient care, and at Dalhousie, focused on teaching and research, would become a single Department with responsibility for all three aspects. Members of this single department holding joint appointments at NSHA and Dalhousie are hereafter referred to as Clinical Faculty. That single Department would also have responsibility for planning, budgeting, and overall administration of all its activities. The pooled expenses for all activities of the Department would be met by pooling the revenues associated with all activities. Much of that revenue derives from the various Alternate Funding Plans. The participants in the Alternate Funding Plans are, for the most part, the same people who are members of the proposed united Dalhousie/NSHA Departments. As such, the AFP members have a strong interest in Evidence-Based Practice and making decisions that allow Evidence-Based Practice to prosper. The AFP members are the agents by which the Cooperative Partnership derives its vitality. Instead of each of three different organizations

acting separately to deal with a single aspect of the inextricably linked activities in which they are all engaged, they should work together as a single entity to deal with all aspects in a coherent and coordinated way. It is recognized that this is a major reform, and that the support of government in making the required legislative changes will be needed. However, this Inquiry is convinced that it is in the best interests of all parties, including the patients and the general public of Nova Scotia, and Atlantic Canada.

The Cooperative Partnership should recognize that from time to time disputes will arise, and so the Cooperative Partnership should provide robust procedures that will achieve a fair, final, and binding settlement of those disputes in a timely manner. These disputes could involve both the actions and inactions of individuals and of the formal representatives of the parties. There must be an effective grievance process accessible by individual members of the Clinical Faculty. Revised disciplinary procedures should be based on constant quality improvement, support for changes in practice required to implement those improvements, and sound investigation and evaluation procedures. During grievance proceedings, individual members of the Clinical Faculty should be able to choose to be represented by a professional association or union formally recognized in the Cooperative Partnership agreement. Recommendations on these matters are discussed below.

Policy and procedure review

It is recommended that the new Cooperative Partnership of NSHA/Dalhousie conduct a thorough review of all policies, procedures, and regulations and make appropriate changes when required to ensure that they are consistent with the basic principles discussed in Chapter 2, the lessons learned from the case studies in Chapters 5, 6, and 7, and the Recommendations in Chapter 9 of this report. In particular those policies, procedures, and regulations should:

- respect, support, and protect academic freedom;
- respect and support a fully collegial environment in which all formal policies, procedures, and regulations are developed through collegial procedures, such as Department and Division meetings, and are formally adopted and promulgated by those bodies.

A new Framework for Quality Assurance and Clinical Management

It is recommended that a new Framework for Quality Assurance and Clinical Management be established. The focus of this new Framework is to establish means by which Evidence-Based Practice can prosper and constant quality improvement, for both the system as a whole and individual members of the Clinical Faculty working in the system, becomes the standard for ensuring the highest standards of care.

The basic purpose of this Framework for Quality Assurance and Clinical Management is to provide means by which individual members of the Clinical Faculty can work together to maintain a high level of Evidence-Based Practice. These means include active integration of

research findings and evidence-based medicine into patient care; ongoing professional development, including regular reviews of research findings and their implications for care; regular practice audits and peer review of standards of practice for both Departments and individual members of the Clinical Faculty; a robust mentoring program; establishment of standard protocols, and constant review to ensure protocols represent the best current understanding of the research evidence; mandatory reporting of adverse events; and processes, such as Morbidity and Mortality Rounds, to discuss frankly those adverse events and what has been learned that would minimize the risk of recurrences and improve care in the future.

At the outset, the Framework for Quality Assurance and Clinical Management must provide for a process by which the required standards are established and requests for initial granting of privileges are vetted. The all-important first step is to ensure that all candidates have appropriate training and experience, are committed to the principles of Evidence-Based Practice, and are prepared to contribute substantively to ongoing quality assurance and clinical management. This first step also provides an opportunity to express definitively the institutional commitment to academic freedom. The current Disciplinary Bylaws could form a useful starting point for a system for vetting initial requests for hospital privileges.

Next, a number of fundamental principles for this Framework must be established.

The intent of this Framework is to be both proactive in supporting improvements through Evidence-Based Practice and proactive in encouraging regular reflection and discussion about how to improve. There must be basic safeguards that encourage and enhance the active involvement of all members of the Clinical Faculty in achieving these basic purposes in a mutually respectful and supportive environment that emphasizes cooperation, support, and mutual assistance rather than assigning blame for errors and taking disciplinary action by means such as the existing provisions in the Disciplinary Bylaws for variation of privileges. These safeguards must include robust protection for academic freedom and explicit recognition that discussions at bodies such as Morbidity and Mortality Rounds are privileged and may not be disclosed or used in any disciplinary or legal proceedings. The purpose of Morbidity and Mortality Rounds is to learn lessons for the future from studying adverse events or "sentinel events" that might indicate systemic problems that need to be corrected.

The normal approach to dealing with concerns about the performance of individual members of the Clinical Faculty should be through proactive training and professional development, and the ongoing review, audit, and reflection that are at the core of Evidence-Based Practice. It should be a clear expectation that all members of the Clinical Faculty will participate actively in these activities.

When questions concerning performance arise, rather than focusing on blame and discipline the focus must be on identifying the events that led to the concern (What happened?), understanding the cause of the events (Why did it happen?), determining the potential consequences (Is there a continuing risk of harm?), and taking corrective action (What can be done to prevent similar events in the future?).

This Framework approach requires a culture shift away from assigning blame and imposing sanctions on individuals, to one of mutual support and collective responsibility for the

overall quality of care in a learning environment built on Evidence-Based Practice. The preferred approach is to address performance concerns through active mentoring to establish appropriate retraining or rehabilitation, and other informal resolutions, such as voluntary restrictions of practice until the source of the concern is addressed. It is expected that this Framework will prove to be more effective at providing the best possible Evidence-Based Practice than could be achieved using the outmoded blame-and-discipline approach embedded in the current Disciplinary Bylaws.

By any reasonable standard, the Disciplinary Bylaws were an abject failure in the cases that were the subject of this Inquiry. The processes took much too long, were clearly unfair to the members of the Medical Staff who were accused of wrongdoing, did not establish authoritative independent external reviews, did not provide for a rigorous evaluation of the evidence, and, in the case of Dr. Horne, prevented the implementation of a mediated settlement that all parties had signed. There was a great deal of work by many people, including a considerable commitment of legal support, and the expenditure of considerable sums of money that go hand in hand with legal support, which did not lead to conclusions that were supported by the CDHA Board when that body ultimately held hearings under the protections of procedural fairness and natural justice.

The "*New Bylaws*" put in force in 2007 corrected two flaws in the "*Former Bylaws*" by redefining the role of PRC to determining if a negotiated settlement could be reached, and by specifying the conditions under which an emergency variation of privileges could occur. Neither of these improvements is sufficient to save the Disciplinary Bylaws. The emphasis, regrettably, remains on making judgments and assigning blame to specific individuals, and applying sanctions based on those judgments. A completely new approach is required.

Ensuring that mentorship is a core resource

The active encouragement of mentorship as a core resource can greatly enrich the academic and clinical environment for faculty and administrators alike. Mentors should be routinely available to new Clinical Faculty, and their use should be encouraged, though not required.

Mentors, confidantes, and advisors can also be of great benefit to academic clinical administrators as they gain experience and encounter new, and sometimes difficult, situations. More generally, when an individual undertakes a new role and responsibilities, active mentorship involving more experienced colleagues can facilitate the transition into that new role.

The importance of mentorship should be recognized, valued, and become part of the overall culture of "what we do and how we do it."

There is an extensive literature on mentorship and its role in academic medicine, which would be useful in establishing, enhancing, and supporting mentorship programs.[28] It is recommended that mentorship become a fully developed core resource.

[28] See *Mentorship in Academic Medicine,* Sharon E. Strauss and David L. Sackett, Wiley, 2014

Resolving performance problems

When the recommended Framework for Quality Assurance and Clinical Management in Evidence-Based Practice is appropriately implemented, most potential performance issues should be resolved before they become problematic. The intention is to have a learning culture that recognizes early signs of potential difficulty and takes corrective action in a mutually supportive environment. Opportunities for honest feedback and reflection, working with colleagues and mentors to maintain high skill levels or upgrade as required, and dealing with problems as systemic matters that require a cooperative and collaborative approach from everyone, will all assist in minimizing issues of concern.

By resolutely applying this proactive and positive framework, it is expected that very few matters would require correction through other means. It must be recognized that some concerns can originate from misunderstandings, differences in medical philosophy, or personality differences, and that a certain degree of difference in clinical judgment is to be expected. The simple fact that colleagues reach different conclusions about appropriate care in a certain set of circumstances does not by itself imply that anyone is wrong. However, when cases arise in which the recommended Framework for Quality Assurance and Clinical Management in Evidence-Based Practice does not resolve questions about the performance of individual members of the Clinical Faculty, there must be appropriate procedures to provide a prompt, final, and binding resolution through other means.

Formal disciplinary actions against individuals should be restricted to genuinely serious misconduct. Removal of an individual from the workplace should be contemplated only in the most exceptional of circumstances in which there is a genuine and immediate need, and the risk cannot be remediated in any other way.

It is recommended that there be two distinct, but related, policies. A Discipline Policy should be designed to deal with issues concerning performance of individual members of the Clinical Faculty that do not relate directly to patient safety. For example, a consistent failure by members of the Clinical Faculty to bill for services in a timely manner requires correction and could be the cause of disciplinary action if other corrective means do not succeed. A Variation of Privileges Policy should be designed to deal with those rare cases in which it has been clearly established that there is an actual or imminent danger of harm to patients, staff, students, or the public. It is expected that each of these policies will be invoked rarely, and only in the most serious cases. Therefore, it is recommended that these policies be administered by the Officer defined in the Cooperative Partnership as having the ultimate authority for clinical care. This Officer could be called the Chief Clinical Care Officer (CCCO).

No matter which one of these policies applies, when a serious concern comes to the attention of the CCCO, there is an urgent need for a high level of skill and experience in dealing properly with the issue. Unfounded or malicious allegations can inflict serious and permanent damage on the reputation and career of members of the Clinical Faculty. Therefore every allegation that comes forward must be promptly and thoroughly investigated. To ensure there is appropriate expertise to call upon when the need arises, it is recommended that the CCCO identify respected individuals having case management skills and case investigation skills and

provide them with appropriate training. It is recommended below that new resources be established to provide these and other related services.

When a concern or allegation arises, the CCCO should appoint a well-trained Case Manager to oversee the case and ensure that it moves to a prompt and thorough resolution. The Case Manager should not normally be anyone who has a direct connection to the individual member of the Clinical Faculty at the centre of the concern. For example, it would be inappropriate for the individual's Department Head to be the Case Manager. The role of the Case Manager is to make operational and procedural decisions that ensure that the matter is resolved effectively and in a timely manner. The Case Manager should not to be involved in the actual investigation or in making a final judgment on the evidence, but should be responsible for recommending to the CCCO what further steps may be required after the investigation is completed. First and foremost, the Case Manager should be a problem-solver.

Upon being appointed by the CCCO, the Case Manager must inform the member of the Clinical Faculty involved, in writing, of the specific allegations or concerns, and advise him or her to seek legal counsel and/or assistance from his or her representative organization (see the discussion of representative organizations below). The Case Manager must make an early determination of whether an informal voluntary resolution is possible or whether a formal investigation is warranted.

If the Case Manager determines that a formal investigation is required, the CCCO should appoint a well-trained Case Investigator to conduct an appropriate, unbiased, and expeditious investigation. The Case Manager should inform the member of the Clinical Faculty that an investigation will be conducted, provide the name of the Case Investigator, and advise the member of the Clinical Faculty how to provide the Case Investigator with evidence the member considers relevant. The member of the Clinical Faculty should also be told the expected duration of the investigation, which would normally not exceed four weeks.

The role of the Case Investigator is to lead the investigation and to ensure that all the facts are established and reported. As an example, the Case Investigator may determine that an external evaluation is required and arrange for an appropriate independent panel to conduct the review. The Case Investigator is not a "prosecutor" securing and presenting evidence against the member of the Clinical Faculty who is the centre of the investigation. Rather, the Case Investigator gathers all relevant facts in an impartial and unbiased manner. The Case Investigator plays no role in judging the evidence. The Case Investigator will make all evidence available to the member of the Clinical Faculty concerned and afford her or him an adequate opportunity to comment or to suggest other witnesses and evidence that should be considered.

A shared responsibility of the Case Manager and the Case Investigator is to ensure that proper confidentiality provisions are in place to protect all parties. If patients are involved, the facts must be presented in detail but should be coded to remove patient identifiers in accordance with relevant law.

The Case Investigator should present a report to the Case Manager within the time limit, which has been disclosed to the member of the Clinical Faculty at the time the Case Investigator is appointed. The time limit should be extended only at the request of the Case Investigator, for a

specified period, and with the agreement of the Case Manager and the member of the Clinical Faculty. The time limit may not be extended for an indefinite time, nor should the extension of one time limit affect the other time limits, which remain in place unless there is explicit agreement to vary them individually. Moreover, the member of the Clinical Faculty and Case Manager should have the option of refusing, without prejudice, any requested extension.

Before considering the Investigation Report, the Case Manager should provide the member of the Clinical Faculty an opportunity to comment on the report, including the accuracy and/or relevance of any of its contents, and any additional evidence that the member of the Clinical Faculty considers should be included in the report. After due consideration of the report and the comments of the member of the Clinical Faculty, the Case Manager will recommend to the CCCO what further steps may be required. After receiving the investigation report from the Case Manager, the CCCO shall make a decision within ten days of receiving the report. The recommendation from the Case Manager will typically be one of the following.

- There is no evidence warranting further action. The CCCO may decide to close the case and will so inform all parties. All documents and materials gathered during the case will be held in a confidential restricted file that may be accessed only by specified individuals for well-defined and agreed purposes, as set out in the recommendation on restricted files below.

- There is evidence of a need for additional training or skill development. The CCCO may appoint a mutually agreed Mentor to work with the member of the Clinical Faculty to propose an appropriate remedial program, subject to approval by the CCCO.

- There is evidence of systemic problems, such as but not limited to interpersonal conflicts, communication breakdowns, unresolved disputes over practice standards or protocols, etc. The CCCO may appoint a Facilitator to work with all parties to resolve the outstanding issues.

- There is evidence of possible misconduct that could become the subject of disciplinary action under the Discipline Policy but not including any variation of privileges. The CCCO will determine an appropriate disciplinary action in accordance with the Discipline Policy and provide written notice to the member of the Clinical Faculty of that decision, giving written reasons in sufficient detail to allow the member of the Clinical Faculty a full opportunity to respond. The member of the Clinical Faculty has the opportunity to file a formal grievance under the Grievance Policy, which provides for a final and binding conclusion by an independent arbitration or other agreed means.

- There is evidence of serious misconduct or unacceptable performance that poses a threat to patient safety, warranting consideration of variation of privileges under the Policy on Variation of Privileges. The CCCO will decide on an appropriate variation of the privileges of the member of the Clinical Faculty and will provide written notice to the member of the Clinical Faculty of that decision, giving written reasons in sufficient detail to allow the member of the Clinical Faculty a full

opportunity to respond. Those reasons must include both the reasons for the decision to vary privileges and the reasons the particular variation is considered just and reasonable. The CCCO will refer the matter to a hearing under the terms of the Policy on Variation of Privileges.

- There is evidence of misconduct so serious that the case should be reported to the College of Physicians and Surgeons of Nova Scotia. The CCCO will refer the case to the Nova Scotia College of Physicians and Surgeons and will provide written notice to the member of the Clinical Faculty of that decision, giving written reasons in sufficient detail to allow the member of the Clinical Faculty a full opportunity to respond to the College.

Policy on Variation of Privileges:

It is recommended that a formal Policy on Variation of Privileges be established to deal with the rare occasions on which it has been established, through an appropriate investigation, that there is an actual or imminent danger of harm to patients, staff, students, or the general public. Performance concerns that do not relate directly to such imminent danger of harm should be dealt with according to the Discipline Policy.

The policy should reserve a variation of privileges for genuinely serious misconduct that involves actual harm or a clear risk of harm. The variation of privileges must be a necessary expedient to ensure the safety of patients, staff, students, and the public. The objective of a variation of privileges is to take the action required to ensure safety. However, the policy must recognize the highly prejudicial effect such an action likely will have on the reputation and future career of the individual whose privileges are varied. Appropriate steps to maintain confidentiality are essential.

Once such serious concerns have been identified by the CCCO, there must be an urgent decision about how to remove the potential for harm. It is desirable that this decision be accomplished by voluntary amendments to the clinical duties of the member of the Clinical Faculty involved while steps are taken to correct the underlying issues. For example, clinical duties could be supervised by a mutually agreeable colleague or could be voluntarily restricted to areas in which there is no likelihood of potential harm. Alternatively, there could be a voluntary, and mutually agreeable, rebalancing of duties, removing some or all clinical duties and replacing them with increased research, teaching, administration, or professional development duties.

In the event that a voluntary amendment or restriction of clinical duties is not possible, temporary restrictions may be imposed for a specific limited time, not exceeding one month, while the investigation continues and the required hearings take place. The particular variation imposed must be the minimum variation required to remove the threat of harm. Possible approaches are similar to those which would preferably be implemented voluntarily. These could include appointment of a Mentor to advise on normal clinical duties, restricting practice to only certain types of clinical duties that are deemed to be safe, or restricting duties to nonclinical activities such as administration, research, protocol development, medical audit activities,

teaching, or professional development. Any imposed changes may be challenged by the member of the Clinical Faculty using the Grievance Policy (see below).

The policy should provide that after one month the variation of privileges expires unless a formal review of the variation has determined that an extension is clearly still required to protect patients, staff, students, or the public from harm. The member of the Clinical Faculty involved should be able to challenge the extension through the Grievance Policy.

An imposed variation of privileges does not, in itself, justify the exclusion of the member of the Clinical Faculty from the workplace. A workplace exclusion should be an exceptional event that is essential to protecting the interests of patients, staff, students, or the public, or the integrity of the investigation. Any exclusion should be for the minimum required time, which should reasonably be no more than one month. As with the variation of privileges, the exclusion should expire after one month unless an extension is clearly justified, and the member of the Clinical Faculty should have the right to challenge any extension using the Grievance Policy.

Furthermore, removing a member of the Clinical Faculty from some or all of his or her clinical duties should not have any automatic effect on his or her research, teaching, and administrative duties. The member of the Clinical Faculty should be able to continue with his or her other work unless doing so would also pose a risk to others.

When a decision has been made that the privileges of a member of the Clinical Faculty must be varied, whether or not accompanied by exclusion from the workplace, the member of the Clinical Faculty must receive written notification of the variation and/or exclusion, the specific terms of the variation and/or exclusion, including the duration, and the reasons for these actions. The member of the Clinical Faculty must also be informed of his or her rights under the policy to challenge these decisions.

One of the conclusions from experience in the cases of Dr. Horne and Dr. Goodyear was that the hearings of DMAC and PRC, which did not provide the protections of procedural fairness and natural justice, were ineffective because the evidence did not receive appropriately rigorous scrutiny, and inclusion of some such evidence created a prejudicial starting position for later deliberations. Therefore, it is recommended that time not be spent on hearings that do not provide the protections of procedural fairness and natural justice. The elimination of such compromised and ineffective procedures is both fairer to the individual who is the focus of the hearings, and more efficient and effective in reaching a final resolution of the issue in dispute in a timely manner.

The member of the Clinical Faculty whose privileges have been varied should have the right to request that the case proceed to a hearing before the NSHA Board. That hearing should be conducted expeditiously and with all the protections of natural justice. The provisions of the "*New Bylaws*" in this regard are appropriate and may be maintained in the Policy on Variation of Privileges, except that the new policy should stress the need for the hearing to take place promptly. If the member of the Clinical Faculty is not satisfied with the conclusion of the Board hearing, she or he has the right to give notice to proceed to a hearing of the Provincial Appeals Board, as specified in the "*New Bylaws*."

External independent resources concerning clinical practice standards

There is a serious weakness in principle in even well-defined policies and procedures that rely solely on internal resources in dealing with the complex issues that can arise regarding clinical practice standards and the investigations that result when concerns arise. Internal resources may not be independent, or be seen to be independent, and may be subject to bias or to pressure from colleagues, government, or others with a perceived interest in the case. It is recommended that new external independent resources be developed to assist individual universities and teaching hospitals with these matters.

These external independent resources should include at least:

- assistance with defining and assessing clinical practice standards consistent with Evidence-Based Practice;
- provision of active support and training to assist individuals and groups to achieve and maintain these standards;
- assistance with performing practice audits;
- assistance in establishing appropriate panels to perform effective independent external reviews and assessments of clinical practice;
- initiation of independent external assessments of the clinical practices of individual members of the Clinical Faculty to evaluate fairly clinical competence;
- provision of Case Managers and Case Investigators for situations in which a dispute has arisen about clinical practice.

Ideally, these independent external resources would be national in scope to provide efficiency, a high level of professional expertise, and assurance that these resources are free from local pressure. For example, these resources could become part of the mission of the Royal College of Physicians and Surgeons of Canada, or an independent arms-length agency could be jointly established by the Canadian medical schools and teaching hospitals. Because of the provincial responsibility for health care in Canada, it is possible that a national resource may be difficult to achieve. In the absence of nationally agreed arrangements, the Nova Scotia College of Physicians and Surgeons and Doctors Nova Scotia should jointly establish a roster of suitably qualified individuals to provide these external independent services. To ensure independence, it would be preferable that the roster consist of physicians from other provinces, or that bilateral agreements be reached to make use of similar rosters established in other provinces.

Principles of independent external assessments

This Inquiry found that an independent external assessment of Dr. Goodyear's practice should have been conducted at an early stage. An effort was, indeed, made at an early stage to assess Dr. Goodyear's practice, but was, as noted in Chapter 7, biased in conception and execution. It is apparent that there was no solid understanding of how such an external independent assessment should be conducted. Likewise there was no apparent solid understanding of the reasons for the steps that are necessary to make such a review both credible

and fair. An appropriate review, either by an individual reviewer or by a panel of reviewers, must be structured to guard against many potential biases. Avoiding bias, to the greatest extent possible, requires the following structure for a review.

- The reviewer must be independent, which requires that he or she be from outside the NSHA, and preferably from outside the province, and with no reason for ongoing interactions with the Medical Staff of the NSHA.
- The reviewer should be blind to who the physician is, and in what institution that physician works, in order to prevent potential positive or negative bias based on the reputation of the individual or institution.
- The reviewer should be blind to the outcome of the cases submitted for review in order to guard against "*outcome bias*" (i.e., the patient got better so the treatment must have worked, or the patient died so there must have been a problem).
- The reviewer should be given charts where no concerns have been identified as well as those where a concern has been identified. These charts should also include cases in which other physicians were attending.
- The reviewer should not be told the nature of the concerns that triggered the review.
- The appropriate question for the reviewer to answer is, "In your professional opinion, is the care provided within the bounds of what would be considered appropriate care within the discipline as a whole?"

Convert all CAPR appointments to tenure or tenure stream

The CAPR system does not provide adequate protection for academic freedom. It is recommended that CAPR be replaced by a full tenure system. Clinical faculty in the Dalhousie Faculty of Medicine did have tenure until it was removed and replaced with CAPR during the 1990s.

An appointment with tenure is the appropriate safeguard of academic freedom for Clinical Faculty. Tenure is a mutual covenant involving the member of the Clinical Faculty and the University/NSHA. The member of the Clinical Faculty makes a commitment to continuing to perform conscientiously her or his duties as a clinician, researcher, and teacher at a level appropriate for tenure, and the University/Capital Health makes a commitment to guarantee academic freedom under an appointment that may be terminated only for just and sufficient cause, determined by a fair hearing, with all the protections of natural justice, before an independent adjudicator or tribunal.

The requirements of a satisfactory tenure system are:

- Initial appointments should be probationary, intended to lead to tenure when the member of the Clinical Faculty has demonstrated his or her academic and clinical competence after a series of assessments;
- Members of the Clinical Faculty on probationary appointments should have a Mentor assigned to work with them to help them understand in detail the rightful expectations that must be met in each aspect of their duties, clinical, research, and teaching, in order to achieve tenure;

- Once per year during the probationary period, the member of the Clinical Faculty should provide a written self-assessment and have an in-depth discussion with his or her Mentor and his or her Department Chief, to identify any issues that need additional attention. If any such issues are identified, they should mutually agree on an appropriate program, in an appropriate time frame, to address these issues. The intent is to provide every reasonable opportunity for the member of the Clinical Faculty to bring his or her performance to the level expected for tenure;
- A formal Probationary Review should be held after a contractually determined period, which should be no fewer than three and no more than four years, to determine if the member of the Clinical Faculty is making satisfactory progress toward meeting the criteria for tenure;
- A successful probationary review should result in an extension of the probationary appointment for an additional contractually agreed period, up to three years;
- A final review for tenure should occur not more than six years after the initial probationary appointment;
- The member of the Clinical Faculty should have full access to the Grievance Policy in the event of any disputes arising during the probationary appointment, including any of the assessments that take place during that appointment;
- The University/NSHA may undertake a formal review of the performance of a tenured member of the Clinical Faculty once per year if there is reasonable cause to believe that the member of the Clinical Faculty is failing to meet her or his commitments to perform conscientiously her or his duties as a clinician, researcher, and teacher at a level appropriate for tenure;
- In the event that such a formal review is unsatisfactory, the University/NSHA may take action under the Discipline Policy or the Policy on Variation of Privileges. The member of the Clinical Faculty shall have full access to the provisions of the Grievance Policy.

Contractual safeguards and effective representation

If events such as those investigated by this Inquiry are to be avoided in the future, it is essential that Medical Staff/Dalhousie Faculty have contractual protections similar to those of other Dalhousie Faculty, and have representation by an organization that is formally recognized in the Cooperative Partnership, has enforceable representation rights, and has the resources to be effective. Dalhousie, the NSHA Administration, and the Medical Staff/Dalhousie Faculty should take the initiative to resolve this deficiency in the current arrangements. There are a number of options for accomplishing appropriate representation and contractual protections. The Medical Staff/Dalhousie Faculty should make the choice that best meets their needs, and that choice should be voluntarily recognized by the NSHA Administration and Dalhousie in the new Cooperative Partnership. However, a number of impediments must be recognized and overcome.

First, the CDHA Medical Staff who are simultaneously faculty members of the Dalhousie University Faculty of Medicine have been excluded from the Dalhousie University Faculty Bargaining Unit. Section 2(2)(b) of the Nova Scotia *Trade Union Act* precludes physicians who are licensed to practice medicine in Nova Scotia from being members of a trade union.

Consequently, regarding the actions of Dalhousie University, Clinical Faculty do not have the protections provided by the Collective Agreement covering other Dalhousie Faculty, or the services of the Dalhousie Faculty Association, the union representing other Dalhousie faculty members. Similarly, these provisions of the *Trade Union Act* preclude members of the CDHA Medical Staff from being represented by a trade union respecting actions of CDHA. These impediments could be removed by requesting that the province amend the *Trade Union Act* to allow licensed physicians to be members of a trade union.

Second, the DMSA faces an important constraint on its ability to provide effective representation for individual members of DMSA. All CDHA Medical Staff are members of the DMSA, including those who hold administrative positions. Consequently, DMSA could be in the position of representing both the member of the Medical Staff with a grievance and the Administrator who took the action or made the judgment that is the subject of that grievance. This impediment could be removed by requesting that the Minister of Health amend the CDHA Bylaws to exclude physicians in administrative positions from the DMSA. Administrative positions would include those who hold the position of Department Chiefs or higher.

Third, the Cooperative Partnership must include provisions to recognize this organization formally as the representative or agent of everyone who is simultaneously a member of the NSHA Medical Staff and Dalhousie Faculty of Medicine (Clinical Faculty) except for those who exercise managerial functions as Department Chiefs or higher ranks. The Cooperative Partnership must recognize this representative organization as being the agent for Clinical Faculty for all aspects of the shared responsibilities specified in the Cooperative Partnership. To establish effective representation and contractual protections, there are at least two obvious possibilities. It is likely that both obvious possibilities would require legislative changes.

The first possibility, which would require an amendment to the *Trade Union Act*, would be to extend the formal unionization of Dalhousie faculty members to include Clinical Faculty. The Collective Agreement between Dalhousie University and the Dalhousie Faculty Association is a mature, comprehensive agreement, with policies and procedures providing most of the required protections, including academic freedom and well-defined discipline and grievance procedures. There would need to be specific articles added to deal with the unique requirements of Clinical Faculty. Special articles of this sort are already common in many University Collective Agreements for such subsets of the bargaining unit as Librarians and Nurses.

A second possibility would be to extend formal recognition to a Staff Association as an advocate, agent, and representative of the Clinical Faculty collectively, and of any individual member of the Clinical Faculty who chooses to request the assistance of the Staff Association. In that case, the Staff Association would negotiate, among other things, protection for academic freedom and appropriate discipline and grievance provisions. Recognition of a Staff Association as a representative of individual Clinical Faculty would mean that a representative of the Staff Association must be present at every formal stage of any disciplinary process or grievance process, including arbitration. The Staff Association may represent the member of the Clinical Faculty if requested to do so. As a representative, the Staff Association should have the right to access any materials in the rightful possession of the member of the Clinical Faculty, whether or not those materials are confidential and/or privileged.

Conduct of meetings on sensitive topics

On a number of occasions Drs. Nassar, Horne and Goodyear were placed at a disadvantage by being involved in meetings with senior CDHA administrators without prior notice of the topics to be discussed or without the opportunity, if they wished, to be accompanied by someone of their choosing. There should be a protocol established for such meetings at which sensitive topics are to be discussed. Sensitive topics would include, at a minimum, possible actions of a disciplinary nature or actions that would have an impact on hospital privileges, reappointments, promotions, or other aspects of the career status of the member.

The protocol should include at least the following: advance notice of the topic to be discussed; advice to the member that (s)he has the right to be accompanied by an advisor of his or her choice, normally a representative of the professional association or union with rights to represent individual members of the Clinical Staff; a written statement provided to the member at the meeting setting out the substance of the communication, including any Bylaws, policies, rules, or regulations that are relevant; advice that no immediate response is expected from the member; advice that (s)he should seek appropriate counsel before responding; written notice of any further steps that will be taken, such as the procedures to be followed in any process that is to be initiated; and written advice to the member about their rights and responsibilities under that proposed process, such as any deadlines (s)he must meet.

Procedures for the Official Files of members of the Clinical Faculty

It is recommended that a new agreement about the maintenance and use of the Official Files of members of the Clinical Faculty be implemented. The basic principle is that all decisions determining the professional performance, employment status, or clinical privileges of a member of the Clinical Faculty must be based solely on documentary evidence that has been placed in the Official File in a timely manner. This provision is essential in order to remove from consideration rumour, innuendo, and unsubstantiated oral statements and to ensure that the reasons for decisions can be examined to determine if they fairly reflect the evidence. Accordingly, all materials and documents used, or intended to be used, in determining these matters should be placed in the confidential Official File of that member of the Clinical Faculty to which (s)he may have access with reasonable notice. The member should be notified of any materials added to his or her Official File, and any materials removed from the Official File should be returned to the member.

Members of the Clinical Faculty would have the right to have included in their Official File their written comments about the accuracy, relevance, meaning, or completeness of the contents of their file. These comments may include a list of supplementary materials and documents maintained and considered relevant by the member, material that will be considered whenever the Official File is used to make a decision affecting the status of the member. The member should also have the right to request removal of any materials, or to object to the addition of any materials. In the event of a disagreement, a grievance process should be in place to allow a final and binding resolution to be achieved. In order to allow a member of the Clinical Faculty a full

opportunity to comment on materials in his or her Official File, anonymous materials, including anonymous letters of reference, should not be included in Official Files.

None of the contents of the confidential Official File should be released or made available to any person without the express written consent of the member of the Clinical Faculty concerned, except when required for normal administrative purposes, for grievance and arbitration purposes, or by law.

In the case of Dr. Nassar, there were agreements made to expunge certain proceedings and the associated documents and materials from the public record. There should also be provision for a member of the Clinical Faculty to request that certain specific materials be held in a confidential restricted file instead of the normal official personnel file. All documents and materials gathered during the case would then be held in a confidential restricted file, which may only be accessed by specified individuals for well-defined and agreed purposes. The member involved should have access to the restricted file. Others who will have access to the restricted file and the purposes for which the restricted file may be accessed shall be negotiated with the member involved and/or the organization representing that member.

Discipline Policy

It is recommended that a formal Discipline Policy be established. The purpose of a Discipline Policy is to deal with those rare cases in which it has not been possible to resolve individual performance concerns through the Quality Assurance and Clinical Management in Evidence-Based Practice policies. Discipline is restricted to cases in which it has been established by an investigation that a member of the Clinical Faculty has engaged in genuinely serious misconduct, or has persisted in failure to correct underperformance or to cooperate with Mentors and colleagues in applying the Quality Assurance and Clinical Management in Evidence-Based Practice policies.

The Discipline Policy must be based on formally established basic principles, which are:

- Disciplinary action shall be taken only for just and sufficient cause, and penalties shall be just and appropriate for the offence;
- The onus is on the party taking the disciplinary action to prove that there was just and sufficient cause and that the penalty was just and appropriate for the offence;
- Written reasons for the action must be provided in sufficient detail to allow the accused a full opportunity to respond;
- A formally established Grievance Policy must be available to the accused, including the right to a final and binding settlement of the matter through independent arbitration or other similar means;
- In cases of dismissal, or suspension involving a reduction in pay and benefits, the individual may be suspended immediately, but where (s)he files a formal grievance within the time limits set out in the Grievance Policy (s)he shall continue to receive full pay and benefits until the grievance and arbitration procedures have been completed.

The decision to impose disciplinary sanctions should be made by the CCCO, following an appropriate investigation. The reasons for taking disciplinary action should be provided in writing and in sufficient detail to allow a full response by the individual who is the subject of the sanctions. The CCCO should also state the reasons that the particular sanction applied is both just and appropriate. It is on the basis of this written communication that the Administration must prove that there was just and sufficient cause for disciplinary action and that the penalty imposed was just and appropriate for the offence. In short, the onus is on the Administration to defend the disciplinary action taken.

The provisions of the Grievance Policy, including final and binding resolution by independent binding arbitration or other appropriate means, may be invoked by the body chosen as the formal representative and agent of the Clinical Faculty.

Grievance Policy

It is recommended that a formal Grievance Policy be established. The purpose of a Grievance Policy is to provide a means for final and binding settlement of allegations by a member of the Clinical Faculty that there has been a violation, misinterpretation, misadministration, misapplication, or nonapplication of the Bylaws, policies, rules, and regulations. That Grievance Policy should be based on the following principles:

- It shall be available to the DMSA or other body with the right to represent the interests of Clinical Faculty, on behalf of an individual or a group of members of the Clinical Faculty;
- It shall cover any dispute relating to the interpretation, application or administration of the Bylaws, policies, rules and regulations or any allegation that they have been violated, misapplied, or not applied;
- It shall contain a provision that all parties will make every reasonable effort to settle all grievances in a prompt, amicable, just and equitable manner;
- It shall provide for informal discussions and other "*without prejudice*" means of attempting to reach a resolution;
- It shall provide for final and binding settlement by an external independent arbitrator or arbitrators, in a timely manner;
- It shall provide for agreement by all parties not to practice any discrimination, harassment, or coercion of any kind against anyone who elects to use, or not to use, the grievance procedures;
- It shall specify how the cost of the arbitration is to borne.

Conclusion

This Independent Committee of Inquiry believes that had the provisions of these recommendations been in place at CDHA, many of the events that were the subject of this Inquiry could have been prevented and the damage caused by these events could have been limited or mitigated. The Committee believes that these recommendations could also find applicability in other Canadian Medical Faculties and their affiliated teaching hospitals.

The Committee is aware that implementing these recommendations is a major task, which will require a great deal of leadership, hard work, and active consultation among the various parties involved. However, the Committee believes that the long-term benefits of this investment can be expected to be substantial, and to lay a sound foundation for the future. The recent establishment of the Nova Scotia Health Authority provides an ideal opportunity for the recommendations of this Committee to be reviewed and implemented.

To date, none of the cases considered by this Inquiry has been definitely resolved, after being active for more than a decade. Outstanding claims for damages by Dr. Nassar and Dr. Horne remain before the Nova Scotia Supreme Court, and there is ongoing injustice to Dr. Goodyear, whose medical oncology career at CDHA was terminated despite the finding by the CDHA Board that the allegations against him did not justify the suspension of his privileges that was the direct cause of that termination.

Justice has been too long delayed. This Committee of Inquiry strongly recommends that a fair settlement be negotiated in a timely manner with each of Dr. Nassar, Dr. Horne, and Dr. Goodyear.