UNIVERSITY OF TORONTO

THE GOVERNING COUNCIL

REPORT NUMBER 198 OF THE ACADEMIC APPEALS COMMITTEE

September 6th, 7th and 11th, 1995

To the Academic Board,
University of Toronto.

Your Committee reports that it held a hearing on Wednesday, September 6th and Thursday, September 7th, 1995 and a further meeting to deliberate upon its decision on Monday, September 11th, 1995, at 10:00 a.m. in the Falconer Room, Simcoe Hall, 27 King's College Circle, at which the following were present:

Professor R. E. Scane, Acting Chairman
Professor B. Brown
Mrs. M. Coleman
Professor J. Smith
Mr. A. Teekasingh

Ms L. Snowden, Secretary

In attendance:

Dr. X, the appellant
Mr. B. Shiller, counsel for the appellant
Dr. D. J. McKnight, Faculty of Medicine
Dr. J. L. Provan, Faculty of Medicine
Ms S. L. Springer, counsel for the Faculty of Medicine

Your Committee considered an appeal by Dr. X from the decision of the Appeals Committee of the Faculty of Medicine, dated February 21st, 1995, upholding a decision of the Anaesthesia Postgraduate Committee, dated January 20th, 1994. This latter decision suspended Dr. X from the anaesthesia residency programme, and recommended that he be dismissed from that programme. This recommendation was subsequently implemented by the Faculty. The decision of your Committee is that the appeal should be dismissed.

Factual Background

Dr. X took his first medical degree in the Union of South Africa, in 1981, and thereafter practiced in that country until entering Canada in 1989. In 1984, he received a diploma in anaesthesia from the College of Medicine in South Africa. On entering Canada, he practiced medicine, under special arrangements with the appropriate licensing bodies, in communities in Saskatchewan, British Columbia and Alberta. In August, 1990, he completed a pre-residency programme required for graduates of non-Canadian medical schools. He then entered the residency programme in anaesthesia at the University of Toronto, under an educational license from the Ontario licensing authority. His rotations as a resident at various teaching hospitals commenced in September, 1990.

Rotations among hospitals in the programme are typically of six months duration, although in Dr. X's case some were shorter as a consequence of certain leaves granted to him. Residents are evaluated throughout the programme through "In-Training Evaluation Reports" (referred to as "ITERS"), an interim ITER at the halfway point, and a final ITER at the end of the rotation. These are completed by the Programme Co-ordinator for residents in the service in question at the particular hospital. The evaluations for the ITERS are usually done in consultation with some of the staff members of the department concerned, but at that time, neither the Faculty nor the Department of Anaesthesia set out requirements with respect to intra-departmental consultation in the preparation of ITERS. The completed interim and final ITERS then flowed back to the Programme Director for the post-graduate programme in anaesthesia, Dr. D. J. McKnight. It is the Director's responsibility to monitor these ITERS, and other information which the Director might receive as to a resident's progress, and take the action, if any, which may appear necessary. This might include calling in a resident for advice, and for a warning, if indicated, and taking information before the Post-Graduate Committee of the Department of Anaesthesia, for review. The latter Committee is chaired by the Programme Director, and also consists of the Programme Co-ordinators at the various hospitals and representatives of the residents in the Programme.

From the beginning, the ITERS concerning Dr. S.L, and often, supplementary letters to the Programme Director, indicated concern, both with respect to some of his medical skills, and with his interpersonal relationships with members of the health care teams at the sites of the rotations. We see no point in itemizing the criticisms directed at the latter failings, which in the end, proved to be the decisive factor in the decisions appealed from here.

Following a rotation at the Hospital for Sick Children in the last half of 1991, in which the appraisals were very critical of him, Dr. X requested and was granted a leave during the first two months of 1992. He had consulted a psychiatrist, Dr. L. Reznek, in late December, 1991, and Dr. Reznek had recommended a break before his next rotation. On his return to duty, his evaluations improved over the period March - June, 1992, and it was remarked that he was making great effort to improve his "difficulties with team relations". Unfortunately, his evaluations at his next placement, St. Michael's Hospital, in the last half of 1992, deteriorated seriously, to the point that, in early November, the Programme Co-ordinator wrote to the

Programme Director that "he and patient care at St. Michael's Hospital would be better served if he left this hospital immediately."

On November 12th, 1992, Dr. X's case came before the Anaesthesia Postgraduate Committee, which recommended that Dr. X be placed upon immediate probation. As that Committee understood at the time, the then Chair of the Department, Dr. Edelist, was not prepared to take that official step at that time, but placed the motion for probation "on hold". A few days later, Dr. McKnight issued a strong letter to Dr. X, warning of the danger of dismissal from the programme if unacceptable behaviour continued.

In January, 1993, Dr. X started a new three-month rotation at Women's College Hospital. His initial placement there, of about six weeks, in cardiology, achieved a very positive review. However, negative appraisals regarding his interpersonal relationships with other doctors and nurses, and his difficulties in accepting guidance, resurfaced in the balance of this rotation, in Respirology.

He then moved to the Toronto Hospital, where he spent the month of April in the Critical Care Unit. He received a generally good appraisal for this service.

However, during this period, Dr. X requested a further two-month leave, on the basis that he wanted to try to come to grips with the problems that had re-emerged at Women's College Hospital. Although he did not disclose them in making the request, he also was sorely troubled by personal matters that he wished to try to resolve. This request came before the Anaesthesia Postgraduate Committee, which again reviewed his progress. The Committee granted the request but also imposed an immediate period of probation, to continue for three months after his return from leave.

Dr. X returned from his leave and entered a rotation in anaesthesia at Toronto General Hospital, commencing in July, 1993. The Programme Co-ordinator in anaesthesia at TGH at that time was the late Dr. A. K. Laws. The interim ITER submitted for Dr. X, for the period ending September 30th, 1993, contained some positive comments, but overall, he was rated as "borderline" in three of the four categories to be assessed, including "professional attitudes". One particular episode referred to in this ITER, a failure to respond properly to an emergency page, of which Dr. Laws had been advised by a staff anaesthetist, was in fact not Dr. X's fault, as it actually resulted from a temporary difficulty in the Hospital's paging system. We have not taken that complaint into account in our consideration of the overall evidence.

This interim ITER was subsequently discussed between Drs. McKnight and X, and Dr. X was orally informed that he was now off probation. Under Faculty rules, this should have been, but was not, communicated in writing to Dr. X. However, as the parties agree on this matter, nothing turns upon this in this appeal.

The final ITER for this rotation, covering the last half of 1993, was far worse. Dr. X was shown as "meeting expectations" in only five of twenty-five categories, "unsatisfactory" in one, and showing "weakness" in all of the others. This ITER included

a three-page detailed evaluation in addition to the summary sheet, which used a "tick-off" system.

Following receipt of this final ITER, the Programme Director brought Dr. X's case before the Anaesthesia Postgraduate Committee, at its meeting of January 20th, 1994. The Committee concluded that "Dr. X is not benefiting from his residency with his current attitudes and that we have failed over the past three and half *(sic)* years to modify his behaviour in any significant way." The Committee passed a motion that Dr. X be suspended from his residency and that action be taken to dismiss him from the programme.

Dr. X then requested, as he was entitled to do under the Faculty's procedures, that the Anaesthesia Postgraduate Committee reconsider its decision after hearing Dr. X's side of the story. That Committee reheard the matter at a meeting on February 17th, 1994, at which Dr. X, Dr. John Cain, and Dr. J. Karski, the latter two from the Toronto General Hospital Anaesthesia Department, spoke on Dr. X's behalf, and some letters from other doctors, favourable to him, were produced. After consideration, that Committee voted against reversing its previous decision.

A further appeal was taken to the Appeals Committee of the Faculty of Medicine. That appeal was dismissed.

***The Issues on this Appeal*:**

The basic issues for decision by this Committee are:

(1) On the basis of all the evidence before the Committees who made the decisions at the lower levels, was the decision that Dr. X should be required to quit the residency programme one at which those Committees could reasonably have arrived?

(2) If the answer to the above question is "Yes", is there nevertheless reason to invalidate those previous decisions because of lack of "fairness" or procedural or other flaws in the process sufficient to have deprived Dr. X of a due and just process?

(3) If the answer to the second question is "No", should this Committee, on behalf of Governing Council, nevertheless intervene and reinstate Dr. X into the programme on the ground that there is a reasonable prospect of remediation which it is at least the moral obligation of the University to undertake?

Decision on the Above Issues:

(1) The Reasonableness of the Decisions Below.

It is our view that the decisions below were those at which reasonable decision makers could have arrived.

Throughout the lengthy series of appraisals, Dr. X received criticisms for what, for simplicity, we call "medical" and "behavioural" shortcomings. It is the latter which were the primary cause of his dismissal from the programme. In its decision of February 17th, 1994, the Anaesthesia Postgraduate Committee, which reconsidered and affirmed its earlier decision of January 20th, 1994, said:

> The Committee wishes it to be understood that the chief reason for confirming this decision to suspend and dismiss was the repeated episodes of unacceptable behaviour which Dr. [X] has failed to modify despite repeated advice and repeated effort at remediation. This behaviour has been disruptive to his own training, the training of other residents and the function of clinical units to which he has been assigned.

Before this Committee, counsel for the Faculty stated that the "behaviour" element in the decisions below was now the only element upon which the Faculty was relying to uphold the decisions below.

However, there is not really as clear a dividing line between the "medical" and "behavioural" aspects of Dr. X's appraisals as might appear at first glance. First, the doctors in contact with him seem to have concluded that he had the necessary skill, and the intellectual capacity to acquire the necessary knowledge base to function satisfactorily as a specialist in anaesthesia, *if* his resistance to accepting advice and direction was not so pronounced. We think it fair to sum up the appraisals of him, in this regard, as being a person unwilling or unable consistently to accept the fact that, notwithstanding his previous experience in practice, he was a student again, and that, in the view of Programme Co-ordinators and some other staff doctors, there was something for him to learn, in order to achieve the professional standard expected at these hospitals and by the accrediting Royal College.

Second, the above failing, coupled with almost chronic tardiness in arriving at assignments and frequent abrasive interactions with other members of the health care team, had the potential to impede seriously the efficiency of a team in its delivery of patient care by reducing confidence in him and by distracting the other members. What must be appreciated in evaluating the Faculty's concerns in this area is that the Faculty, and the Department of Anaesthesia, are committed to a "team" approach which emphasizes a high degree of interdependence and co-operation between the doctors, nurses and technicians involved in the care of a patient. Dr. X's behaviour was seen as disruptive to the development and functioning of this interrelationship, and thus as creating a risk to patient care.

The evidence was not all one way. In addition to a few ITERS which were very, or on balance, positive, and some supportive letters, there was the evidence of Dr. John Cain, a senior member of the anaesthesia staff at TGH. Dr. Cain felt that the very negative final ITER from TGH, for the rotation ending in December, 1993, was far more negative than was his own appraisal of Dr. X's performance, and, he thought, than that of many other staff doctors in the Department at TGH. Suspecting that the techniques used by Dr. Laws to sample staff evaluations of the residents, or at least of Dr. X, were inadequate, he conducted his own poll of thirty of the staff anaesthetists at TGH. Of twenty-nine who would comment, he found six with predominantly negative views, twenty who had little or no criticism of his performance, and three of mixed reaction. There was also the evidence of Dr. X, who denied some of the events which were the basis of criticisms of himself, and stated that he viewed some other episodes, and the conclusions drawn from them, as exaggerated.

This positive evidence was considered by the February, 1994 meeting of the Anaesthesia Postgraduate Committee, and by the Appeal Committee of the Faculty, as well as by this Committee, in arriving at the respective decisions. The balancing of these conflicting views in this case is, we think, more a matter of weight than credibility. This Committee believes that, on the questions of determining the weight to be given to the assessments, and the importance of the factors assessed in arriving at the decision to terminate the residency, the opinion of the professionals in the field is entitled to deference. In addition, despite his denials or downplaying of some of the episodes referred to in the evidence, Dr. X did acknowledge before us that other episodes were correctly stated and that in general, he now realized that his attitudes towards others had made him his own worst enemy. Our own weighing of the evidence we read and heard did not lead us to doubt the correctness of the decisions below. On the first basic issue, as set out above, this Committee's answer is "Yes".

(2) Was There Lack of "Fairness" or "Due Process" in the Decisions Below?

Three general sub-themes emerged at the hearing before this Committee on this basic issue. First, did those involved in evaluating Dr. X's performance, and in considering whether he should be permitted to continue his residency, realize and sufficiently take into account that, during the period of his residency, he was not only under abnormal stress, but was suffering from a medical condition, of a psychiatric nature, which, combined with those stresses, significantly contributed to the behavioural problems which were the root cause of his removal from the programme? Second, was there some "bias" in the collection and presentation of the evidence upon which the Committees below acted, sufficient to invalidate the conclusions based upon the evidence? Third, did the failure to afford Dr. X a hearing at the January 20th, 1994 meeting of the Anaesthesia Postgraduate Committee, prior to passing the motion to suspend him and recommend dismissal from the programme create a denial of natural justice sufficient to invalidate that decision and those which affirmed it subsequently?

As the issue of Dr. X's health is at the core of the third basic issue, "Remediation", we will discuss it more fully under that heading. For the purpose of our conclusions on the basic issue of "fairness" or "due process", we merely state here that we do not believe that anything the Faculty or its individual members did or did not do in reaction to or accommodation of Dr. X's health state, either by itself or in combination with other factors, constituted unfairness or lack of any due process which should invalidate the conclusion to terminate him from the residency programme.

The allegation of "bias" in the collection and presentation of evidence principally focused upon the rotation ending December 31st, 1993, at TGH. There are two parts to this issue. The first consists of a suggestion that the Programme Co-ordinator, the late Dr. Laws, was prejudiced to some degree against Dr. X because of Dr. X's past history in the residency; that this prejudice affected Dr. Laws' own perception of Dr. X's performance in the rotation; that it influenced him to seek out, and request documentation of, negative appraisals of Dr. X, and to ignore more positive appraisals which were available. The second issue was an attack on the Departmental evaluation process itself.

It may well be that Dr. Laws' general approach to the supervision of residents was not an approach which would minimize the "behavioural" problems which he perceived in Dr. X. Dr. Cain described him as one who tended to "marginalize" residents of whom he had formed, or was forming a poor opinion, and who believed in "applying the screws" to make them "shape up". But, such an approach is not in itself unfair, however unpleasant it might be to be on the receiving end of the pressure. Both the final and the interim ITER for this rotation noted strengths as well as weaknesses, and Dr. Laws' comments on each were generally consistent with comments in ITERS from earlier rotations. All that we can know of Dr. Laws' views, apart from what is contained in the ITER which he prepared, are some short passages in the minutes of the meeting of the Anaesthesia Postgraduate Committee of February 17th, 1994, which revisited its earlier decision to recommend termination:

> In response to discussion about the possibility that Dr. [X] may have been prejudged before his Toronto General rotation, Dr. Laws stated that although he knew Dr. [X] was on probation he did not know the details of earlier problems, having missed the meeting at which they were discussed. He also commented that during the first month at Toronto General Dr. [X] had very little problem.

and

> In discussion of the sampling method used to formulate the Toronto General evaluation Dr. Laws noted that among the evaluators he had included Dr. Richard Cooper as Dr. [X] had particularly identified him as someone with whom he had had a good experience.

This Committee finds that personal bias on the part of Dr. Laws, with respect to his evaluations of Dr. X, is not established.

The second branch of the attack on the evidence upon which the Committees below acted, and upon some of which we are asked to act, was upon the lack of inclusiveness of the sources of data upon which the Programme Co-ordinator based the evaluations for the rotation. The evaluation was characterized as inherently too subjective because it did not require some formal consultation of all of the staff doctors who had professional contact with a resident during a rotation, to ensure that all had opportunity for effective input. The discussion focused upon the last rotation at TGH, but to the extent that the criticism is valid, it might be found to apply to evaluations of other rotations as well.

The evidence of Dr. Cain as to his informal poll of the staff in Anaesthesia at TGH, after he became aware of the negative final ITER completed by Dr. Laws, is summarized earlier in this Report. Dr. Cain is a severe critic of what he believes was a too exclusive sampling of Departmental opinion. He points out that the Department now requires a staff doctor working with a resident to complete daily reports on the resident's work.

On the other hand, Dr. McKnight and Dr. Provan, who, during the period in question, was the Associate Dean of Medicine responsible for postgraduate studies, both expressed doubts as to whether a wider sampling would necessarily improve the accuracy of evaluations of residents. They argued that some staff doctors have little interest in either teaching or evaluation and, unless some episode particularly attracts their attention, are unlikely to be perceptive about evaluations. Also, it was argued, although the administration of Anaesthesia can quickly become extremely dangerous to patients if anything goes wrong in the process, in most cases it turns out to be a routine process which might not give rise to occasions for the display of the behavioural problems which were the ultimate cause of Dr. X's downfall.

While the present procedures for evaluation of residents, as described by Dr. Cain, may engender more confidence, at least as to the completeness of the data available, than those in place when Dr. X was in the programme, this Committee does not believe that it follows from this that the older procedure was either so inherently flawed in general, or so flawed in the particular case of Dr. X, that the decisions below cannot stand. Evaluation of clinical or practical work of students, as distinct from that of written work, is always extremely difficult, particularly where much of that work must take place out of the presence of the person primarily responsible for preparing the evaluation. How information from other sources than himself or herself, coming through formal or informal channels, is weighed, must in the end be the decision of those principally entrusted by the University to perform this function. The results of Dr. Cain's poll, and the more general arguments as to inherent defects in the system, were considered by the Anaesthesia Postgraduate Committee at its February 17th, 1994 meeting, and again by the Faculty Appeals Committee. We do not defer to any "professional" opinion which anaesthetists may have held as to the general validity of their system. However, as indicated above, we do not believe that the then system was so flawed as to justify our interference with a result based upon it. We do afford some deference to the doctors, and particularly those in Anaesthesia, who weighed the effect of Dr. Cain's evidence against the formal evaluation of Dr. Laws and of the other doctors who were named as contributing to the preparation of the ITERs from TGH in that final rotation, as well as the information from

previous rotations which was before them. Our own consideration of the evidence before us does not lead us to interfere with the decisions below on this ground.

Finally, on this second basic issue, we consider the argument that the failure to afford a hearing to Dr. X at the January 20th, 1994 meeting of the Anaesthesia Postgraduate Committee invalidated the results of that meeting, and of everything that followed. Our decision on this is that, first, if a hearing, after notice to Dr. X, was required, the defect was cured by the three subsequent opportunities given to Dr. X to bring forth evidence in support of his case. Second, that meeting was not of a type which required notice to Dr. X and an opportunity to attend and present his case prior to any decision being reached. The meeting, in so far as it dealt with Dr. X, was part of a process of *evaluation*. In the case of evaluation of clinical work, as in the case of formal examinations, papers or theses, the "hearing" component, if it may be so called, is provided by what the candidate writes on the paper, or how the candidate performs in the practical setting. If, after evaluation of that input from the candidate, the decision is appealed in accordance with the applicable rules, an inherent right to some form of further "hearing", or input from the candidate, no doubt arises, but that right was fully accommodated here, from the time it arose.

In summary, this Committee's answer to the second basic issue set forth above is "No".

(3) Should the Governing Council Exercise Discretion to Restore Dr. X to the Programme as a Matter of Accommodation and Remediation?

Much time was spent during the proceedings before us with respect to the underlying causes of Dr. X's behaviour. The normal stress of residency was exacerbated by some "non-medical" factors. He had received his preliminary training abroad, where he found the relationship between the instructors and students to be much less hierarchically structured than he found the situation in our residency programme to be. He had also been practicing in smaller centres in western Canada, in a setting where he functioned much more independently than a resident is permitted to do at this University. He found it difficult to adapt to a more overt student position. Also, from the beginning of his residency he was trying unsuccessfully to achieve landed immigrant status, and also to obtain a license to practice medicine independently, rather than only in the status of a student. He was also attempting, again unsuccessfully, to persuade the Royal College to give some credit for some of his training in South Africa. These problems were compounded by an unfortunate personal relationship which was extremely worrying for him.

These external stresses combined with problems internal to himself. Near the end of 1991, Dr. X consulted Dr. L. Reznek, a psychiatrist, and subsequently continued consultations with him. Dr. Reznek identified two problems. The first was major clinical depression, to which the combination of stress factors sketched above were a major contributor. This, in Dr. Reznek's opinion, was successfully treated with drugs over time.

In addition, Dr. Reznek has diagnosed Dr. X as possessing a "vulnerable personality", making him extremely sensitive to criticism, and prone to interpret actions of others toward him as "deliberately demeaning and threatening". He easily feels slighted and is quick to react angrily towards those who he feels are "threatening" him. "As a defence against these feelings, he tries to bolster his own self esteem with some exaggeration of his own abilities and talents as well as to put others down in a disparaging manner". We note that this description is consistent with the evaluations which he received throughout his rotations. This condition, we understand, is much more difficult to deal with medically than the depression. Dr. Reznek has been attempting to help Dr. X to develop coping techniques, while he also attempts long-term treatment of the vulnerable personality. We understand that the road to achievement of this goal is probably a long one, and that success is not assured, although it is possible.

This Committee's concern was whether, treating Dr. X as a person with a recognized medical disability of a psychiatric nature, which was particularly susceptible to the combination of stresses which to which he was subject during his residency, that disability was sufficiently accommodated by the University during his residency. Further, even if it was, given our present knowledge of the background, should we exercise an ultimate discretion on behalf of Governing Council to restore him to the programme, in a further remedial effort?

We conclude that the University did take reasonable steps to accommodate the disability. There is ample evidence of advice, warning and counseling offered to Dr. X throughout the programme, both by the Programme Director and the Programme Co-ordinators in the various rotations, and by individual staff doctors. Two leaves of absence were granted, to assist him in dealing with his problems. One can always suggest more that could have been done, such as assigning a mentor to support him, but we have no confidence that this would have made much difference.

With regard to extraordinary remedial action, we conclude that, if such action on the part of this Committee is ever proper, this is not the occasion. The evidence of Dr. Reznek indicates that a cure, if attainable, is probably a distance down the road. Dr. Reznek had hoped that, by the end of his leave in 1993, Dr. X had acquired sufficient coping skills to sustain him. Unfortunately, this did not turn out to be so. Dr. McKnight and Dr. Arellano testified before us that the behavioural problems displayed by Dr. X as a resident created a potential risk to patient care. After hearing the evidence, including that of Dr. X, and hearing Dr. X's personal summation to us, we regret that we are not sufficiently confident that he is ready to function at the required level in the Department to cause us to intervene in this manner. The Department must get on with its work. A student suffering a disability, after all reasonable allowances have been made to assist him or her to compensate for that disability, must meet the required standards. In this case, realistically, the Department could not shield the appellant from the criticism of staff doctors and from other sources of stress to which he is unfortunately still particularly vulnerable.

The Appeal is dismissed.

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<tr><td>Ms L. Snowden
Secretary</td><td>Professor R. E. Scane
Acting Chairman</td></tr>
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October 11th, 1995