IN THE MATTER OF *THE MEDICAL PROFESSION ACT, 1981*,
S.S. 1980-81,C.M-101 AND DR. CARLOS HUERTO,
MEDICAL PRACTITIONER, OF SASKATOON, SASKATCHEWAN

BETWEEN:

THE COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN

-and-

DR. CARLOS HUERTO

BEFORE:

Beth Bilson, Chairperson
Dr. Brenda Hookenson
Dr. Keith Ogle

APPEARANCES:

Bryan Salte, for the College of Physicians and Surgeons of Saskatchewan
Brian Scherman, for Dr. Huerto

Heard at Saskatoon, Saskatchewan, on April 12, 13, 14, 15, 16, 17, 26, 27, May 3, 4, 5, 6, 24, 25, 26, 27, 28, July 1, 2, 3, 17, 18, 19, 20, 21, August 24, September 14, 15 of 1999

DISCIPLINARY HEARING COMMITTEE DECISION

This disciplinary hearing committee of the College of Physicians and Surgeons of Saskatchewan was established to hear a series of charges made against Dr. Carlos Huerto, a specialist in cardiology and internal medicine practising in Saskatoon. These charges related to three patients who had been under the care of Dr. Huerto, [redacted]. At an early point in the proceedings, albeit after some evidence had been presented, the College withdrew charges relating to a fourth patient, [redacted].

At the outset of the hearing, counsel for the College acknowledged that his client bore the onus of establishing the charges against Dr. Huerto, and counsel for both parties provided the committee with authorities relating to the nature of the burden of proof in cases such as this one.

In *Sen v. Discipline Committee of the College of Physicians and Surgeons of Saskatchewan* (1969), 69 W.W.R. 201, the Court of Queen's Bench affirmed that the appropriate standard of proof in disciplinary proceedings involving physicians is the civil standard of proof on a balance of probabilities, rather than the criminal standard. This has been confirmed in numerous cases, including *Green v. College of Physicians and Surgeons of Saskatchewan* (1987), 51 Sask.R. 241 (C.A.), and more recently in *Huerto v.Council of the College of Physicians and Surgeons of Saskatchewan* (Q.B. No. 1192 of 1998, March 16, 1999, *per* Smith, J.).

The courts have, nonetheless, recognized that there is much at stake for professional persons facing disciplinary charges made by the regulatory bodies which can determine whether they can continue to engage in the practice of their profession. In *Re Miller and Saskatchewan College of Physicians and Surgeons* (1967), 59 D.L.R.

(2d) 736 (Sask. Q.B.), MacPherson, J. referred to the following comments made by the English Court of Appeal in *Bater v. Bater*, [1950] 2 All E.R. 458, at 459:

> Many great judges have said that, in proportion as the crime is enormous, so ought the proof to be clear. So also in civil cases. The case may be proved by a preponderance of probability, but there may be degrees of probability within that standard. The degree depends on the subject-matter. A civil court, when considering a charge of fraud, will naturally require a higher degree of probability than that which it would require if considering whether negligence were established. It does not adopt so high a degree as a criminal court, even when it is considering a charge of a criminal nature, but still it does require a degree of probability which is commensurate with the occasion.

In *Miller*, MacPherson, J. interpreted the significance of this as follows:

> Thus, on the authorities I have quoted, the proof of guilt of the doctor must be clear and convincing.

In a more recent Saskatchewan case, *Re Camgoz* (1989), 74 Sask. R. 73, the Saskatchewan Court of Appeal laid out its understanding of the correct principles with respect to the appropriate onus of proof, at 74:

> It is the opinion of this tribunal that the law applicable to this hearing is as set out by Mr. Justice Grotsky in *Bahinipaty v. College of Physicians and Surgeons of Saskatchewan* (1986), 50 Sask. R. 15. There is naught to be gained by repeating the law set out therein. However, in summary, this tribunal is of the view as follows:
>
> 1) The onus or burden of proof lies upon the college to establish the allegations by a fair and reasonable preponderance of credible testimony.
> 2) This being a civil proceeding, this tribunal, in assessing the evidence and in deciding the issues, is to act on a balance of probabilities.

3) In view of the nature of the allegation, that is to say, the allegation of crime, and in view of the seriousness of the potential repercussions to the medical career of Dr. Camgoz, the standard of proof to be applied is the highest possible standard applicable in a civil case. Yet, however, this standard is not proof beyond a reasonable doubt.

In *Brett v. Ontario (Board of Directors of Physiotherapy)* (1991), 77 D.L.R. (4th) 144 (Ont. Gen. Div.), the Court made a comment similar in tone:

> The board is bound to follow the law laid down in many cases, including *Re Bernstein and College of Physicians and Surgeons of Ontario* (1977), 76 D.L.R. (2d) 447 (Div. Ct.), to the effect that findings of professional misconduct can only be made when the proof of that misconduct is clear and convincing and is based on cogent evidence.

The committee accepts that the standard which must be applied to findings concerning the charges made against Dr. Huerto requires that they must be established by clear and compelling evidence within the framework provided by an exacting understanding of the civil standard of proof.

Another legal issue which was put before the committee during the hearing has to do with the extent to which it is open to members of the committee to make use of their own medical knowledge in making findings with respect to disciplinary charges. The concern which was the focus of discussion and argument was that members of the committee might be bringing their own expertise to the making of decisions, independent of the evidence presented at the hearing, particularly the testimony of expert witnesses. This concern is, of course, particularly acute when many of the issues raised by the charges are ones relating to deviation from standards applying to particular areas of professional specialization, rather than to instances of unethical conduct.

The extent to which members of professional disciplinary hearing bodies are able to insert their own professional expertise into the making of decisions appears to have been severely restricted by two recent cases in the Saskatchewan courts. In *Huerto v. College of*

Physicians and Surgeons (Sask.) (1994), 124 Sask. R. 33 (Q.B.), Halvorson, J. made the following observations, at 40:

> When the Committee stated initially that it "did not agree that the proper standard of care in any case was to be determined solely on the basis of expert testimony", that would be correct if the committee meant that it must consider all the evidence, not just the experts' opinion. But, if the committee meant that it was entitled to determine the standard of care by supplementing the evidence with its own medical knowledge, serious problems arise. Seemingly, the latter was the intended meaning when viewed in light of the committee's closing comments that "it is not expected to act solely as a judicial body, weighing only the evidence before it.
>
> While there is a degree of fuzziness in this paragraph, it conveys the impression the committee believed it was entitled to use its medical knowledge beyond simply assessing the evidence. In particular, it appears the committee thought that in addition to the evidence, it could bring to bear its personal knowledge in determining the proper standard of care. If this were permissible, mischief could ensue. The committee had evidence from expert cardiologists as to the standard expected of a cardiologist like Dr. Huerto. The committee members are not cardiologists. It would be inappropriate to allow them to impress on the evidence their private views of the standards demanded of a cardiologist.

Halvorson, J. went on to comment, at 42:

> The heart of Dr. Huerto's challenge to this misuse of personal medical knowledge is that he was afforded no opportunity to test it. What specific knowledge did each member bring to bear on the admitted occasions? Was that knowledge reliable? What is the expertise of the members? These are only a few of the host of inquiries Dr. Huerto would have been entitled to explore on cross-examination and to respond to in a normal evidence tendering scenario. All we know is that one committee member is a surgeon, one an anaesthetist and two are general practitioners.

> While Dr. Huerto was able to cross-examine the experts who gave evidence on behalf of the college, there may be segments of unknown evidence emanating from the committee which he was unable to validate. This would have lesser significance if Dr. Huerto were charged with dishonesty or immoral behaviour, rather than deviation from an acceptable standard of care, because there is likely to be more universal consensus condemning the former.

The Saskatchewan Court of Appeal explicitly approved these comments at (1996), 141 Sask. R. 3, at 8.

In *Huerto v. Council of the College of Physicians and Surgeons of Saskatchewan* (Q.B. No. 1192 of 1998), *supra,* Smith, J. commented in a similar vein as follows:

> In the first place, the members of the committee are not cardiologists and are therefore not competent independently to establish the standard of care appropriate to the practice of a cardiologist. More than this, if a committee were entitled to augment the evidence with its own medical knowledge and experience, the accused doctor would be required to contend with views that have not been expressed and with expertise which has unknown limits. Even were he to anticipate what medical opinions the members might bring to the disciplinary forum, he has no right or opportunity to cross-examine upon such opinions. This point is particularly well illustrated in the circumstances of the treatment of this issue in this hearing and it is especially critical where, as here, the allegations of misconduct rest upon the extent of a physician's deviation from and acceptable standard of specialist practice rather than upon an ethical breach.

We understand the comments in these two cases to be expressions of familiar principles of fairness and natural justice requiring that someone whose interest is at stake in a proceeding such as this must have an opportunity to address any evidence which will have an impact on the decision which is made. In this instance, too, none of the members of the disciplinary hearing committee claim specialized expertise in cardiology; two of them are family physicians, one of whom has teaching responsibilities in the area

of medical ethics at the College of Medicine at the University of Saskatchewan, and the third, the chair, has legal rather than medical training.

We are mindful of the implications of the comments made in these two judicial decisions, and we have been cognizant of the reasonable restriction imposed that the committee cannot provide an independent evidentiary foundation for its conclusions based on the medical expertise of its members, and not open to challenge by Dr. Huerto and his counsel at the hearing.

On the other hand, we do not understand from either of these decisions that the court is taking the position that the role of the committee is simply to register and accept the testimony of expert witnesses without making any assessment of the usefulness of the evidence, or that the medical expertise of members of the committee is totally irrelevant to the decision-making process. In the second of the two cases, Smith, J. made the following comment:

> Members of a discipline committee established in accordance with the relevant statutory provisions are all medical doctors and it is reasonable to assume that the legislature intended that they would bring their medical knowledge to bear in assessing the evidence before them and reaching their verdict. Medical knowledge is relevant to understanding the facts as presented and gives the members of the discipline committee a frame of reference within which to place the information presented during the hearing. The cases have, nonetheless, clearly distinguished this use of medical expertise by members of a disciplinary committee from a committee's use of its medical knowledge to expand or alter the evidence before it or to substitute its own opinions for those of the experts as to what constitutes appropriate cardiovascular care.

In the other decision, Halvorson, J. made the following statement, beginning at 39:

> The main body of this paragraph [which included the statement "The Committee did not agree that the proper standard of care in each case was to be determined solely on the basis of the expert testimony."] is, of course,

> correct in that it simply states a rule pertaining to all triers of fact. That is, personal knowledge and experience may be utilized in judging an expert as well as other evidence adduced...

These comments echo some of those made in the cases to which the committee was referred in connection with the standards applicable to the qualification of experts and the admission of expert testimony. In a discussion of the criteria which should be applied by this committee to the qualification of expert witnesses, counsel for the College invited the panel to consider some of the recent commentary from the courts on this issue. In *R. v. Mohan* (1994), 89 C.C.C. (3d) 402, the Supreme Court of Canada summarized their position on the criteria which should govern the admission of opinion evidence from expert witnesses in the following terms, at 411:

> Admission of expert evidence depends on the application of the following criteria:
> a) relevance;
> b) necessity in assisting the trier of fact;
> c) the absence of any exclusionary rule;
> d) a properly qualified expert.

In defining how the term "properly qualified expert" should be interpreted, Sopinka, J. commented in the following terms in *Mohan*, at 414:

> Finally, the evidence must be given by a witness who is shown to have acquired special or peculiar knowledge through study or experience in respect of the matters on which he or she undertakes to testify.

It was pointed out to the committee by counsel for the College that, although there are criteria which must be satisfied in the qualification of expert witnesses, the courts have been moving away to some extent from an excessively technical approach to the admission and assessment of expert evidence.In *R. v. R. (D.)*(1995), 98 C.C.C. 363, for example the Saskatchewan Court of Appeal identified the fundamental rationale for the admission of expert evidence by quoting from *R. v. Abbey* (1982), 68 C.C.C. (2d) 394 (S.C.C.), at 409:

> With respect to matters calling for special knowledge, an expert in the field may draw inferences and state his opinion. An expert's function is precisely this: to provide the judge and jury with a ready-made inference which the judge and jury, due to the technical nature of the facts, are unable to formulate. *"An expert's opinion is admissible to furnish the Court with scientific information which is likely to be outside the experience and knowledge of a judge or jury. If on the proven facts a judge or jury can form their own conclusions without help, then the opinion of the expert is unnecessary": R. v. Turner* (1974), 60 Cr. App. R. 80 at 83, *per* Lawton, J. [emphasis added by the Saskatchewan Court of Appeal]

Referring to the decision of the Supreme Court of Canada in *Mohan*, the Court went on to summarize their understanding of this point, at 376:

> ...Mr. Justice Sopinka noted at p. 413 that whether expert evidence is necessary or unnecessary in this sense is not to be judged by "too strict a standard" and is generally dependent on whether the subject-matter is such "that ordinary people are unlikely to form a correct judgment about it, if unassisted by persons with special knowledge."

The Court of Appeal went on to make the following point about the standards for the qualification of witnesses as experts:

> As for the second - the qualifications of Dr. Yelland - Crown counsel had to show that this witness had acquired special or peculiar knowledge through study or training or experience in the subject-matter at issue, though the threshold for qualification is comparatively low.

In *R. v. Marquard* (1993), 85 C.C.C.(3d) 193, the Supreme Court of Canada made a similar point, *per* McLachlin, J. at 224:

> The only requirement for the admission of expert opinion is that the "expert witness possesses special knowledge and experience going beyond that of the trier of fact": *R.v. Beland* (1987), 36 C.C.C. (3d) 481 at 494.

In the *Marquard* case, the Supreme Court also cautioned against making efforts to confine too narrowly the bounds within which an expert can provide an opinion to the tribunal, at 225:

> Important as the technical qualification of an expert witness may be, it would be overly technical to reject expert evidence simply because the witness ventures an opinion beyond the area of expertise in which he or she has been qualified...In the absence of objection, a technical failure to qualify a witness who clearly has expertise in the area does not mean that the witness's evidence should be struck. However, if the witness is not shown to have possessed expertise to testify in the area, his or her evidence must be disregarded and the jury so instructed.

These passages make several important points, among them that a tribunal should adopt a fairly relaxed approach to the qualification of expert witnesses and the admission of their evidence in order to have access to the largest body of opinion evidence which may be of assistance to the tribunal.

A corollary of this, however, is that the tribunal must clearly be allowed to assess the evidence once it is admitted. Indeed, this is what these cases invite courts or other tribunals to do, as is suggested in the passage from *Marquard* reproduced above. In *R. v. L.S.*, [1999] O.J. No. 877 (C.A.), the Ontario Court of Appeal made this suggestion, at 4:

> In our view, Dr. Langevin was qualified to give the expert opinion evidence for which he was being tendered as a witness. The concerns raised by the trial judge about the extent of his experience and the focus of his involvement in the field, as well as about the manner in which he gave his evidence are all issues which would go to the weight to be accorded his evidence by the trier of fact, rather than to the threshold issue of his qualification to testify.

In these circumstances, we have conceded that, as none of the members of the committee are themselves experts in cardiology or internal medicine, or in several other fields relevant to these proceedings, we must look for assistance in the specialized issues

arising in these areas to expert witnesses tendered by the parties in these proceedings, and not purport to provide our own "expert" assessments of these issues. The cases which have just been reviewed, however, do not suggest that the committee should take an entirely passive role in relation to the evidence of expert witnesses. We are not relieved of our responsibility to draw conclusions about the soundness, relevance and usefulness of this evidence.

In doing this, it is our understanding that the committee may, as with other evidence, assess such factors as the coherence of the evidence given by a witness, the degree to which it is consistent with other evidence, the credibility of a particular witness, the ability of the witness to address issues which are central to the disposition of the case, and the degree of confidence with which a witness states particular conclusions.

In this case, it is important to note that both Dr. Huerto himself and Professor Jane Heaslip, who has a close connection with Dr. Huerto's practice, were qualified as experts by agreement of the parties. It is clearly difficult in the case of experts such as these to separate their expert testimony from other aspects of their evidence concerning the events which were the basis of the charges, or from their personal interests in the disposition of the charges which the College has made against Dr. Huerto.

A further legal issue which was the subject of argument before the committee concerned the proper standard to be applied in defining what constitutes professional misconduct of a kind which is subject to censure by the College. Section 46 of *The Medical Profession Act* reads, in part as follows:

> 46. Without in any way restricting the generality of "unbecoming, improper, unprofessional or discreditable conduct," a person whose name is entered on the register, the education register or the temporary register is guilty of unbecoming, improper, unprofessional or discreditable conduct, where he:
>
> o) does or fails to do any act or thing where the discipline hearing committee considers that action or failure to be unbecoming, improper, unprofessional or discreditable;
>
> p) does or fails to do any act or thing where the

> council has, by bylaw, defined that act or failure to be unbecoming, improper, unprofessional or discreditable.

With one or two exceptions, the charges made against Dr. Huerto cite one of these two clauses of Section 46. A review of the bylaws of the College demonstrates that, over time, the Council has identified a number of specific kinds of conduct which can be regarded as "unprofessional" (to use the word which is generally chosen to encapsulate the kind of conduct sanctioned under Section 46 of the *Act*). In addition to the specified conduct which is described as "unprofessional" in other parts of Section 46, Section 46(p) captures all of the specific conduct catalogued in the bylaws as instances of conduct which is regarded as unacceptable.

It must be recognized, however, that no set of by-laws or statutory provisions can set out an exhaustive list of all the possible ways in which a professional person may fall short of the standards of conduct which are expected. Section 46 accommodates this fact by providing in Section 46(o) that the discipline hearing committee itself can characterize conduct as unprofessional.

A scheme in which the discipline hearing committee has jurisdiction to characterize conduct not specifically interdicted in either the statute or the by-laws was supported on the following basis in *Samuels v. College of Physicians and Surgeons of Saskatchewan* (1966), 57 W.W.R. 385 (Sask. Q.B.), at 391:

> [T]he Medical Acts have always entrusted the supervision of the medical advisor's conduct to a committee of the profession. For they know and appreciate better than anyone else the standards which responsible medical opinion demands of its own profession.

This does not mean, of course, that a discipline hearing committee is free to censure whatever conduct it finds distasteful or impose sanctions on physicians for making the kinds of errors which may occur in the professional life of any conscientious person.

A distinction has been drawn in cases where a tort action in negligence is under consideration between "errors of judgment" and "negligence". In *Wilson v. Swanson* (1956), 5 D.L.R. (2d) 113, the Supreme Court of Canada made this point at 120:

> An error in judgment has long been distinguished from an act of unskilfulness or carelessness or due to lack of knowledge. Although universally accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation.

In other words, a physician with a high level of skill may conscientiously make a clinical choice which has a negative effect, and most such "mere errors of judgment" do not constitute a departure from the standards of the profession. They are simply an inevitable component of human judgment, no matter how informed and careful.

A physician may also, of course, commit errors of a careless nature which do represent a lapse in compliance with the professional standard expected of a reasonable physician, and these may be characterized as "negligent." As with most errors of judgment, most conduct described as negligent does not raise questions of the suitability of the physician as a member of the profession or invoke the disciplinary authority of the College of Physicians and Surgeons.

In the *Camgoz* case, *supra*, the Saskatchewan Court of Appeal made the following comment, at 405:

> Assuming, but without deciding, that the impugned decision to conduct a vaginal examination could form the basis of a charge under [the previous] s. 43(m) of the Act and even if the decision so taken could be characterized as an error of judgment or a mistaken exercise thereof, it was not so blatant an error as to amount to professional misconduct. An exercise of judgment by a medical practitioner engaged in general practice even though it turns out to be mistaken (which we do not find in this case) is not necessarily outside the range of possible courses of action that a reasonably competent general practitioner might choose to take.

In *Huerto v. College of Physicians and Surgeons (Sask.)*(1994), 124 Sask. R. 33, which was referred to earlier, Halvorson, J. distinguishes both errors of judgment and negligence from professional misconduct, at 53:

> Moreover, I likely would have held that all the transgressions by Dr. Huerto were no more than errors of judgment falling short of negligence and far short of professional misconduct.

It should be noted parenthetically that Halvorson, J. went on to make the following statement, at 54:

> It was open to the committee, however, to find otherwise on the evidence.

We do not interpret the comments of Halvorson, J. as purporting to create three distinct and unconnected notions arranged in the hierarchical formation, going from least to most serious, of error of judgment, negligence and professional misconduct.The picture is considerably more complicated than that, however helpful these concepts may be as rough divisions. Though most errors of judgment are not negligent, some are. Though much negligent conduct - if by that term is meant simply careless or substandard conduct, and it does not refer to the nexus of conduct causing harm of a sort which exposes the perpetrator to an action for damages in tort - is so fleeting or atypical that it does not or should not raise the question of whether the professional status of the physician concerned should be reexamined, there is negligent conduct which is so extreme or so sustained that it is surely a basis for disciplinary action.

In any case, we take the point that allegations of unprofessional conduct must be taken very seriously, as they put in jeopardy the professional standing of a physician, and may bring about serious consequences for the career and reputation of that physician.

In instances where the allegations raise the question of whether medical treatment given by a physician falls outside the standards of practice which are expected by the profession, the standard clearly cannot be one of whether other physicians would make different choices or would prefer to practise in a different way.

The practice of medicine calls on all physicians to make complicated and difficult judgments, and to apply all of their accumulated skill and knowledge to the making of these judgments. As with any profession, there are legitimate differences of opinion about the best approaches to take to these problems. Furthermore, though medical science has provided a vast amount of technical information about medical conditions and the ways they might be treated, there are many instances where physicians must make their best judgment in circumstances where there are significant gaps in scientific knowledge or where it is difficult to predict possible outcomes.

In this context, the standard which was suggested to us by counsel was one which would not sustain a finding of failing to meet the standards of the profession so long as the conduct of the accused physician would be supported by a body of responsible and competent medical opinion. In *Brett v, Ontario (Board of Directors of Physiotherapy), supra*, the Ontario Divisional Court proposed the following standard, at 153:

> In my view, when a professional disciplinary body is passing judgment on whether a member of the profession has failed while performing his professional work to maintain the standards of the profession, the member cannot be found guilty on the basis that the vast majority of the profession feels the conduct or judgment of the member was wrong if there also exists a responsible and competent body of professional opinion that supports his conduct or judgment. It is not sufficient for a conviction that the disciplinary panel prefer the opinion of the vast majority over that of the smaller though equally competent and responsible body of opinion that supports the member in his conduct or judgment.

This test was approved by the Saskatchewan Court of Queen's Bench in *Thompson v. Chiropractors Association of Saskatchewan* (1996), 145 Sask. R. 35.

In his testimony before this committee, Dr. Bernard Dickens, who was qualified as an expert in medical ethics, conjured up a picture of medical opinion as a spectrum with a number of bands. In the centre is mainstream medical opinion, that body of theories and

practices which represents the position of the majority of members of the medical profession. On one side of this band is a smaller band which represents the position of those physicians who subscribe to views or use methods which have been abandoned by most physicians as being outdated. On the other side of the main body of medical opinion is a band which represents the position of those who are willing to try new methods or subscribe to new theories which do not yet enjoy the support of a majority of physicians. At both extreme ends of the spectrum are the bands which represent those physician whose practices are so outdated or so untested that they are unacceptable to responsible members of the profession.

Thus, insofar as the charges against Dr. Huerto require us to consider whether he failed to meet appropriate standards of practice of the medical profession, it is necessary for us to consider this in light of whether there is any body of responsible and competent medical opinion, even that of a minority, which would support the conduct of Dr. Huerto.

In order to appreciate the discussion of the charges against Dr. Huerto which follows, it is necessary to understand the distinctive features of his practice. Dr. Huerto obtained his first medical degree in Spain in 1965. He went on to pursue further study in neuroscience, anatomy, internal medicine, psychiatry and cardiology, and to gain clinical experience in Britain, the United States and Canada. It is clear from documents submitted to the committee on behalf of Dr. Huerto that he received very positive reports from many of his clinical supervisors.

He obtained certification in internal medicine and cardiology in the United States, though for various reasons he has not been similarly certified by Canadian examining bodies.

In 1981 or 1982, Dr. Huerto arrived in Saskatoon. He had admitting privileges at St. Paul's Hospital, and was involved in clinical teaching for students of the College of Medicine at the University of Saskatchewan. From 1986, Dr. Huerto also engaged in the private practice of cardiology, and established a clinic in the Medical Arts Building for this purpose.

In the late 1980s, a decision was made to deny Dr. Huerto an extension of his hospital privileges, a decision he put down to personal differences with medical staff at St. Paul's Hospital.

Whatever the reasons - and these events were not germane to the charges we are considering here - Dr. Huerto has not had admitting privileges in any Saskatoon hospital since 1989.

In 1994, Dr. Huerto established the Saskatoon Cardiovascular Centre in a separate building on Spadina Crescent East in Saskatoon. It was designed by an architect according to his specifications, and he acquired a range of very sophisticated equipment for diagnosing, monitoring and treating patients. Much of this equipment is the equivalent of that which would be found in an intensive care unit or a coronary care unit in a well-equipped hospital, although the question of whether the clinic operated by Dr. Huerto is the equivalent of such a unit is a matter of some controversy, as will be seen.

Counsel for Dr. Huerto suggested in his argument that the origin of many of these charges against Dr. Huerto lies in the view held by the majority of the medical establishment that all specialized medical services of the kind offered by Dr. Huerto should be housed in a hospital, and should not be provided outside a hospital setting.

It is understandable to some extent that Dr. Huerto should choose to characterize the matter in this way. There is no doubt that the practice conducted by Dr. Huerto in his clinic has come under exceedingly heavy scrutiny since he has been working outside the hospital system. A variety of charges have been laid against him by the College of Physicians and Surgeons, and by the agency responsible for paying him for his medical services. The College initiated a review of his competency in 1991, which resulted in findings favourable to Dr. Huerto. We are unfamiliar with the details of these proceedings, though counsel for both sides, as well as a number of witnesses, alluded to them in the course of the hearing, and counsel provided the committee with some of the judicial decisions on review of the results of disciplinary proceedings initiated by the College.

We wish to make it clear, however, that we think the characterization of the issue as one of whether it is legitimate to offer specialized medical services outside a hospital is an oversimplification. In any case, no member of the committee takes the position that there is anything inherently wrong with a physician choosing to provide certain specialized medical services

outside a hospital setting in proper circumstances.

CHARGES RELATING TO [redacted]

The charges against Dr. Huerto involving his treatment of Ms. [redacted] are as follows:

> *1. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of* ***The Medical Profession Act, 1981 S.S. 1980-81 c. M-10.1*** *and/or Bylaw 51(2)(q), particulars whereof are that you committee an act of sexual impropriety with* [redacted] *by acting in a manner which reflected a lack of respect for her privacy.*
>
> *The evidence which will be led in support of this particular is that on one or more occasions at your office in Saskatoon, Saskatchewan, you permitted* [redacted] *to be nude or partially nude from the waist up without being properly draped and/or while the door to the room in which was situated was open.*
>
> *2. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of* ***The Medical Profession Act, 1981 S.S. 1980-81 c. M-10.1*** *and/or Bylaw 51(2)(j), particulars whereof are that you failed to maintain the standards of the profession in your treatment of* [redacted].
>
> *The evidence which will be led in support of this particular will include that:*
>
> *a. you injected or caused* [redacted] *to be injected with Synvisc and/or;*
>
> *b. you diagnosed* [redacted] *as suffering from migraine but failed to provide appropriate treatment for this diagnosis and/or;*
>
> *c. you did not strongly advise* [redacted] *that she should discontinue her use of the oral*

contraceptive medication which she was receiving and/or;

d. *you initiated anticoagulation therapy without first obtaining a CT scan for* [redacted] *and/or;*

e. *you initiated anticoagulation therapy without ruling out a hemorrhage as a possible cause of* [redacted]*'s symptomatology and/or;*

f. *you initiated Warfarin therapy without giving heparin to* [redacted]*, after* [redacted] *exhibited a possible stroke-like episode and/or;*

g. *you initiated Warfarin therapy in a quantity which did not result in an INR in the therapeutic range for anticoagulation.*

3. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of ***The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1*** *and/or Bylaw 51(2)(p), particulars of which are that you utilized a treatment or remedy with* [redacted] *which is not generally accepted as having therapeutic value by the medical community.*

The evidence which will be led in support of this particular will include that you injected [redacted] *with, or caused* [redacted] *to be injected with, Fluanxol, and/or Synvisc, and/or Betaseron.*

4. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to Section 46(p) of ***The Medical Professor Act, 1981*** *S.S. 1980-81 c. M-10.1 and/or Bylaw 51(2)(b), and/or Bylaw 51(1)(f)(iv), particulars whereof are that you had a conflict of interest in relation to your professional practice.*

The evidence which will be led in support of this

particular will include that you supplied Fluanxol and/or Synvisc and/or Betaseron at a profit to [redacted], which were not demonstrably necessary to her medical care.

5. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(k) and/or Section 46(o) and/or Section 46(p) of ***The Medical Profession Act, 1981 SS. 1980-81, c. M-10.1 and/or Bylaw 51(2)(d).*** *The evidence which will be led in support of this particular will include that:*

a. *you submitted, or caused to be submitted an invoice dated January, 1997 to [redacted] in which you charged her for administering injections of Betaseron and Fluanxol;*

b. *by letter dated October 7, 1997, the College of Physicians and Surgeons asked that you respond to a complaint by [redacted] and [redacted]. The letter of complaint asked, among other things, "Why weren't we informed of the cost of the injections prior to them being administered?";*

c. *by letter dated October 12, 1997 you replied to the College of Physicians and Surgeons stating "The issue of payment for injections was brought up with Mrs. [redacted] who stated that she was insured for these and that there was no concern about the cost. I did not pursue the matter further";*

d. *by letters dated April 11, 1998 and April 14, 1998 to the College of Physicians and Surgeons you stated that you had not provided injections of Fluanxol or Betaseron to [redacted];*

e. *by letter dated April April 11, 1998, you advised the College of Physicians and Surgeons that "On two occasions she received Synvisc into each knee joint (to provide relief in a patient who I wanted to remain as active as*

possible while still experiencing pain relief)";

f. [redacted] *will testify that you did not provide her with any injections into her knee or shoulder joints.*

5A. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to Section 46(o) and/or Section 46(p) of ***The Medical Profession Act, 1981 S.S. 1980-81, c. M-10.1*** *and/or Bylaw 52(2)(g).*

Particulars of this conduct are that you falsified a record of your examination and/or treatment of [redacted] *by:*

1. *falsifying the hand-written notes of your examination and/or treatment of* [redacted]*; and/or*
2. *falsifying the typed notes of your examination and/or treatment of* [redacted]*; and/or*
3. *removing a document from your file containing a record of prescriptions received by* [redacted]*.*

Ms. [redacted] was sixteen years old when she first saw Dr. Huerto on October 2, 1996. For some time, Ms. [redacted] had been troubled by headaches which, according to her evidence, prevented her from engaging in a full range of activity from time to time. Prior to seeing Dr. Huerto, Ms. [redacted] had been under the care of Dr.Helen Bowden, who had been the [redacted] family physician in Lloydminster for some years.

In an effort to identify the causes of Ms. [redacted] s headaches, Dr. Bowden referred her to a dental specialist, and also to Dr. N.J. Witt, a neurologist in Edmonton. In April, 1996, Dr. Witt advised Dr. Bowden that he thought the headaches might be aggravated by the amount of Tylenol Ms. [redacted] was taking, and suggested that she cease to take that medication.

Ms. [redacted] apparently followed this advice, but continued to be troubled by headaches. In the fall of 1996, Ms. [redacted] and her mother, Ms. [redacted], asked Dr. Bowden to refer them for a

consultation to Dr. Huerto, who was at that time treating [redacted]'s mother. Dr. Bowden declined to refer them to Dr. Huerto, and [redacted] decided to seek an appointment with Dr. Huerto directly. Dr. Huerto agreed to see [redacted], and she visited his clinic on a number of occasions between October 2, 1996 and April 9, 1997.

We should comment at the outset that there were aspects of the evidence in relation to the charges arising from the treatment of [redacted] which were troubling for the committee. The differences in the description given of the events involving Ms. [redacted] and of the [redacted] family in the testimony at the hearing make it impossible to arrive at any reconciliation of the evidence without making findings of credibility.

On the one hand, Dr. Huerto and the witnesses who gave evidence on his behalf, created a picture of [redacted] as a psychologically troubled young woman who was virtually disabled throughout this period by her headaches, whatever their cause, unable to walk for more than a few steps, on occasion unable to lift a glass to her lips. The picture advanced on behalf of Dr. Huerto also portrays her mother, [redacted] as a discontented, aggressive and highly critical person; with her husband, she is supposed to have had an unhealthy, almost obsessive, interest in the health of their daughter. As a unit, this picture suggests, the family was fairly severely dysfunctional and in need of help.

The picture created by the [redacted] themselves is somewhat different. In this version, [redacted] was suffering from a medical condition which caused her and her family significant concern, but this concern was not unusual. She had a close relationship with her parents and her two siblings, which included a variety of joint activities. She participated in sports, including skiing and snowboarding, throughout the period we are considering. She led a very busy life in ways which were fairly typical for a person her age, although these activities were occasionally disrupted by bouts of illness.

In some respects, the differences between these two visions of [redacted] and her family might arise from misunderstandings which lie within the normal range of interaction between a doctor and a patient, particularly since [redacted], as a patient, was somewhat different than many of the patients with whom Dr. Huerto

had had experience.

On the other hand, not all of the discrepancies in these two pictures can be explained in this way. It is not, in the final analysis, possible to find that the descriptions given of [redacted] are descriptions of the same person.

Dr. Jeff Donat, a neurologist called to give evidence on behalf of Dr. Huerto, described [redacted] as a "dangerous" patient. By this, he meant that it was self-evident from the documentation that she was suffering from "severe psychiatric problems" and that it was likely that this was in part at least attributable to her relationship with her family. He based his conclusions in this respect on the copy of the medical file provided by Dr. Huerto, and on the notes of Dr. Bowden, which included an allusion to the fact that Dr. Bowden had prescribed an antidepressant drug to Ms. [redacted].

Under cross-examination, Dr. Donat conceded that it might influence his opinion were he to hear from Dr. Bowden that Ms. [redacted] was, psychologically speaking, an ordinary adolescent. He also acknowledged that antidepressant drugs are prescribed in the treatment of fibromyalgia, a condition which a number of physicians, including both Dr. Huerto and Dr. Bowden, speculated might be the cause of the headaches.

It is also significant that Dr. Donat was using a typed transcript of notes from the medical file which Dr. Huerto had been asked by the College of Physicians and Surgeons to make because of the difficulties in trying to read his handwriting. The members of the committee have devoted considerable effort to comparing the typed transcripts with the notes concerning all of the patients whose treatment is the basis of these charges, and there are clearly some differences. The significance of some of these will be the subject of comment later on, but one difference has some importance in relation to this particular facet of the testimony of Dr. Donat. In the original handwritten notes for October 23, 1996, Dr. Huerto includes in his working diagnosis of Ms. [redacted] the fact that she might have a personality "problem." In the typed notes which Dr. Donat was working from, the term used is "personality disorder," which seems a somewhat stronger term.

It should also be noted that, when asked to explain the fact that no physician treating Ms. [redacted] since April of 1997 had given any

hint that she might be suffering a psychological disorder, Dr. Donat speculated that the complaint about Dr. Huerto to the College of Physicians and Surgeons might have had a cathartic effect, or that she might have benefited from being away from her family. Both of these seem to be somewhat speculative suggestions. It may also be remembered that Dr. Donat was not qualified as a an expert in psychology or psychiatry.

In any case, Dr. Huerto himself did not describe [redacted] or her family in quite such extreme terms. He did, however, describe her as being almost completely disabled during the period when he saw her, and he did identify psychological disturbance as something which he wished to pursue. He noted, for example, that he might refer her to Dr. Declan Quinn, a Saskatoon psychiatrist, for a consultation. He and other members of his staff described her mother [redacted] as taking charge of most of the discussion of [redacted]'s treatment and her condition, as complaining frequently and in strong terms about the incompetence and unhelpfulness of other physicians, and as exerting constant pressure for some sort of answer to the uncertainties about the source of [redacted]'s headaches.

These descriptions are impossible to square with the impression which the committee formed of [redacted] and of [redacted] on the basis of their testimony and of their demeanour as they provided it. It is also difficult to square with the references in the documentation produced by Dr. Bowden, Dr. Witt or Dr. Sonja Pienaar, the family physician who treated [redacted] after she left Dr. Huerto. For example, in her oral testimony, Dr. Bowden stated that, though [redacted] was troubled by fairly frequent headaches, it did not seem to interfere unduly with the wide range of activities in which she was involved.

Our conclusion is that the accurate picture of [redacted] and her family is closer to the one which emerges from her testimony and that of her mother than to that which was outlined in the evidence of witnesses called on behalf of Dr. Huerto. [redacted] impressed us as an intelligent young woman to whom academic achievement was clearly important. At the time she began to see Dr, Huerto, she was maintaining an excellent scholastic record, working at two part-time jobs and participating in a number of sports and other extra-curricular activities.

She seemed to us an ambitious young person, and it is credible, given the range of activities in which she was involved at the time she saw Dr. Huerto, that she seemed somewhat tense and driven at that time. In her testimony, [redacted] agreed that she might have told Dr. Huerto that [redacted] "went overboard" about some things, but she denied that she had said that [redacted] "went overboard about everything" or that the reactions of [redacted] to the events in her life went beyond what might be expected of an adolescent girl.

We accept the testimony of [redacted] that, though she may have been disabled from her normal activities on the occasions when she had headaches, there were many times during the period of her contact with Dr. Huerto when she was able to carry on the things she was used to doing. We accept that this included going on several hunting trips with her father in the fall of 1996.

[redacted] impressed the committee as a forthright person who enjoyed a close relationship with her daughter. Her reaction to [redacted]'s illness, and the reaction she described for the rest of the family, do not seem to have been disproportionate. [redacted] and her husband were, not surprisingly, concerned about the frequent headaches which [redacted] was experiencing, and about the fact that it seemed difficult to identify a satisfactory explanation for them. [redacted] and [redacted] were clearly consumers of medical services who had their own opinions about those services and who wanted full explanations of all of the treatment which was being given to [redacted].

Though it is likely that [redacted] felt some frustration that the physicians previously seen by [redacted] had not been able to "cure" the headaches, we do not believe that she criticized those doctors in the incessant, pressing and vulgar manner attributed to her by Dr. Huerto and the members of his staff. It is not surprising that the [redacted] wanted to obtain as wide a range of medical opinion as possible in the search for an answer to the riddle of the headaches, but we do not accept the suggestion that [redacted] repeatedly called into question the competence or intelligence of Dr. Bowden or other doctors seen by [redacted].

This is an important point, because the reported attacks on physicians seem to have been a factor in the conclusion reached by Dr. Donat that the [redacted] family - and [redacted] and [redacted] in

particular - were demonstrating what he referred to as a "deep psychopathology."

According to the testimony of [redacted] and [redacted], Dr. Huerto led them to believe that [redacted] had a "serious heart condition". They also said that their understanding was that he was the only one who would be able to help them deal with this condition, and that it might require surgery. They claimed to have asked Dr. Huerto to explain the condition to them, and he had answered that it was too complicated for them to understand. [redacted] was still taking the "heart condition" seriously enough in April that she asked Dr. Pienaar to arrange a referral so that [redacted]'s heart could be assessed.

Dr. Huerto said that in fact [redacted] had a mitral valve prolapse, a relatively benign heart malformation which had no serious implications and would in any case likely disappear as [redacted] reached maturity. He stated that he would not have said that surgery would be necessary, although he acknowledged that surgery is on rare occasions a treatment for mitral valve prolapse. He said that there were illustrated booklets available in his waiting room which could have been consulted for a clear and simple explanation of this phenomenon.

It is difficult to know how this misunderstanding arose, although it may have been because there were a number of conversations about the possible links between the heart and headaches. It is not surprising, if [redacted] and [redacted] were under the impression that [redacted] had a heart condition which placed her in a precarious position, that [redacted] would manifest a degree of anxiety about her daughter's situation.

In our view, the notes placed in the file by Dr. Huerto, along with his testimony and that of members of his staff, created a somewhat exaggerated and inaccurate picture of [redacted] and her family.

Charge 1: Failing to Respect the Privacy of [redacted]

Like many of the charges which were heard by this committee, Charge 1 is framed as a charge under both Section 46(o) and 46(p). As we have indicated earlier, Section 46(p) allows the committee to make a finding of unbecoming, improper, unprofessional or discreditable conduct where any act or omission has been defined by the council

in the bylaws as constituting such conduct. Section 46(p) allows the committee to make a finding that conduct is unbecoming, improper, unprofessional or discreditable in circumstances where the act or omission in question has not been specifically enumerated in the bylaws or in other provisions of the Act.

In this case, the charge does refer to a specific bylaw, namely Bylaw 51(2)(q), which reads as follows:

> 51.(2) The following acts or failures are defined to be unbecoming, improper, unprofessional or discreditable conduct for the purpose of Section 46(p) of *The Medical Profession Act, 1981*. The enumeration of this conduct does not limit the ability of the Discipline Hearing Committee to determine that conduct of a physician is unbecoming, improper, unprofessional or discreditable pursuant to Section 46(o):
>
> q) Committing an act of sexual impropriety with a patient or an act of sexual violation of a patient.

In his oral argument at the conclusion of the case, counsel for Dr. Huerto said that making a charge referring to this bylaw and suggesting that "sexual impropriety" had occurred in the circumstances of this case was unduly inflammatory and demonstrated the bias of the College against Dr. Huerto. It is clear from the definition of "sexual impropriety" in Section 51(1)(g), however, that the allegations made by the College do fall, *prima facie*, into one part of the definition, that in Section 51(1)(g)(i), which refers to:

> g)(i) acts or behaviours which are seductive or sexually demeaning to a patient or which reflect a lack of respect for the patient's privacy, such as examining a patient in the presence of third parties without the patient's consent or sexual comments about a patient's body or underclothing

There is, of course, room for debate about whether the examples given in the subsection are analogous to the situation which was the subject of the allegation here, but we think there can be no doubt that the bylaw contemplates that a lack of respect for

privacy can be the basis of a charge under Bylaw 51(2)(q).

The allegation on which the charge is based is that Dr. Huerto had [redacted] take off her clothing above the waist, and that she was then left in an examining room with the door open. She and her mother testified that they were never given a sheet or gown, and that, so far as they knew, there were none in the room. [redacted] testified that on one occasion another patient was on a stretcher in the hallway, and could have seen [redacted] on the bed in the examining room. Another allegation is that [redacted] was instructed to perform a stress test on a treadmill in one of the rooms at the clinic, and that she was given only a mesh singlet to wear for the test. She and her mother testified that during the stress test, the door to the room was open.

Dr. Huerto, Professor Heaslip, and Ms. Kathy Tiegen, the receptionist at the clinic, all testified that sheets and gowns were as a matter of course provided to patients, and that they were in any event available on shelves in all of the examining rooms. Dr. Huerto testified that when he was examining a patient, he would normally keep the door closed, except when he was using one of the monitoring machines which required a small amount of light from the hallway; in that case, he would keep the door open a crack. Both Ms. Tiegen and Professor Heaslip testified that when their duties required them to be in an examining room with a patient, they would keep the door closed; if they had to leave the room for some reason, they would close the door behind them.

Dr. Huerto testified that the clinic had in fact been designed to ensure maximum privacy for patients. For example, the doors to the examining rooms were placed on an oblique angle to prevent any possible sight lines from one room to another. He also testified that it would be virtually impossible for anyone to see into the room where the stress tests take place because it is at the back of the building and there is no reason for anyone other than himself and his staff to go there.

The committee was given a tour of the clinic during the hearing. At that time, there were gowns and sheets in evidence in every room. This is not, of course, entirely conclusive of the question of whether there were sheets and gowns available during the period when [redacted] was attending the clinic, as it was clear in the evidence prior to the visit of the committee that this would be a

contested issue.

[redacted] was accompanied to the clinic on almost all occasions by her mother. Though it is possible that [redacted] herself would be uncomfortable enough in the surroundings of the clinic that she would not take the initiative to ask for a gown or sheet if one were not provided, it is difficult to imagine what would prevent her mother from bearing some responsibility for securing a gown if she thought [redacted] should have one. We are persuaded that there were gowns or sheets on the premises, if not in plain view in the examining room as Dr. Huerto and his staff testified. Particularly as they became more familiar with the operation of the clinic, it is not clear why [redacted] would not have requested a covering if [redacted] was feeling exposed.

The design of the clinic has made very efficient use of floor space, and the examining rooms and other parts of the clinic are very close together in a small space. The view taken of the clinic facility, however, convinces us that it would be difficult for anyone outside one of the examining rooms to get a clear view of a patient on the bed, even with the door open. Though it is possible that [redacted] and [redacted] might have had a glimpse of a patient on a stretcher, if not in the hallway, then in the patient care area opposite the examining room, it is unlikely that such a patient would have had a clear view of [redacted].

The allegation with respect to the exercise test is a slightly different matter. It is credible that [redacted] and her mother were reluctant to ask for an explanation as to why [redacted] was not provided with a gown, when she had already been provided with a mesh covering to keep the electrodes in place on her upper body.

The diagnostics room where the stress tests take place is a large room at the rear of the clinic which is used for a variety of purposes, including the storage of certain supplies, and the administration of other kinds of tests. Dr. Huerto and Ms. Tiegen said that during a stress test Ms. Tiegen might find it necessary to enter the room to get something, and that she might come in and out more than once during the test.

It is true that it would be difficult to see far enough into the diagnostics room from the hallway to get a clear view of the treadmill area, and it is also true that this room lies beyond the

areas of the clinic where one might expect to find anyone other than Dr. Huerto or members of his staff. On the other hand, it might not be clear to a patient using the treadmill how secluded the room is, and anxiety about the opening and closing of the door is understandable.

On the whole, though there are perhaps things which could have been done to allay the sensitivities of [redacted] on this score, we do not think this charge has been proved to our satisfaction.

Charge 2: Failure to maintain professional standards in the treatment of [redacted]

a. Use of Synvisc

Dr. Huerto testified that one of the symptoms of which [redacted] complained was pain and swelling in her joints and bursae, including her knees, shoulders and hips. To address this problem, he said, he gave her injections of Synvisc.

Dr. Wayne Marshall, an orthopedic surgeon whose practice is focused mainly on the treatment of knee joints, gave evidence on behalf of Dr. Huerto. He indicated that Synvisc is a remedy which has proved useful in the treatment of osteoarthritic conditions,though the exact reasons for its success are not entirely known. Synvisc is based on the molecule of hyaluronin, a constituent of the synovial fluid which is part of the mechanism of the joint.

In patients with osteoarthritis, the synovial fluid deteriorates and is not as useful in the lubrication and cushioning of the action of the joint. For thirty years or so, synthetic forms of hyaluronin, such as Synvisc, have been used in an effort to replace and replicate the synovial fluid. It has been very effective in many osteoarthritic patients in alleviating pain and restoring flexibility in the joint. Though Synvisc has been considered a prosthesis rather than a medication, and as such has not required prescription, Dr. Marshall testified that there is more recent evidence that Synvisc may actually have an effect in improving the synovial fluid and restoring its function.

Dr. Marshall acknowledged that there are many orthopedic specialists who do not place any reliance on Synvisc. In his experience, however, it is a useful treatment, and in many

circumstances has proven successful at delaying or eliminating the necessity of surgery.

Dr. Marshall said that the usual regime for the administration of Synvisc is to give a course of three injections one week apart. Ms. Laura Cholowski, a pharmacist, gave evidence that Synvisc is packaged in a "kit" of three doses. She further testified that it is not usually obtained through a pharmacy, but that it may be ordered by the patient or the physician directly from the manufacturer.

Under examination, Dr. Marshall testified that there may be sound reasons for departing from this usual pattern of three injections. He said that a physician may judge that the patient has had adequate benefit from two injections, and decide to withhold the third one. He said that, although Synvisc is an exceedingly safe medication, there is a small chance of infection, and a physician might legitimately decide that further injections should not be given.

Though the most common use of Synvisc, and the one with which Dr. Marshall said he had most experience, is in patients with osteoarthritis, he said that he has also used it in two patients with patello-femoral syndrome, a term loosely describing pain in the fat pads and other areas around the joints. He is also aware, from discussions at conferences, that other physicians have occasionally used it in this context.

In his evidence, Dr. Marshall said that one of his major objectives, particularly with young patients, is to find alternatives to surgery, and he has found Synvisc useful in meeting this objective. He said that using Synvisc to address patello-femoral syndrome lies legitimately within the scope of appropriate professional standards, though he would say that this is perhaps a minority opinion among members of the profession.

Dr.Robert McDougall, a rheumatologist called by the College, also gave evidence about the use of Synvisc, which he has used himself fairly extensively. He was also in attendance at a professional meeting in Montreal in 1995 where the administration of Synvisc was discussed.

The description given by Dr. McDougall of the use of Synvisc was

quite similar to that given by Dr. Marshall. Dr. McDougall felt, however, that the usefulness of Synvisc was really limited to treatment of osteoarthritic conditions in the knee. He acknowledged that he knew some physicians who had used it for similar conditions in other joints. He said, however, that he did not think it would have any usefulness in the case of inflammatory, as opposed to degenerative, conditions. Though what is described as patello-femoral syndrome might be associated with the eventual development of osteoarthritis, which generally does not appear until a person is fifty or sixty years old, it does not have a degenerative component. Dr. McDougall also said that he does not view Synvisc as a first-line treatment, but rather as an option to be tried after other treatments have proved ineffective.

Dr. McDougall was also asked to comment on the term "arthralgia" which he said was a general term for pain in the joints, and is not a condition in itself; it is used in association with both degenerative and inflammatory conditions. He responded to an editorial article put to him by counsel for Dr. Huerto by agreeing that knee pain may result from conditions which are not easily classified or which are not characterized by symptoms which manifest themselves in X-rays or other tests; he said, however, that it is important to make efforts to arrive at an accurate diagnosis even where there is no degeneration of tissue or other identifiable cause of the pain.

Dr. McDougall agreed that a range of uses have developed for Synvisc, but he was of the opinion that it is not open to a physician to try a treatment, even one as apparently safe as Synvisc, unless there is some evidence supporting its use in the circumstances. As he put it, it is not open to a responsible physician to say "Let's try it and see how it goes." He agreed that there have been cases when a physician has discovered some additional application of a treatment, but these have generally come about by coincidence, when the physician has been using the treatment for an established purpose.

The only possible diagnosis mentioned by Dr. Huerto which addressed pain in the knees was fibromyalgia, a condition whose nature is still a matter of some debate, but which is not a degenerative condition. In the view of Dr. McDougall, Synvisc is not a useful treatment in these circumstances, and he stated that he was not aware of any body of medical opinion which would support its use in

those circumstances.

The evidence of Dr. McDougall and Dr. Marshall therefore supported the use of Synvisc in some circumstances, although there was a slight difference between them as to what the range of those circumstances might be. Dr. Marshall agreed when answering questions on cross-examination that he had framed his opinion supporting the use of Synvisc by Dr. Huerto in the case of [redacted] on the premise that Ms. [redacted] was suffering from patello-femoral syndrome. He conceded when asked to refer to the clinical notes made by Dr. Huerto that there was no indication in the notes that Dr. Huerto had made a diagnosis of patello-femoral syndrome before using Synvisc with Ms. [redacted].

The testimony of neither of these expert witnesses could be taken as supporting the use of Synvisc in circumstances where there is no indication for its use. Dr. McDougall, in particular, stated that the safety of a substance like Synvisc does not in itself support its use unless there is some indication that it is going to have a beneficial effect. Neither of the witnesses really supported the use of Synvisc where there was no diagnosis of a degenerative arthritic condition or, possibly, patello-femoral syndrome.

Our review of the notes of Dr. Huerto does not show that he diagnosed either of these things in the case of [redacted], and we have therefore come to the conclusion that, had he given injections of Synvisc to [redacted], such use would lie outside the scope of the standards of the profession, and we would have found that this part of the charge was established.

In her evidence, [redacted] stated that she had never had anything wrong with her knees. She said that she had had pain in her neck and sometimes her shoulders, which was linked to her headaches, but she said that she never complained of pain in her knees or suffered any swelling or stiffness.

When asked by counsel for the College to consider the range of activities in which [redacted] said she was taking part in, Dr. McDougall said he thought this was inconsistent with a diagnosis of patello-femoral syndrome, and there was nothing in the file to indicate an arthritic condition. He further noted that Synvisc is gone from the system in about seven days, and that there seemed to have been no subsequent use of Synvisc, either by Dr. Huerto or

other physicians.

In the notes made by Dr. Huerto in relation to his examinations of [redacted], he referred to tenderness in her knees on only a couple of occasions, while he made many references to the problems with her neck and shoulders. Certainly there was nothing to suggest the severe knee pains which he described in his testimony before the committee.

Both [redacted] and [redacted] testified that [redacted] had had no injections in her knees, although [redacted] remembered having injections in her buttocks, hips, and shoulders, and once in the base of her skull.

Both Dr. McDougall and Dr. Huerto described the technique for the administration of Synvisc. A process called arthrocentesis is used to draw fluid out of the joint, and then the Synvisc injection is given to replace the fluid.

A review of the notes made by Dr. Huerto indicates that he performed arthrocentesis in a number of different joints, although it is not specified which joints these might have been. There is no direct reference in the notes to the administration of Synvisc.

Because he is administering medications outside a hospital, Dr. Huerto is permitted to charge patients for these drugs, and his evidence was that, though he does not charge patients for all of the things he gives them, he does tell them that he may bill them. [redacted] said in her evidence that she had told Dr. Huerto that this was not really a concern because the family was covered by an insurance plan attached to Mr. [redacted]'s employment.

[redacted] was given a bill dated January, 1997, which was made up by Ms. Tiegen, the clinic receptionist, after several requests. The first version of the bill which was given to the [redacted] simply contained a list of injections:

Nov. 15/96	injections	25x2	$ 50.00
Nov. 19/96	"	25x6	150.00
Dec. 11/96	"	100x4	400.00
Jan. 30/97	"	100x2	200.00

The total bill was $800.

Mr. [redacted], [redacted]'s father, asked to have an indication on the bill of the actual medications and their official numbers, as his insurance plan would not otherwise reimburse him for the cost. A list was added to the bottom of the bill by Ms. Tiegen:

Cortrosyn	#00022381
2% Xylocaine	06001821
Depomedrol	01934341
Synvisc	075010
Betaseron	
Fluanxol	02156032

At a later time, and after a further request by the [redacted], the number for Betaseron was also added, though Ms. Tiegen could not say by whom, as she did not recognize the handwriting.

She was uncertain as to where the information came from which she used to make up the initial bill,as she had not received any information from Dr. Huerto of Professor Heaslip. Her usual practice was to wait until one of them gave her a list of medications; she would then fax it to the pharmacy to ask for the current prices, and use that as the basis for the bill.

The evidence of Ms. Laura Cholowski was that it was her impression that the cost of Synvisc is about $300.00 for a three-injection course. She said that she did not normally stock or sell it, so she could not be sure; Synvisc is ordinarily obtained directly from the manufacturer by a physician or by the patient. Dr. McDougall gave evidence that the cost was between $325.00 and $375.00 for each course of injections.

There is nothing on the bill which would correspond to the Synvisc injections, either in terms of cost or frequency. The dates November 15 and November 19 are closest to the one-week interval between the two Synvisc injections which Dr. Huerto is supposed to have given to [redacted], but there were two injections listed for one of these dates and six for the other; the cost of these injections was listed as $25.00 each, which does not correspond to the cost of Synvisc. The $100.00 injections listed for the December 11 and January 30 dates might be closer to an approximation of the cost of Synvisc, but the intervals do not coincide with the supposed timing of Synvisc injections.

It is our conclusion that there were no injections of Synvisc given to [redacted], and that therefore this part of the second charge is not established.

b. Failure to provide appropriate treatment for migraine

One of the working diagnoses which Dr. Huerto arrived at with respect to the headaches which [redacted] experienced was that they might be migraine.

Dr. Huerto testified that the major focus of the treatment he offered while he had [redacted] as a patient was the advice that she should take vigorous exercise, that she should eat properly, that she should avoid caffeine, and that she should avoid situations where she would be exposed to smoke. He said that he also gave her some samples of vitamins to take.

There was some discrepancy in the evidence of Dr. Huerto and that of [redacted] and [redacted] concerning Beverly's attitude to oral medication. Dr. Huerto testified that they were adamant that [redacted] should not take any oral medication, and that part of [redacted]'s disaffection with doctors was expressed when she referred to them as "pill-pushers."

Both [redacted] and her mother acknowledged that they were wary about medications. Dr. Bowden testified that she had reached a possible diagnosis of migraine in May of 1995, though there were some aspects of [redacted]'s condition which were not consistent with migraine. She had prescribed Tofrenil, a tri-cyclic antidepressant, to address the migraine, but [redacted] did not have the prescription filled. She had also prescribed Voltaren, and was not sure whether [redacted] had tried that.

A document from the pharmacy in Lloydminster which was entered in evidence in fact suggests that [redacted] had the Voltaren prescription filled twice. It must also be remembered that Dr. Witt had said her headaches could possibly be attributed to her over-consumption of Tylenol as a pain-killer, which may have made her wary of the value of oral medication.

It should also be noted that both Dr. Huerto and [redacted] testified that the latter had expressed the hope that Dr. Huerto would be able to produce some extraordinary medication - a "magic

pill" - which would provide a definitive cure for the headaches.

It seems to us that Dr. Huerto overstated the reluctance of [redacted] and [redacted] to contemplate oral medications as part of a treatment program, although they clearly had some reservations.

[redacted] testified that she had tried to follow the advice of Dr. Huerto, although she sometimes found it difficult because of the headaches to engage in the regime of long and vigorous walks he suggested. She quit her part-time job in a restaurant because of the smoky environment, and her brother, a smoker, agreed to try and ventilate his apartment when she was visiting.

Leaving aside the question of the appropriate reaction to the birth control medication taken by Ms. [redacted], which we will be discussing shortly, we do not think the evidence establishes that the basic approach which Dr. Huerto was taking to the treatment of migraine fell outside the standards of the profession.

c. Failure to strongly advise discontinuation of birth control medication

[redacted] testified that, some time before she began to see Dr. Huerto, she had been prescribed oral birth control medication by Dr. Bowden in order to control her irregular menstrual cycle, which Dr. Bowden thought might be linked to her headaches. She was given a prescription for Marvelon on January 31, 1996, initially for a three-month trial period, which was extended after that.

The question of the appropriateness of the response of Dr. Huerto to the fact that this patient was taking oral birth control medication depends in part on when he became aware that this was the case.

Dr. Huerto testified that he did not become aware that [redacted] was taking birth control medication until February of 1997, after she experienced what he concluded was a transient ischemic attack (TIA), which he described as a "mini-stroke." Overnight on February 12, [redacted] had an episode of numbness on the left side of her face and in her left arm which lasted about thirteen hours. Dr. Huerto saw her on February 19, at which time no lingering effects of the attack were apparent; it was at this time, he said, that he became aware that she had been taking birth

control medication.

Counsel for Dr. Huerto pointed to the form which was filled in by [redacted] and [redacted] in connection with the Holter monitor testing which they undertook to do. The Holter monitor is a monitoring device which allows and ambulatory patient to record medical events which occur between clinical consultations. At the bottom, the form contains a space to record medications, and the [redacted] never recorded anything in this space. We do not find it credible that Dr. Huerto would have relied on this as a primary source of information, as he saw this patient so often and had access to other sources. In any case, there was no occasion on which he instructed the [redacted] to fill out this part of the form, or suggested to them that their recording of data was unsatisfactory.

Along with Dr. Huerto, two neurologists, Dr. Donat and Dr. Carol Boyle, testified that oral birth control medication can pose an increased risk of stroke in combination with other factors, including family history of stroke, migraine, exposure to smoke and TIA episodes. Though the risk posed by this link between birth control medication, migraine and stroke, has lessened somewhat with the new generation of lower-estrogen birth control pills, this nexus does still create enhanced risks.

Dr. Donat took the position that the risks for young women associated with pregnancy are greater than those posed by the connection between birth control medication and stroke, and that he would therefore generally not advise patients to discontinue their birth control medication under these circumstances. Both Dr. Boyle and Dr. Huerto, however, thought the proper approach where a patient had migraine and other risk factors would be to advise the patient to stop taking the birth control medication.

[redacted] and [redacted] were quite sure that Dr. Huerto knew or, at least, should have known that [redacted] was taking birth control medication from the outset of their relationship with him. [redacted] testified that she had obtained from the Shopper's Drug Mart in Lloydminster a computer printout, bearing the date September 20, of all of the medications which had been prescribed for [redacted] in the previous three years, including the prescriptions for Marvelon. She said that she had given this to Dr. Huerto when [redacted] first visited the clinic.

This document was not in the copy of the original [redacted] file from Dr. Huerto's office which was produced at the hearing, although it was in a copy of the file in the possession of the [redacted], and in one which had been made for Dr. Pienaar. Both of these copies of the files were also produced to this committee. There was in the copy of the file from Dr. Huerto's office a smaller, handwritten memo, also headed "Shoppers Drug Mart," and having no date, containing the names of two antibiotics which had been prescribed for [redacted] in 1992 and 1993, and Dr. Huerto testified that this was the only list of drugs which had ever been provided to him.

Ms. Kendra Flegel, a pharmacist from the Shoppers Drug Mart in Lloydminster, was called to give evidence on behalf of Dr. Huerto. She testified that she knew who [redacted] was, and she remembered her visiting the pharmacy and obtaining the shorter list which appeared in the file. She said it was her recollection that a short time later, possibly a couple of weeks, [redacted] phoned and said she was in a doctor's office, and needed to have a more extensive list of medications faxed to her. Ms. Flegel said that she got a printout from the computer and arranged to have another employee in the pharmacy fax it to [redacted].

Counsel for Dr. Huerto argued that this account meant that this computer printout had been provided to [redacted], but that it had never been given to Dr. Huerto. He intimated that the [redacted] might have added it to the file when they obtained a copy to be forwarded to Dr. Pienaar. Counsel for the College, on the other hand, suggested that the printout had likely been faxed to [redacted] when she was in the office of Dr. Witt in Edmonton.

The testimony given by Ms. Flegel about the production of a computer printout is not terribly helpful. She may well have arranged for a computer printout to be faxed to Ms. [redacted], but it is hard to see how it could be the one which was included in the copies of the file in the hands of the [redacted] and of Dr. Pienaar. Though counsel for Dr. Huerto tried to suggest that any computer printout faxed to the clinic would have had the time and date recorded by the clinic fax machine, it is, of course, the stamp of the transmitting, not the receiving, fax machine which appears across the top of a faxed document.

This particular document has no fax notation on it at all, which

supports [redacted]'s testimony that she obtained it by going to the pharmacy in person.

Ms. Tiegen testified that she had photocopied the whole file from Dr. Huerto's office and sent it to the [redacted]. They then arranged to have a copy made for Dr. Pienaar, and kept a copy themselves. The theory that [redacted] added the document to the file when she had it copied for Dr. Pienaar does not seem to be borne out by a close examination of the documents. Both the photocopied versions of the file, the one in the hands of the [redacted], and the one supplied by Dr. Pienaar, have distinctive markings. In the case of the copy provided to the College by the [redacted], the pages have a shaded gray area on the right hand side of the page; the photocopy of the computer printout of the medication list has this gray marking of a width and in a location which exactly matches the other pages of the file.

The photocopy which Dr. Pienaar had has a pattern of black specks in the upper portion of all of the pages, including the computer printout.

The conclusion which must be drawn is that both the copy of the file in the hands of Dr. Pienaar and, more importantly, that in the hands of the [redacted], were photocopied in one session and on the same machine.

The other thing which undermines the theory that the medication list was added to the file by either [redacted] or [redacted] before the file was photocopied for Dr.Pienaar is that it is difficult to ascertain any reason for doing it. The [redacted] did not raise any issues with the College of Physicians and Surgeons until October of 1997, and the birth control question was not among them. Indeed, this matter did not become an issue until considerably further along in the preparation for the series of hearings before this committee.

It is difficult to know what to make of the shorter, undated, list of medications which did appear in Dr. Huerto's file, but not in either of the copies of the file which were with the [redacted] and Dr. Pienaar. It is possible that [redacted] brought it to the clinic along with the other list, though she did not remember seeing it before the hearing. She may have acquired it initially from Ms. Flegel, and then realized it was not a complete or current list of

medications.

The theory which Dr. Huerto put forward to explain why neither [redacted] nor [redacted] told him about the birth control medication until after the TIA episode was that [redacted] did not want her parents to know she was on the pill. He suggested that [redacted] may not have known [redacted] was on the pill when she first consulted him, and that [redacted] did not want her parents to know she was sexually active.

[redacted] testified that both she and her husband were aware that [redacted] was on the pill. She said that Mr. [redacted] had included these prescriptions in previous insurance claims. The letter to Dr. Bowden from Dr. Witt in April of 1996 certainly suggests that [redacted] knew about the birth control medication, as he stated in the letter that she had been present during his conversations with [redacted], which had included reference to her history of being on the pill.

On November 15 and December 11, 1996, tests were done which recorded low estradiol levels for [redacted], consistent with her being on birth control. The results of these were available to Dr. Huerto, but they did not, he said, bring home to him the [redacted] was on the pill. He said they might indicate other things, although he apparently did not pursue the matter. These documents in the original file from his office had red notations, expressing surprise as they seemed to indicate she might be on birth control medication, but Dr. Huerto indicated in his testimony that these notations were not made on the documents until he was preparing for this hearing.

Dr. Huerto said that, once he found out in February that [redacted] was on birth control medication, he did strongly advise her of the possible risks in connection with her TIA episode and her headaches. He testified that he suggested other forms of birth control which would not pose such significant risks, including depo-provera, a contraceptive administered by injection.

He said, however, that she was adamant that she would not go off birth control medication, as she feared pregnancy and wanted to maintain her independence. He testified that, when he saw them on February 19, 1997, [redacted] joined him in trying to convince [redacted] to discontinue taking Marvelon, and that [redacted] had a

"temper tantrum" which provoked a lengthy and heated argument between mother and daughter. Ms. Tiegen and Professor Heaslip also testified that they heard the [redacted] raising their voices in Dr. Huerto's consulting room, although they were not present during this meeting.

[redacted] and [redacted] both testified that they were sure Dr. Huerto knew [redacted] was taking birth control medication from the time she started seeing him. In her evidence, [redacted] said that, if she had known there was any risk attached to this medication, she would have stopped taking it immediately, particularly after the TIA episode.

There is support for this testimony in the contact which [redacted] subsequently had with Dr. Pienaar. On the first occasion when she went to see Dr. Pienaar, [redacted] accepted her advice that she should cease to take Marvelon and receive the depo-provera injections instead. It is difficult to believe that, if she had taken the obdurate position with respect to the birth control medication which Dr. Huerto described, she would accede to the advice of a new physician on the first visit and move to a form of contraception which Dr. Huerto said he had described as one of her options.

In this part of Charge 2, it is alleged that Dr. Huerto "did not strongly advise [redacted] that she should discontinue her use of the oral contraceptive medication which she was receiving."

It is, of course, difficult to interpret the term "strongly" in relation to this aspect of the charge. We accept that, once Dr. Huerto came to the realization that Ms. [redacted] was taking birth control medication and understood the implications of that in relation to the TIA event, he made efforts to advise her about the possible consequences of continued use of birth control medication. We are not convinced that he made it clear enough to her what was at stake, as she could, in our view, have been persuaded to use alternative methods of contraception; this is supported by her immediate transition to depo-provera when she Dr. Pienaar began seeing her.

In any case, we are persuaded that he knew, or should have known, before the TIA episode in February, that Ms. [redacted] was taking birth control medication, and that he should have advised her about the

risks that entailed in relation to her headaches.

We therefore find that this part of the charge has been established.

d.,e. and f. Initiation of anticoagulation therapy

In February of 1997, according to Dr. Huerto, he found out that [redacted] was taking oral contraceptives, and he was unable to persuade her to discontinue their use. In this context, he decided that the risk of stroke could be reduced by placing her on a regime of anticoagulation. For this purpose, he prescribed Coumadin, a brand name of warfarin.

Dr. Carol Boyle gave evidence as to the practice which she and many of her medical colleagues follow in the case of a young person with the combination of risk factors evident in [redacted]'s case. She expressed her opinion that a patient who had had a TIA and had other risk factors for stroke should be strongly advised to discontinue the use of oral contraceptives, but she conceded that there are times when a patient may decide to override this advice.

In a case where there is a risk of stroke as suggested by the occurrence of a TIA, Dr. Boyle said that she would ordinarily admit the patient to hospital so that various tests could be performed. She said that anticoagulation therapy would in many cases be used; she would generally have a CT scan performed first so that any organic problems with the brain could be identified. Then she would start the anticoagulation therapy with a gradual infusion of heparin, an anticoagulating agent which has minimal risks of inducing a hypercoagulable state, an especially important point in young people. She then gradually increases the dose if additional CT scans show no indications of hemorrhage. Warfarin therapy is initiated when it is clear the patient is not showing signs of a hypercoagulable state.

Dr. Boyle conceded that, although this represents the method for most of the physicians she works with, not all physicians think it necessary to proceed in this way. She mentioned in particular Dr. Donat, a very experienced neurologist, who does not always have a CT scan done before commencing anticoagulation therapy. Nor does he think it necessary to use heparin in all cases prior to initiating warfarin therapy.

It seems clear to us that this is an area where there is legitimate disagreement between medical specialists over what it necessary when commencing anticoagulation therapy. The method adopted by Dr. Boyle represents a thorough and cautious approach, in which, she conceded, the main reason for admission of the patient to hospital is to enable a full range of tests to be done expeditiously. On the other hand, it cannot be suggested that Dr. Donat is not practising within the scope of proper professional standards, and, in his evidence, he expressed his own support for the procedure adopted by Dr. Huerto.

We therefore find that these aspects of Charge 2 have not been established.

g. Failure to achieve an INR level in the therapeutic range for anticoagulation

The final element of Charge 2 is the allegation that Dr. Huerto instituted warfarin (Coumadin) therapy without attaining an international normalized ratio (INR) level in the therapeutic range for anticoagulation.

In her testimony, Dr. Carol Boyle addressed the significance of INR levels for patients who are at risk for stroke. INR levels are an indicator of the activity of clotting factors in the blood, and are therefore indicative of the success of anticoagulation therapy in breaking up blood clots. In treating young patients who have experienced a stroke or who are at risk for stroke, Dr. Boyle said that her understanding was that an INR level of between 2.0 and 3.0 would be indicative that anticoagulation therapy is having the desired effect. She said that any lower level would not suggest that the anticoagulants are taking effect. She further stated that the 2.0-3.0 figure is the normally accepted level for which physicians should be aiming in these circumstances, and she is not aware of any responsible medical opinion to the contrary.

Dr. Huerto testified that it is his practice to aim for levels at 1.4 or 1.5. He said that, in the case of [redacted], he was afraid that the level of anticoagulation indicated by a higher INR level would result in bruising, and he felt that in any case, such an INR level indicates a satisfactory result of anticoagulation. He could point to no support in medical literature for this, but said that there was nothing in the literature which stated the correct

INR levels in this kind of circumstance with any exactitude.

Dr. Jeff Donat, like Dr. Boyle a neurologist, said that there was no certainty about the INR levels which are appropriate in this kind of case. He said that the generally accepted level is 2.0-3.0, and that he is somewhat doubtful that lower levels are acceptable. He said that he had tried the lower levels in some patients, and was not certain whether that was a reasonable thing to aim for.

In response to a question from the committee, Dr. Donat said that, with a patient like Ms. [redacted], he would monitor INR levels once a day when he had started anticoagulation therapy; once the INR levels had reached the therapeutic range, he would monitor them once a week, and then once every two weeks. A review of the test results for Ms. [redacted] which are included in her file indicates that the first time she reached what Dr. Huerto regarded as the therapeutic level of 1.4-1.5 was on April 9, which was the date of her last visit to Dr. Huerto. Tests done shortly after the possible TIA episode, in February, showed that the INR levels were considerably lower, at 0.8 and 0.9.

The question thus arises of whether Dr. Huerto could have known whether the INR levels for [redacted] were in the therapeutic range, whatever that might be. The INR level of 1.4 was not achieved until April 9, the last time Ms. [redacted] saw Dr. Huerto. Dr. Huerto said that he expected that the INR levels would be monitored by the family physician rather than by himself.

It must be remembered, however, that an essential component of the description given by Dr. Huerto of [redacted] and her family had to do with their aversion to the treatment provided by local doctors and their low opinion of the members of the medical profession they had previously consulted. He said that he had never communicated to Ms. [redacted] herself or to her mother the importance of the INR levels, as he felt they would not understand them. Though Ms. [redacted] did see Dr. Huerto fairly often, it is clear that there was no way her INR levels could have been monitored on a daily basis, as Dr. Donat said was desirable at the outset of anticoagulation.

It is true that [redacted] did consult Dr. Pienaar in Lloydminster very shortly after her last visit to Dr. Huerto. In transmitting the file to Dr. Pienaar, the only comment he made

about the INR levels was the statement "While taking Coumadin 2 mg od her INR was 1.4." This statement contains no indication that Dr. Huerto regarded this as an acceptable therapeutic level or that this level had only been reached in test results on the day before he wrote the letter.

Though we are inclined to accept the evidence of Dr. Boyle that INR levels of 2.0 to 3.0 are generally accepted as indicative of effective anticoagulation, sufficient doubt was cast on this by the evidence of Dr. Donat that we do not think it can be said categorically that the levels which Dr. Huerto aimed for were unreasonable. We do think, however, that this part of the charge is established in the sense that Dr. Huerto could not have known much of the time whether INR levels for Ms. [redacted] were within the desirable range for anticoagulation. He did not communicate to his patient or her mother that it would be desirable to have these tests done, and he made no arrangements to ensure that tests were carried out in Lloydminster or that he could do the desirable monitoring himself.

Charge 3: Injection with Fluanxol, Synvisc or Betaseron

Under this charge, the College has alleged that Dr. Huerto injected [redacted], or caused her to be injected, with Fluanxol, and/or Synvisc and/or Betaseron, in circumstances where these did not constitute treatments regarded as having therapeutic value by the medical community.

We have mentioned earlier the bill which was created at the request of [redacted] in the early months of 1997. When Ms. [redacted] asked for more detailed information to be included in the bill, a list of medications was added, and this list included Fluanxol, Betaseron and Synvisc.

Dr. Huerto testified at the hearing that neither Fluanxol nor Betaseron was ever given to [redacted]. Professor Heaslip testified that these medications were included in the list in error, and there is no evidence which would contradict this. We do not, therefore, find that the College has established this charge with respect to Fluanxol or Betaseron.

We have already described at length our reasons for finding that Dr. Huerto did not inject Ms. [redacted] with Synvisc, or cause her to

be injected with it, and we therefore find that this aspect of this charge has not been established either.

Charge 4: Conflict of interest - providing Fluanxol, Betaseron or Synvisc at a profit

Both Dr. Huerto and Professor Heaslip gave evidence concerning the financial affairs of the clinic over the past several years, since the body responsible for making payment for the medical services provided by physicians declared a number of the services provided by Dr. Huerto as ineligible for payment. One of the changes which came about because of this was that Dr. Huerto began to charge patients for drugs dispensed through his clinic, as he is permitted to do under the rules governing the medical care system of the province.

Dr. Huerto testified that he informs patients of this at the outset of their treatment. He produced for the committee a copy of a notice which stands on the reception desk at the clinic; this notice is intended to draw the attention of patients to the possible costs which may be incurred for medications by giving examples of the current costs of particular drugs.

We have described the process which was used for drawing up the bill which was given to [redacted] when she asked for an account to submit to the drug plan provided to her husband through his employment. We will be describing at a later point the process which was used to formulate a bill for the medications provided to Mr. [redacted]. Both of these instances are indicative of serious disorganization in the methods used at the clinic for recording and calculating the costs for medications which are to be charged to patients. Dr. Huerto, of course, bears general responsibility for this chaos, although, as he testified, he may not be directly involved in every step of the process.

The portions of the bylaws alluded to in this charge read as follows:

> **51(1)** In this section:
> f) "conflict of interest" includes a situation whereby a physician or a member of the physician's family, or a corporation, wholly, substantially or actually owned and controlled by the physician or a member of the

physician's family,
(iv) sells or otherwise supplies any drug, medical appliance, medical product or biological preparation to the patient at a profit, unless the physician can demonstrate that the product sold or supplied was reasonably necessary for the treatment of the patient.

51(2) The following acts or failures are defined to be unbecoming, improper, unprofessional or discreditable conduct for the purpose of section 46(p) of *The Medical Profession Act, 1981*. The enumeration of this conduct does not limit the ability of Discipline Hearing Committees to determine that conduct of a physician is unbecoming, improper, unprofessional or discreditable pursuant to Section 46(o):
b) Having a conflict of interest in relation to the physician's professional services.

The charge also invokes Sections 46(o) and 46(p) of *The Medical Profession Act, 1981*, which we have discussed earlier.

The form of "conflict of interest" addressed in Bylaw 51(1)(f)(iv) is just one of a number of manifestations of conflict of interest which are prohibited in Bylaw 51(2)(b). Other parts of the definition address such things as the relationship between a physician and a supplier of medical goods or services and that between a physician and a landlord who may supply medical goods or services.

The aspect of conflict of interest which is specifically addressed in Bylaw 51(1)(f)(iv) is the possibility that a physician may place profit above the best interests of the patient if there are no restrictions on the ability of the physician to provide medications or medical supplies to patients at a profit. It should be noted that a fair amount of latitude is given under this definition, as it is open to the physician to demonstrate that the service provided or treatment given is warranted, and this will be accepted as a justification for accruing a profit.

Dr. Huerto and Professor Heaslip both testified that they had no intention of making a profit by charging patients for the medications which were provided, but only to recoup some of the costs of providing treatment which they could no longer obtain from

the medical care system. They both described the method they used for calculating the costs of medications. Either Ms. Tiegen or Professor Heaslip would receive from Dr. Huerto a notation about medication provided to a patient, generally on a post-it note. When one of them came to make up an account, she would telephone the pharmacy and receive information about the current cost of the drug. To this the pharmacist would add a 10% administrative cost, and the total would be put into the account given to the patient.

No evidence was put before us to contradict the evidence of Dr. Huerto or Professor Heaslip that they did not intend to profit from the medications they provided to patients. On the other hand, there was considerable evidence that their system for recording and calculating the costs was disorganized. Furthermore, as we will describe when we come to the evidence of Professor Heaslip with respect to the account given to Mr. [redacted], she did not apparently have a strong commitment to accuracy when it came to formulating bills. Both she and Dr. Huerto clearly felt that the steps taken by the authorities to restrict the services for which the clinic would be compensated were unfair and unjustified. Professor Heaslip seems to have felt that this unfair treatment justified a less than meticulous attention to the charges which appeared in the accounts rendered to patients.

Thus, there were, for a number of reasons, opportunities for charges to appear on these accounts which did not bear a direct relation to the costs of the treatment which was provided. Perhaps the most dramatic examples of this were the charges attributed to Fluanxol and Betaseron which appeared on the bill for the treatment of [redacted], when she had never received either of these drugs. To this, as we have said, we would add the charges for Synvisc, which we are persuaded was not given to her either. A letter from Mr. [redacted] which is contained in the medical file shows that he was prepared to take the word of Dr. Huerto at that point that the costs indicated in the bill were justified, although he needed more detailed information to submit the account to his insurers. Though Mr. [redacted] and his wife raised the question of the bill with the College of Physicians and Surgeons, that was at a later time.

The focus of a charge under Bylaw 51(2)(b) is on the tension which exists when a physician allows a concern for his or her financial welfare to outweigh the obligation to provide sound medical care to

a patient. It is our view that the notion of a conflict of interest requires that the tension is known to the physician, or that it ought to be known. The rationale for imposing discipline for conflict of interest, it seems to us, is that the physician has made an unacceptable choice in balancing a legitimate concern for financial well-being against the interest of patients, as would be the case when a physician elects to charge patients for medical treatment which is not helpful in the context of a particular medical condition, or accepts payments from suppliers which may influence a choice of medications on other grounds than medical ones. This rationale suggests to us that what was contemplated by the wording of the Bylaw was that a physician would either be aware of the conflict of interest, or that there are circumstances which justify the attribution of such knowledge.

It is our view that Dr. Huerto was not making a conscious choice here to profit in the sense that is contemplated under Bylaw 51(2)(b), that he was not, in the terms we have just suggested, resolving the tension between the interests of his patient and his own financial welfare in an unacceptable fashion. Neither do we think that there was a conflict about which knowledge may be attributed to him. We do not find that he was in breach of Bylaw 51(2)(b).

This leaves the question of whether the charge has been established under the more general provision of Section 46(o) of *The Medical Profession Act, 1981*. Under this provision, as we have previously noted, it is open to a discipline hearing committee to find that a physician has committed unbecoming, improper, unprofessional or discreditable conduct, notwithstanding that the impugned conduct is not specifically prohibited under the bylaws. Such a finding would be based on a general understanding of professional obligation as described in the statute and the bylaws. It is, of course, necessary to the making of such a finding to be sure that the physician whose conduct is impugned has had a fair opportunity to respond to the allegation on which the finding is based.

We have concluded that the account rendered with respect to the treatment given to [redacted] was an instance of unbecoming, improper, unprofessional or discreditable conduct within the meaning of Section 46(o) of *The Medical Profession Act, 1981*. Though we have accepted that there is no clear evidence that Dr. Huerto intended to profit from supplying medications to his

patients, his methods for composing accounts clearly created opportunities for patients to be charged for things they had never received, or to be overcharged for things they had received. Indeed, such methods probably made it possible that some patients were not charged for things they had received, but Dr. Huerto cannot, as Professor Heaslip seems to have supposed he could, justify inaccuracies in accounts on the grounds that he did not wish to, was not able to, or was not likely to, achieve full compensation for other items.

Dr. Huerto pointed out that he was not able to maintain a large staff because of the financial problems of the clinic after the compensation which he received had been restricted, and said that the priority for himself and his staff was to provide adequate care to the patients. The obligations of Dr. Huerto to his patients are, of course, important, but they do not justify the carelessness and inaccuracy which seemed to attend the compilation of the accounts. If it is an obligation of a lesser order to provide patients with accounts which accurately represent the treatment they have received and the medications which they have consumed, it is still an obligation which can resound in disciplinary action if it is not fulfilled.

Though there are a number of things which are not clear about how the bill presented to the [redacted] came to include all of the items enumerated on it, it is clear that the bill purported to charge them for the administration of Fluanxol and Betaseron, which Dr. Huerto categorically stated had not been given to Ms. [redacted], and for Synvisc, which we have found was not given to her. Though Dr. Huerto would presumably have included the Synvisc charges on the bill even if he had reviewed it with care, the same could not be said for the charges allocated for Betaseron and Fluanxol, which he said would never have been considered as appropriate medications for Ms. [redacted].

<u>Charge 5: Invoice with respect to Synvisc</u>

Though this charge is again related to the administration of Synvisc to [redacted], it focuses on Section 46(k) of *The Medical Profession Act, 1981*, as well as on Sections 46(o) and 46(p). Section 46(k) reads as follows:

> **46.** Without in any way restricting the generality of

"unbecoming, improper, unprofessional or discreditable conduct", a person whose name is entered on the register, the education register or the temporary register is guilty of unbecoming, improper, unprofessional or discreditable conduct, where he:
k) charges a fee or causes a fee to be charged for a service that he has not rendered.

In the charge, it is alleged that the itemized account which was ultimately rendered to the [redacted] purported to charge them for injections of Synvisc which had never been provided, according to [redacted] herself.

We earlier expressed reservations as to whether those aspects of Charge 4 which focused on Bylaw 51(2)(b) could be established where there was not a conscious choice, or circumstances suggesting there should have been a conscious choice, in balancing financial gain against the interests of patients.

Such restrictions do not apply, in our opinion, to Section 46(k). Though the term "conflict of interest" suggests some tension which requires mental attention from a physician to be resolved or perpetuated, we think Section 46(k) is of a less restricted nature. As we interpret this provision, it can include situations in which a physician permits inaccurate accounts to be rendered, as well as those in which the physician intentionally charges a patient for services which were never provided.

Earlier in these reasons, we have stated our finding that Dr. Huerto did not give injections of Synvisc to [redacted]. We would thus find that Dr. Huerto is guilty of unbecoming, improper, unprofessional or discreditable conduct within the meaning of Section 46(k), in that he rendered an account to the [redacted] for treatment which was never carried out.

In the event we are mistaken about this interpretation of Section 46(k), we are still of the opinion that Dr. Huerto was guilty of unbecoming, improper, unprofessional or discreditable conduct according to Section 46(o) of the Act. Subject to the restrictions we have mentioned above requiring us to give Dr. Huerto a fair hearing, and, in this respect, to give him an ample opportunity to answer fully all of the allegations against him, it is open to us to designate conduct as unbecoming, improper, unprofessional or

discreditable, even though it may not be enumerated in a specific bylaw or in a specific section of the statute itself.

We are of the view that Dr. Huerto has a general responsibility for the accuracy and proportionality of the accounts which are presented to the patients in his clinic, even if he does not directly formulate them himself. In the circumstances surrounding the treatment of [redacted], it is clear that Dr. Huerto did not fulfill his obligations in this respect, and we find this to have been an instance of unbecoming, improper, unprofessional or discreditable conduct.

Charge 5A: Falsification of medical records of [redacted]

1. Falsification of hand-written notes

We have earlier mentioned that the committee was provided with two sets of the clinical notes kept by Dr. Huerto with respect to his treatment of [redacted]. One of these was the original hand-written notes in each case. The other was a typed transcript. In the case of [redacted], Dr. Huerto testified that he had made the transcript at the request of Dr. Lowell Loewen, the Deputy Registrar of the College of Physicians and Surgeons. In the case of the notes pertaining to [redacted] and [redacted], Dr. Huerto testified that he made the transcripts in order to assist the medical experts who would be asked to give evidence on his behalf at the hearing before this committee. He said that in the case of [redacted], he attempted to make a verbatim transcript from the notes. In the transcripts relating to [redacted] and [redacted], he acknowledged that he included some additions and modifications which would allow the expert witnesses to understand the course of treatment he had followed and the judgments he had made.

We wish to note that the members of the discipline hearing committee have made considerable efforts to read both sets of notes, and to compare them. Notwithstanding the difficulties entailed in reading the handwriting in the notes, which was the basis on which the transcripts were prepared, we are satisfied that we have made a thorough comparison of the two sets of notes, and we are confident that we are able to comment on them.

It was clear from the testimony of Dr. Huerto, at least in respect

of the transcripts which were made of his notes for use by the expert witnesses, that he regarded it as legitimate in making these transcripts to comment on and justify the treatment he had given to [redacted] and [redacted]. It was also clear in the testimony of Dr. Huerto that he did not feel he was constrained to preserve the original medical file in a pristine form. We have already commented on the fact that he made notations in red ink on the test results showing the estradiol levels for Ms. [redacted] in the file, and his testimony that he made these notations in preparation for the hearing before this committee.

In relation to the first part of this charge, the important question is whether Dr. Huerto actually altered the original hand-written notes in the file with respect to [redacted]. As we have said, we have made a close examination of the hand-written notes, and considered them carefully in light of the evidence which was given at the hearing.

One of the discrepancies between the evidence given by Dr. Huerto and that given by [redacted] and [redacted] had to do with the terms in which the [redacted] had expressed their gratitude to Dr, Huerto. According to Dr. Huerto, both [redacted] and [redacted], as well as Mr. [redacted], expressed themselves in very fulsome and effusive terms. On November 20, for example, Dr. Huerto noted the following:

> NOTE:***patient and mother extremely grateful for the extraordinary improvement that [redacted] has experienced in the last 24 hours. They have communicated this information to her husband by phone at night and he was elated about the response.

On January 30, the following notation was made:

> NOTE: Mrs. [redacted] expressed profound gratitude for the remarkable improvement of her daughter. She and her husband and also other daughter are very thankful for the improvement that [redacted] has experienced in the past one and a half months. "For the first time in three years she is happy and the whole house is OK!"

At another point, Dr. Huerto recorded that Ms. [redacted]'s older brother had wished her to convey his gratitude to Dr. Huerto. The

note indicated that the brother had stopped smoking because of [redacted]'s reports of the advice of Dr. Huerto, and that the brother also wished to become a patient.

Both [redacted] and her mother testified that they had never spoken to Dr. Huerto in such fulsome terms. Both of them said that they had initially been quite pleased with the attention given to them by Dr. Huerto, and with the progress which [redacted] had been making. Though they had eventually become dissatisfied with the inability of Dr. Huerto to provide a clear diagnosis of [redacted]'s medical condition, they acknowledged that they had been satisfied with the treatment provided by Dr. Huerto for some time. According to their description, they were always polite to Dr. Huerto, and thanked him for his treatment, but they did not express themselves in the superlative terms recorded in the notes.

Having seen and heard both [redacted] and [redacted], we think it unlikely that they did express themselves in the terms recorded by Dr. Huerto. The word "extraordinary," for example, was used by Dr. Huerto on numerous occasions in his testimony, but it does not seem to be a word which the [redacted] would have used. According to the testimony of [redacted] and [redacted], the older brother had not given up smoking, though he had agreed to ventilate his apartment when his sister was staying there, and showed no particular interest in the medical treatment provided by Dr. Huerto.

In the notes, many of the descriptions of the gratitude of [redacted] and [redacted] are either entered after the signature of Dr. Huerto, which normally concludes his account of a particular visit, or are written in very cramped writing between segments of the notes devoted to other issues. Either of these suggests that the notations were made after Dr. Huerto had concluded his notations concerning a particular visit.

We have concluded that Dr. Huerto added things to the notes after their original completion. The question is whether this amounts to a violation of Bylaw 51(2)(g), which reads as follows:

> **51(2)** The following acts or failures are defined to be unbecoming, improper, unprofessional or discreditable conduct for the purpose of Section 46(p) of *The Medical Profession Act, 1981*. The enumeration of this conduct does not limit the ability of Discipline Hearing

> Committees to determine that conduct of a physician is unbecoming, improper, unprofessional or discreditable pursuant to Section 46(o):
> g) falsifying a medical record in respect of the examination or treatment of a patient.

The term "falsification" may arguably be intended to address only circumstances in which the physician intends to create a false impression by altering a medical record, and it may be that it is not intended to comprehend circumstances in which the alterations are made inadvertently or without any specific motive.

Our conclusion from observing and listening to Dr. Huerto is that he does not regard the original medical records as sacrosanct, and that he sees it as being legitimate to make additions or annotations to them in order to remind himself of certain things, to register his reaction, or to editorialize about the events as they unfolded.

We have concluded that he did falsify the handwritten medical notes in this sense, and that he did commit a violation of Bylaw 51(2)(g), by adding to the notes in order to create a different impression of his interactions with the [redacted] than may have occurred. It is particularly difficult to reconcile these effusive expressions of gratitude which he recorded with the picture which was created in the testimony of Dr. Huerto and of witnesses who appeared on his behalf. Dr. Huerto described the [redacted] as being somewhat difficult to deal with. His description of [redacted], in particular, is hard to bring into consonance with these exaggerated expressions of gratitude. The members of the staff, Professor Heaslip and Ms. Tiegen, created an even more unflattering portrait of the [redacted], drawing them as given to complaining and dissatisfaction. Finally, Dr. Donat added to this the sketch of a severely dysfunctional and unhappy family who would put any physician at risk.

As we have said, we are not persuaded that the [redacted] were subject to the "severe psychopathology" attributed to them by Dr. Donat, or that they were as carping and unpleasant as the description of them given by Professor Heaslip. Nor do we think they were given to the kind of gushing expressions of gratitude recorded by Dr. Huerto in his notes. We have concluded that Dr. Huerto added many of these notes in order to create a picture of a patient and her family who

were more dependent on his treatment than may in fact have been the case.

What his reasons for doing this might be is not altogether clear. From his evidence before the committee, it would seem that one element of the response of Dr. Huerto to the successive investigations and proceedings initiated by the College of Physicians and Surgeons has been his concern to show that he enjoys the confidence and trust of his patients, and this may lie behind the comments recorded in the file of [redacted].

There is clearly a distinction between adding the kind of editorial comments we have cited to the clinical notes, and the kind of changes in the clinical record which would create a misleading impression of treatment or medication given, or which would disguise errors in diagnosis made by a physician. Nonetheless, we are of the view that the clinical notes kept by a physician should give as clear and accurate a description as possible of the essential elements of the interchange with a patient on a particular occasion, and this account should not be subject to being obscured by later addenda or alteration. If further commentary or correction is needed, it should be clear in the notes that it has been added at a different time, in order to maintain the clarity of the original record.

Whatever the motive of Dr. Huerto in making additions to the original handwritten notes, the effect would be a relatively benign one. There was "falsification" of the notes in the sense that the relationship of Dr. Huerto with [redacted] and her mother was to some extent misrepresented, but this was not an example of a particularly serious or dangerous interference with the written record.

2. Falsifying the typed transcript

Dr. Huerto said that, in the case of the transcript made from the handwritten notes in the file of [redacted], he had made an effort to make the transcript as close as possible to the original, because he understood that to be what was being requested by the College.

Many of the differences between the handwritten notes and the typed transcripts fall into the category of natural errors of

transcription, or, in some cases, clarification, as when abbreviations are replaced by a full word or term.

There are also instances in which certain comments are added in the typed transcript. For example, in the entry for November 14, 1996, [redacted] is quoted as saying "On one occasions she ([redacted]) could not lift a glass of water to her mouth. She needed to put a straw." In the typed transcript the following words were added: "and bring it to her mouth."

In the entry of the same date, the original notation says at one point "Pain all day and all night: neck..." The typed transcript has the words "the worst" after the word "neck."

Though Dr. Huerto must clearly be convinced of the importance of resisting the temptation to correct or improve the original record, most of the changes which occurred in the process of transcribing the handwritten notes to their typed form were of no particular significance.

There is one exception to that, however. In the entry for October 23, 1996, under the heading "working diagnosis," the handwritten notes contain the term "personality problem." In the typed transcript, the more technical - and more serious - term "personality disorder" is used. It may be that this error was one of the things which led Dr. Donat to the rather extreme assessment he arrived at concerning the psychological health of [redacted] and her family.

We have concluded that, although few of the changes constituted misrepresentations of substantive portions of the diagnosis made or treatment given by Dr. Huerto, they did have the potential to mislead readers. It seems that his motivation for making the changes was he wished to provide a justification or a defence of his treatment and his assessment of this patient; whatever the motivation, such changes are inconsistent with the obligation of a physician to keep accurate notes.

The alteration of written medical records, for whatever reason, is a matter of serious and legitimate concern to those regulating the medical profession and to the public. The integrity of written records is important because it permits other physicians responsible for the treatment of a patient to have an accurate

basis on which to make their assessments and to take into account prior treatment. It is also critically important to proceedings such as these, as it provides a basis for a fair and accurate judgment about the medical treatment which has been given when the conduct of a physician is impugned.

We have concluded that Dr. Huerto did make changes in both the handwritten record and the typed transcript. We have also commented earlier on the additional notations he inscribed on the test results for the estradiol levels, as he was preparing for the hearing. Though Dr. Huerto claimed that he was simply trying to draw attention to his perception that [redacted] had not been candid with him, these notations could potentially have created the impression in those reviewing the file that he had noted the elevated estradiol level at the time the test was done, an impression which would not be consonant with his recollection of the sequence of events. We think that he must have impressed upon him the importance of these written records. Though, as Dr. Huerto commented, the notes are primarily for the use of the treating physician, they are of crucial importance if a patient consults another physician, or if it is necessary to obtain a second opinion about treatment. Others involved in the treatment of a particular patient, or in the assessment of the treatment provided by the physician in circumstances such as those before us, must be able to rely on the written record as conveying an accurate picture of what assessments were made at a particular time, and how the treatment unfolded.

As we have concluded in the case of the handwritten notes, we find that Dr. Huerto did breach bylaw 52(2)(g) and that this did constitute unbecoming, improper, unprofessional or discreditable conduct within the meaning of Sections 46(o) and 46(p) of *The Medical Profession Act, 1981.*

3. Removal of medication list from file

We have already discussed at length our reasons for finding that [redacted] did provide Dr. Huerto with the computer printout from Shoppers Drug Mart in Lloydminster which listed the medications prescribed for [redacted] in the period between January of 1995 and the time when she first went to Dr. Huerto in October of 1996. This was the list which included the prescription of Marvelon, a contraceptive, which Dr. Huerto stated he was not

aware that [redacted] was taking.

This list was included in both the copy of the file which was retained by the [redacted] and later turned over to the College of Physicians and Surgeons, and in the copy of the file which was made by the [redacted] and given to Dr. Pienaar.

The list was not, however, present in the version of the file from Dr. Huerto's office which was produced for the use of this committee, or in the copy which was made by the College from that version of the file.

The file did contain, of course, the shorter, undated, handwritten note which Ms. Flegel attested she had prepared at the request of [redacted], and which contained the names of two antibiotics prescribed for [redacted] in 1992 and 1993. [redacted] did not recall this document at all, and it is not clear why she obtained it, or how it ended up in the file. This document was not included in the copies of the file which were produced by the [redacted] and Dr. Pienaar.

It may be that [redacted] originally understood that Dr. Huerto only wanted a list of antibiotics which [redacted] had taken, and got the longer list when she was informed he wanted a fuller and more recent list of medications. To draw any conclusions about this would be purely speculative, and we do not feel we can make any findings about this document.

As we have said, however, we find that the longer computer printout was provided by [redacted] to Dr. Huerto when [redacted] made her first visit to his clinic, and we are satisfied that it was in the photocopy of the file which was sent to the [redacted], and copied again by them for the use of Dr. Pienaar.

We have concluded that the evidence is clear that this list was removed from the file which was retained in the office of Dr. Huerto, and that this occurred after the file had been photocopied and sent to the [redacted].

In the judgment rendered by Madam Justice Smith to which we have alluded above, she concluded that the evidence was not sufficiently clear that Dr. Huerto should be held responsible for certain actions in the absence of documentation from his office file. In

that case, there was no basis for determining whether the documentation had gone missing while the file was in the possession of Dr. Huerto or that of the College of Physicians and Surgeons.

In this instance, however, we are satisfied that the document must have disappeared during the time when the file was in the possession of Dr. Huerto, and that he must be held responsible for its removal.

We thus find that the part of charge 5A which relates to the computer list of medications has been established.

CHARGES RELATING TO [redacted]

The charges relating to [redacted] read as follows:

> *6. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of* ***The Medical Profession Act, 1981*** *S.S. 1980-81, c. M-10.1 and/or Bylaw 51(2)(j), particulars whereof are that you failed to maintain the standards of the profession in your treatment of* [redacted].
>
> *The evidence which will be led in support of this particular will include that during the period of your treatment of* [redacted] *you did not arrange for appropriate medical care for* [redacted] *which may have included cardiac catheterization and/or PTCA and/or bypass surgery.*
>
> *7. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or 46(p) of* ***The Medical Profession Act, 1981,*** *S.S. 1980-81, c. M-10.1 and/or Bylaw 51(2)(j), particulars whereof are that you failed to maintain the standards of the profession in your treatment of* [redacted] *on or about June 5, 1997.*
>
> *The evidence which will be led in support of this particular will include that:*
>
> *a. you failed to arrange for* [redacted] *to be*

transported to a hospital without delay; and/or

b. *you provided aggressive treatment for* [redacted] *within your facility including one or more of Lasix, morphine, aminophylline, sodium bicarbonate and dopamine drip; and/or*

c. *you prescribed or provided to* [redacted] *medications including one or more of aminophylline and/or sodium bicarbonate in circumstances in which the prescribing or provision of these drugs was not within the standards of the medical profession; and/or*

d. *you advised the family of* [redacted] *upon his admission to Royal University Hospital that he was in stable condition or used words to similar effect when he was not stable.*

The charges numbered 6 and 7 are related to the treatment of Mr. [redacted]. Mr. [redacted] had been a patient of Dr. Huerto since March of 1995, and had been treated at the clinic on a number of occasions. Charge 6 concerns the general course of treatment provided by Dr. Huerto to Mr. [redacted]. Charge 7 relates specifically to the treatment provided by Dr. Huerto on June 5, 1997, the date on which Mr. [redacted] died.

Charge 6: Failing to arrange appropriate medical treatment

From the beginning of his treatment of Mr. [redacted], Dr. Huerto diagnosed him as suffering from congestive heart failure and other related conditions. In his evidence, Dr. Huerto said that he attempted to impress upon Mr. [redacted] the seriousness of his condition, and outlined the options for further testing and treatment. He said that from the outset Mr. [redacted] refused to have any invasive tests, including angiography, or to contemplate any invasive treatment procedures, such as bypass surgery.

Dr. Calvin Wells, a cardiologist who was called as an expert witness by the College of Physicians and Surgeons, gave evidence that there was a clear deterioration in the condition of Mr. [redacted] after Janizary 28, 1997. Prior to that, he felt that the

medical treatment provided by Dr. Huerto was a reasonable choice as an option for Mr. [redacted]. After that, however, his opinion was that Mr. [redacted] should have been referred for surgery, as the nature and seriousness of his condition made any other kind of treatment less effective. Dr. Wells gave evidence to support his contention that the benefits of surgery are considerable for those patients suffering from atherosclerotic heart disease of the kind which Mr. [redacted] was experiencing.

It should be noted at this point that counsel for Dr. Huerto urged this committee to discount all of the evidence given by Dr. Wells. His argument in this connection was related to the fact that Dr. Wells had been one of the attending physicians for Ms. [redacted], a patient of Dr. Huerto whose treatment was the subject of other charges which were initially placed before this committee; those charges were later withdrawn from our consideration by the College, but Dr. Wells gave his evidence at a time when the charges concerning the treatment of Ms. [redacted] were still alive. Counsel argued that because Dr. Wells was treating Ms. [redacted] at the time of her death, and had been required to give an explanation of her treatment before a mortality committee at the Royal University Hospital, he should be regarded as having a conflict of interest which makes his evidence of no value.

Dr. Wells was called by the College initially to give evidence concerning the case of Mr. [redacted]. He apparently had not made any connection between the case of Ms. [redacted] and Dr. Huerto until he was reminded of it by counsel for Dr. Huerto.

Though the committee has some concerns about the wisdom of calling Dr. Wells as an expert witness under these circumstances, we are confident that we have been able to give appropriate weight to the comments made by Dr. Wells concerning the treatment of Mr. [redacted], and that he does not have a true conflict of interest with respect to the testimony about Mr. [redacted]. We do not think the value his observations in this connection is entirely negated by his link to the treatment of Ms. [redacted].

In his evidence, Dr. Huerto insisted that he had given Mr. [redacted] a clear description of the treatment options, and that he had encouraged him to have further testing and to consider surgery. According to Dr. Huerto, however, Mr. [redacted] was adamantly opposed to any invasive testing or treatment. In his discussions with Mr.

[redacted], Dr. Huerto said that his patient said that he was determined to enjoy what remained of his life as much as possible. He was a religious person, who believed that God would control the timing of his death, and that he should not attempt to avoid this by agreeing to surgical interventions into his condition.

Dr. Bernard Dickens, a medical ethicist called as an expert witness by Dr. Huerto, stressed the ethical importance of taking into account the choices made by a patient. He made the following comment:

> The ethical approach, I think, turns on drawing out what is meant by the concept of appropriate care. It's often taken as care appropriate to the patient's condition, but account also has to be taken of what is appropriate to the patient's personality. If the patient indicates that he doesn't want certain options such as a surgical option, such as a hospitalization option, then clearly that is not appropriate for that person. It may be appropriately indicated for the condition. It's the sort of thing that a doctor ought to ensure that a patient has thought about. If the patient seems not to have thought about it, the physician has to draw it to the patient's attention, but once the patient is aware that this is an option and declines it, that is no longer care appropriate to the patient, although it may otherwise be indicated for the condition, so to treat the patient within the parameters of choice set by the patient is ethical and appropriate.

The resistance of Mr. [redacted] to invasive testing and surgical intervention described by Dr. Huerto in his evidence was confirmed by the evidence of Ms. [redacted], Mr. [redacted]'s daughter. Ms. [redacted] is a licensed practical nurse, who manages a long-term care home, and is accustomed to dealing with senior citizens and mentally challenged persons suffering from infirmities of various kinds. She kept notes concerning the progress of her father's illness, and it is clear from those notes that he had expressed his aversion to hospitalization on numerous occasions. That Dr. Huerto reached an accurate interpretation of the wishes of Mr. [redacted] is further confirmed by the fact that Mr. [redacted] failed to appear at several appointments even for non-invasive tests at the Royal University Hospital.

The evidence of Dr. Wells, who works within a hospital setting, was that hospitalization and surgery would have been a preferable way of treating Mr. [redacted]. Dr. Huerto conceded that it would probably have been to the advantage of Mr. [redacted] to have angiographic tests and to consider the benefits of bypass surgery.

We accept the position taken by Dr. Dickens and Dr. Huerto, however, that a physician cannot ethically prevent a patient from making the choices which the patient considers appropriate. The primary responsibility of a physician in these circumstances is to ensure that the patient has all of the information required to make an informed choice, not to override the choice made by the patient or to coerce or fool the patient into making a different choice.

We have some concerns, which we will expand upon somewhat later in this decision, about the capacity of Dr. Huerto to fulfill his responsibility to give full information to patients in all circumstances, but we are satisfied that in the case of the overall treatment of Mr. [redacted], Dr. Huerto did provide him with the necessary information, and that it was the choice of Mr. [redacted] to continue pursuing the treatment given to him by Dr. Huerto rather than to consider surgery.

Charge 7: Treatment of June 5, 1997

Ms. [redacted] testified that she was called by her mother very early in the morning of June 5 to be told that her father was extremely ill, and was asking to go to the clinic. In consultation with Dr. Huerto, several members of the family tried to persuade him to go directly to the hospital, but Mr. [redacted] was insistent that he should be taken to the clinic.

When he arrived at the clinic a little after 7:00 a.m., Mr. [redacted] was exceedingly ill. He was gasping for breath, and unable to walk unaided or to speak. Dr. Huerto identified his symptoms as those of pulmonary edema, and, with the assistance of Professor Heaslip and Ms. Tiegen, began treatment and monitoring.

Although Mr. [redacted] could not really talk, Dr. Huerto said that he did his best to ascertain whether Mr. [redacted] was genuinely refusing to be taken to hospital, and was confident that he wished to be treated as well as possible in the clinic. Dr. Huerto said that he was sure Mr. [redacted] knew that his chances of survival were

not good; he further said that, though the condition of Mr. [redacted] on this occasion was more serious than it had ever been, he had been at the clinic with similar symptoms before, and had been treated there.

Dr. Huerto said that a number of aspects of the treatment and monitoring were begun in a very short time, and it was difficult to reconstruct the exact sequence of events. The priority was to make Mr. [redacted] more comfortable and to relieve some of his symptoms. Oxygen therapy was begun; because it was impossible to put a mask on Mr. [redacted]'s face, oxygen was administered through nasal prongs. Nitroglycerin was administered sublingually by Dr. Huerto, by giving regular puffs of a uniform dosage.

During these minutes, an electrocardiogram was done and eventually an echo cardiogram was also done. Dr. Huerto concentrated on convincing Mr. [redacted] that he should accept an intravenous line so that some medications could be administered to him, and he accepted that. This permitted the administration of furosemide (Lasix), a diuretic, which was aimed at eliminating some of the fluid which was responsible for the discomfort and breathlessness being experienced by Mr. [redacted]. Digoxin was also administered to Mr. [redacted].

During the time he was at the clinic, Mr. [redacted] was also given morphine, nitroprusside, aminophylline, sodium bicarbonate, dopamine, gravol and atropine. The administration of some of these medications is the subject of specific aspects of this charge, and will be discussed in more detail below.

The therapy undertaken by Dr. Huerto did have the effect of relieving the symptoms somewhat, and Mr. [redacted] was more comfortable, though he was undeniably still very sick. He was able to talk, and even engaged in some joking with members of his family.

The members of the family who were present at the clinic included Mr. [redacted], a son, who remained convinced that Mr. [redacted] should be treated in hospital, and he continued to try to persuade his mother and sister that his father should be transported there. Naturally enough in the circumstances, the conversation was an emotional one, and the staff of the clinic reported to Dr. Huerto that this discussion was becoming somewhat

disruptive and might disturb Mr. [redacted].

The substance of this conversation was reported to Mr. [redacted] around 9:30 a.m. Though he was still not happy about the idea of going to the hospital, Mr. [redacted] told Dr. Huerto that he did not want his wife to have to bear the burden of defending his decision, so he would agree to go to the hospital.

At this point, Mr. [redacted] and Ms. [redacted] were asked to take some blood samples to St. Paul's Hospital to be tested for blood gases. The evidence about this event is somewhat confusing. Dr. Huerto said that he made this request because he wanted to use the tests performed at St. Paul's Hospital as a confirmation of the accuracy of the tests done on his own machine in the clinic. Professor Heaslip testified that they were asked to take the blood samples in order to give Mr. [redacted] an opportunity for a quiet conversation with his wife in the absence of their children.

Ms. [redacted] said that she and her brother had been asked to take the blood samples because the test results were needed urgently and they could obtain the results more rapidly by going to the hospital than by waiting for the samples to be taken in a cab. She said that when they were at St. Paul's Hospital, she and her brother were paged, and informed that their father was to be taken to the Royal University Hospital, and they should go there.

All of these explanations are quite odd, not least the one given by Dr. Huerto. It seems strange that he would ask the children of a patient who was so ill, and whose imminent departure for hospital was being considered, to assist in checking his testing equipment for accuracy. It is hard to imagine why that would be a priority in the circumstances.

The reason given by Professor Heaslip was also hard to accept, as it involved misrepresenting to Mr. [redacted] and Ms. [redacted] the rationale for sending the to St. Paul's Hospital. It is difficult to believe that they would have consented to leave the clinic had they been given the explanation proffered by Professor Heaslip.

The reason Ms. [redacted] understood to underlie the request was that there was an urgency to getting the test results which justified asking them to undertake the journey across the city. This is not

compatible with the insistence of Dr. Huerto that he had equipment adequate to the task of testing blood gases.

Though none of the charges deal directly with this episode, we mention it because it seems to reinforce the allegation that Dr. Huerto was prepared to be less than candid with members of the [redacted] family, an issue which is directly raised by part (d) of the charge.

At about 9:50 a.m., Dr. Huerto testified that he began telephoning Saskatoon hospitals to find a bed for Mr. [redacted]. He gave evidence that he talked to Dr. Pinilla, a cardiologist at the Royal University Hospital who was in charge of the Cardiac Care Unit; in the version of this conversation given by Dr. Huerto, Dr. Pinilla said that he was unwilling to move any of his patients to give room to a patient of Dr. Huerto. Dr. Huerto said that, on previous occasions, he had been successful in having patients admitted directly to the Intensive Care Unit or the Cardiac Care Unit.

Dr. Pinilla testified that he had merely outlined the usual procedure to Dr. Huerto, which was to have patients in the situation of Mr. [redacted] admitted initially to the Emergency Department of the hospital. His evidence was that this was considered the best way to provide initial treatment to serious cardiac cases, and to provide access most swiftly to the widest range of specialized equipment and medical expertise.

In any case, it was decided that Mr. [redacted] would be conveyed to the Emergency Department at Royal University Hospital. An ambulance was called, and Mr. [redacted] transferred to the ambulance for the journey. According to the notes taken by the emergency medical technician, Dr. Huerto requested that Mr. [redacted] be immediately intubated, and during the transfer to a stretcher, the technicians could find no pulse. These notes suggested that there had been a cardiorespiratory arrest during the time Mr. [redacted] was still at the clinic, a conclusion which was contested by Dr. Huerto.

Mr. [redacted] was taken to the Royal University Hospital. Dr. Huerto accompanied the patient in the ambulance, and said that Mr. [redacted] was still able to squeeze his hand. On arrival at the hospital, Mr. [redacted] was admitted to the Emergency Department. The clinical notes kept by Dr. Huerto indicated that the patient was "stable but guarded" at this point. After overseeing his admission, Dr. Huerto

went to talk to the members of the family.

The hospital records indicate that the initial assessment of Mr. [redacted] was noted at 10:26 a.m. Various tests were done, including an ECG which was recorded at 10:50 a.m. At 11:02, Mr. [redacted] suffered a cardiac arrest and CPR was commenced. After a further ECG at 11:18, CPR was resumed until 11:33, when Mr. [redacted] was pronounced dead.

a. Failing to transport to hospital without delay

The essence of this part of the charge is somewhat similar to the allegations in Charge 6. It is based on the assumption that hospital treatment would have been preferable to the treatment which Mr. [redacted] received in the clinic, and that, once it was evident how ill Mr. [redacted] was, Dr. Huerto should have arranged to transfer Mr. [redacted] to hospital. This assessment was supported by the evidence of Dr. Wells, who described the kind of treatment which might have made a difference in the progress of Mr. [redacted] had he been taken straight to the hospital on June 5, 1997.

Dr. William Hughes, a cardiologist called as an expert witness by Dr. Huerto, also considered this allegation. Dr. Hughes clearly saw hospitalization as valuable in situations where a patient is suffering a condition of such severity as that of Mr. [redacted]. He stated, however, that there is no way a patient can be forced into hospital against his will, and that, in the circumstances faced by Dr. Huerto on this occasion, he responded reasonably by not insisting at the outset that Mr. [redacted] should go to the hospital.

Ms. [redacted] testified that her father was determined on June 5 not to go to the hospital, in the face of contrary advice from members of his family, and in full awareness of the seriousness of his medical circumstances.

We are satisfied that it was reasonable for Dr. Huerto to conclude that Mr. [redacted] was determined not to go to the hospital on June 5, notwithstanding the seriousness of his condition, and that the decision to perform what treatment could be given at the clinic was not one which was outside the standards of the medical profession.

b. Provision of aggressive treatment, including Lasix, morphine, aminophylline, sodium bicarbonate and dopamine

At the core of this aspect of the charge lies a distinction made by counsel for the College between care of a purely palliative kind which is designed simply to make a dying patient as comfortable as possible as nature takes its course, and aggressive treatment through which the physician hopes to bring about an improvement in the condition of the patient.

In his testimony, Dr. Huerto stated that his objective in the treatment he gave Mr. [redacted] at the clinic on June 5 was to make him as comfortable as possible in light of the fact that there was very little chance of his survival without more invasive treatment, and that Mr. [redacted] refused to consent to such treatment. Counsel for the College argued that this statement was belied by the fact that Dr. Huerto administered a number of medications which did not serve this objective, but which were aimed at curing Mr. [redacted].

As Dr. Hughes and Dr. Huerto himself pointed out, the line between palliative and aggressive therapy is a difficult one to draw. The evidence of Dr. Huerto was that he had very little hope of Mr. [redacted] surviving when he presented at the clinic on June 5. On the other hand, he said that Mr. [redacted] had come to the clinic with symptoms similar in kind, though not in severity, on previous occasions, had been just as determined to avoid invasive treatment, and had shown considerable improvement under the medical regime established for him at the clinic.

On this occasion, Dr. Huerto acknowledged that his primary concern was to make Mr. [redacted] more comfortable, and to create an environment in which he could have some kind of more relaxed contact with his family if he was destined to die on that day. In addition, Dr. Huerto said that he wished to try a number of medications which might in fact improve the condition of Mr. [redacted], delay his death and permit him to return home, as he had in previous instances. In any event, many of the medications which are appropriate as part of a regime of palliative care are also appropriate as curative therapy, as they address the symptoms which make the patient uncomfortable.

We do not see how a physician can be forced to make an election between palliative care or aggressive treatment in the sense that, in choosing the former, he or she would be precluded from doing anything which would improve the prospects of the patient. As long as the physician is being guided by the wishes and interests of the

patient, the physician cannot be faulted for taking steps to increase life expectancy as well as creating a comfortable environment in which the patient can die with dignity. Neither, as we have said, do we see it as a cut-and-dried choice between palliative care or hospitalization, given the aversion of Mr. [redacted] to treatment in hospital.

We do not find that this aspect of the charge has been established.

c. Prescription of aminophylline and sodium bicarbonate

It will be recalled that this element of the charge reads as follows:

> You prescribed or provided to [redacted] medications including one or more of aminophylline and/or sodium bicarbonate in circumstances in which the prescribing or provision of these drugs was not within the standards of the medical profession...

Aminophylline is described in the following terms in the Compendium of Pharmaceuticals and Specialties (CPS), under the heading "Theophylline and its Salts":

> Theophylline is an alkaloid of the methylxanthine group. Aminophylline and oxtriphylline are complexes of theophylline...Theophylline's principal pharmacological actions include stimulation of the [central nervous system], simulation of cardiac muscle, relaxation of bronchial smooth muscle and diuresis.

At a later point in this discussion, the CPS entry reads as follows, under the sub-heading "Precautions:"

> There is a marked variation in blood concentration achieved in different patients given the same dose of theophylline which may lead to serious adverse effects in some patients...Theophylline clearance is decreased in certain situations, which can lead to toxicity:...in patients over 60 years old;...where the patient has a concurrent disease such as...congestive heart failure, acute pulmonary edema...

The indications for theophylline are described as follows:

> The symptomatic treatment of reversible bronchoconstriction associated with chronic obstructive pulmonary disease, bronchial asthma, chronic bronchitis and related bronchospastic disorders.

Dr. Wells said that aminophylline is a highly toxic medication, which is very dangerous to use, and which is no longer used in the hospital for anything at all. The risk in circumstances such as the ones facing Dr. Huerto in the case of Mr. [redacted] would be that the stimulation of the cardiac muscle would result in increased heart rate.

Dr. Hughes acknowledged that the use of aminophylline has declined, and that there are risks associated with its use. The major risk in these circumstances would be that the administration of aminophylline would result in increased demand for oxygen, which might result in an arrhythmia of the kind described by Dr. Wells. Dr. Hughes said, however, that having reviewed the notes recorded by Dr. Huerto, he thought the explanation given for the use of aminophylline to address the bronchial spasm which was one of the symptoms presented by Mr. [redacted] was a plausible one. He also expressed the opinion that other aspects of the treatment given to Mr. [redacted] by Dr. Huerto would to some extent have counteracted the risks posed by the use of aminophylline.

We did not interpret the testimony of Dr. Hughes to mean that he would necessarily prescribe aminophylline in circumstances similar to those in which it was used by Dr. Huerto. We do, however, accept his evidence that the use of aminophylline in this situation did not constitute treatment which fell outside the standards of the medical profession. Though the evidence of Dr. Wells, and, indeed, that of Dr. Hughes, suggest that the majority of physicians would think the use of aminophylline inappropriate in these circumstances, we are persuaded that the opinion of a competent minority would think it acceptable, and we therefore do not find that this aspect of the charge has been established to our satisfaction.

The second part of this aspect of the charge is the allegation that the use of sodium bicarbonate in the circumstances involving Mr. [redacted] constituted treatment falling outside the standards of the

medical profession.

At one time, it was common to give sodium bicarbonate to patients who had suffered cardiac arrest, particularly if the arrest was not witnessed by a physician, in order to correct the pH levels in the blood. From about 1986, however, the literature cautioned against the routine use of sodium bicarbonate. The reasons for this are described as follows in one of the references put before the committee, *Essentials of ACLS[Advanced Cardiac Life Support]*:

> Sodium Bicarbonate is considered a Class III or harmful agent in prolonged cardiac arrest when the patient is not intubated. It is a Class IIb or possibly helpful agent in prolonged cardiac arrest when the patient is intubated.
>
> The reason for this is that sodium bicarbonate, after buffering lactic or other strong acids, forms carbonic acid, which then dissociates into CO^2 and water. Thus, unless the patient is intubated and being ventilated, sodium bicarbonate administration will actually worsen acidosis.

As this passage indicates, one of the concerns about the use of sodium bicarbonate in the case of a patient who has not been intubated - as was the case with Mr. [redacted] until just before he was transferred to the ambulance, an eventuality which was not expected when the administration of sodium bicarbonate was started - is that there will not be sufficient oxygen going into the system to counteract the formation of carbonic acid and carbon dioxide in the blood.

As Dr. Wells described it, a further problem is that the effect of the normal dosage of sodium bicarbonate is that it draws water out of the cells into the intercellular space, and that this will aggravate pulmonary edema.

One of the difficulties attending a consideration of this aspect of the charge is the confusion surrounding the dosage of sodium bicarbonate which was administered. In the photocopy of the clinic medication record which was sent to Dr. Wells, it appeared that the total amount of sodium bicarbonate which had been administered was 5 ampoules, enough to draw out of the cells between 1.5 and 2 litres of water, according to him.

Dr. Huerto said that he had only given what he referred to as "homeopathic doses" of sodium bicarbonate to Mr. [redacted], which would be one-tenth of the dosage which was discussed by Dr. Wells in his testimony.

Dr. Wells was sceptical that the these smaller doses could even be administered. Dr. Huerto produced to the committee a syringe with demarcations showing how such a small dose could be measured and injected.

He also produced the original medication record from the clinic, as completed by Professor Heaslip, and pointed to small dots which he said were decimal points in front of the numbers showing the size of the doses, and demonstrating that they were indeed one-tenth the size of the dosage levels on which Dr. Wells had based his opinion.

There was considerable discussion at the hearing of this document, and further photocopies were made on two photocopiers on the premises of the College of Physicians and Surgeons. Professor Heaslip denied that she had altered the document, or that the dots differed from other decimal points on the document to which she was referred by counsel for the College.

The contested dots which were the subject of this discussion, and which would indicate what dosage of sodium bicarbonate was actually administered to Mr. [redacted], were indeed of a different sort than the decimal points which are clearly entered in a number of places to show the dosages of other medications. These dots, which do not reproduce on the photocopies at all, but which are faintly visible on the original, look more like a point at which a pen touched down on the paper without pressing, or faint dots which might have been added later. We have to say we have no confidence whatsoever in this document as proof that Dr. Huerto administered "homeopathic doses" of sodium bicarbonate.

On the other hand, as Dr. Wells conceded, there is nothing in the tests given to Mr. [redacted] to show that he was displaying any of the signs of an overdose of sodium bicarbonate. One would have expected, given the descriptions of the mechanism by which sodium bicarbonate works in the blood in the testimony of Dr. Wells and the reference works put before the committee, that there would be something in the test results to indicate that the higher doses of sodium bicarbonate had been injected.

In spite of our doubts, therefore, we must conclude that, though the administration of sodium bicarbonate in the amounts discussed by Dr. Wells might indeed be grounds for censure of Dr. Huerto, the evidence that such doses were given is not clear enough for us to find that this element of the charge has been established.

d. Advising the family of Mr. [redacted] that he was in stable condition

After Mr. [redacted] had been admitted to the Emergency Department of the Royal University Hospital, Dr. Huerto had a conversation with the members of his family who were present at the hospital. These were the wife of Mr. [redacted] and two of his children, Mr. [redacted] and Ms. [redacted].

In her evidence at the hearing, Ms. [redacted] said that a member of the hospital staff had talked to the family shortly after her father was admitted to the hospital. This person, who was not identified, had spoken in terms of the transfer of Mr. [redacted] into a ward sometime in the near future, and had shown them the ward where he would be.

Dr. Huerto had also given the family what they considered to be good news. He showed them an ECG which was taken shortly after Mr. [redacted] was admitted to hospital. He said, according to Ms. [redacted], that the ECG showed there had been little or no damage to the heart itself, and that this was indicative that the status of her father could improve.

Ms. [redacted] acknowledged that Dr. Huerto had said her father was still seriously ill, but said that the members of the family had been encouraged by the news he had given them, and were very shocked when two "students" from the emergency room came out and told them that Mr. [redacted] had died.

Dr. Huerto recorded in his clinical notes that the condition of Mr. [redacted] when he reached the hospital was "stable but guarded."

In the autopsy subsequently done on Mr. [redacted], the finding was made that Mr. [redacted] had suffered an MI at some time shortly before his death. The notes taken by the EMT were interpreted by Dr. Wells as meaning that this arrest occurred when Mr. [redacted] was being transferred to the stretcher at the clinic. Dr. Huerto denied

that Mr. [redacted] had suffered an MI at any time while he was at the clinic, and intimated that the MI must have occurred either in the ambulance or in the hospital. He said he was sincerely of the view that the condition of Mr. [redacted] had improved while he was being treated at the clinic, and that the ECG which was done at 10:50 a.m., after the admission to the Royal University Hospital, indicated that this improvement was continuing.

Dr. Wells said that his reading of the file indicated that the prognosis was always poor, and continued to be poor after Mr. [redacted] was admitted to hospital. He said that Mr. [redacted] continued to be ventilated the whole time, and that his blood pressure never improved; these were both signs that little progress was being made.

Dr. Hughes said that Dr. Huerto was justified in drawing the conclusion that Mr. [redacted] was making some progress on the basis of the ECG which was done at 10:50 a.m. He conceded in cross-examination that, in giving this opinion, he had not taken into account the record of the blood gases which was kept for Mr. [redacted] during the period he was at the clinic. Both that record, and the test results taken at St. Paul's Hospital, indicate that there was a steady decline in the metabolic function, indicative of a worsening of the overall condition of Mr. [redacted]. Dr. Huerto would not have seen the latter of these, of course, but the test results confirm that the picture created by the blood gas measurements did not give cause for the kind of optimism expressed by Dr. Huerto to the family.

It is difficult to make a judgment about the kind of communication with family members which is appropriate in any given circumstance. A physician cannot be criticized for being as tactful as possible with family members, nor for softening the blow as much as possible for people who are experiencing serious distress. Nor can a physician be held responsible for the misunderstandings which occur when family members misread the news they are given or refuse to contemplate negative possibilities.

A physician must be careful, however, to give as accurate an account of the situation as possible, and not to raise the hopes of family members unfairly. It is an exercise of the professional skills of the physician as much as anything else to be able to convey important, and possibly distressing, information to family

members in a way which is sensitive but does not compromise accuracy.

We have concluded that in this instance Dr. Huerto did unduly compromise accuracy in his effort to lift the spirits of the [redacted] family, and that he did paint an unwarrantedly optimistic picture of the outlook for Mr. [redacted]. Though he was careful to point out that Mr. [redacted] was still seriously ill, he did convey the impression to Ms. [redacted] and, according to her, to the other members of the family, that, as she put it, the "grave time was over," and that they were talking about a slow process of recovery, not about the possibility of Mr. [redacted] dying within minutes.

We find that this aspect of the charge has been established.

CHARGES RELATED TO [redacted]

The charges respecting the treatment of [redacted] read as follows:

> *8. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of* ***The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1 and/or Bylaw 51(2)(j), particulars whereof are that you failed to maintain the standards of the medical profession in your treatment of*** [redacted].
>
> *The evidence which will be led in support of this particular will include that:*
>
> *a. you did not arrange for* [redacted] *to be admitted to hospital after he presented to your office on or about March 4, 1997; and/or*
>
> *b. you treated* [redacted] *with milrinone (Primacor) in your clinic when he should only have received such therapy in a hospital; and/or*
>
> *c. you treated* [redacted] *with milrinone (Primacor) in circumstances in which the treatment you provided was*

not within the standards of the medical profession; and/or

d. you treated [redacted] *with thrombolytic therapy (rtPA and/or Streptokinase) in circumstances in which the treatment you provided was not within the standards of the medical profession; and/or*

f. [sic] you prescribed or provided to [redacted] *some or all of the following drugs:*

- *i. Adalat (nifedipine)*
- *ii. Lescol (fluvastatin sodium)*
- *iii. Primacor (milrinone)*
- *iv. Streptokinase*
- *v. rt-PA*
- *vi. Norvasc (amlodinpine besylate)*
- *vii. Morphine*
- *viii. MS Contin*
- *ix. Digoxin*
- *x. Gentamycin*

g. you maintained in your patient record for [redacted] *ECG interpretations which were erroneous.*

9. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of ***The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1*** *and/or Bylaw 51(2)(d), particulars whereof are that you charged* [redacted] *a fee which was excessive in relation to the services performed.*

The evidence which will be led in support of this particular will include that you charged [redacted] *a total of $3000 for IV circulatory support.*

10. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of ***The Medical Profession Act, 1981*** *S.S. 1980-81, c. M-10.1 and/or Bylaw 44(2) particulars whereof are that you did not provide* [redacted] *with the information which he needed in order to make an informed*

decision about his care.

The evidence which will be led in support of this particular will include that you submitted a bill to [redacted] *for a total of approximately $11,150.68 in medications, without advising* [redacted] *of the approximate total cost of the medication before he received those medications.*

11. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of ***The Medical Profession Act, 1981,S.S. 1980-81, c. M-10.1*** *and/or Bylaw51(2)(d), particulars whereof are that you dispensed narcotics to* [redacted] *without writing a prescription for those drugs.*

12. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of ***The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1*** *and/or Bylaw 51(2)(d), particulars whereof are that you wrote a prescription for MS Contin dated May 7, 1997, and a prescription for morphine dated May 7, 1997, which prescriptions were written without the intention that* [redacted] *should receive the medications in the prescription.*

13. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of Section 46(o) and/or 46(p) of ***The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1*** *and/or Bylaw 51(2)(i).*

The evidence which will be led in support of this particular will include that:

a. *Section 94 of* ***The Vehicles Administration Act*** *requires legally qualified medical practitioners to report to the administrator the name, address and clinical condition of every person who is 15 years of age of over attending on the medical practitioner for medical services and who, in the*

opinion of the medical practitioner, is suffering from a condition that will make it dangerous for him to operate a vehicle;

b. *you were aware, or should have been aware, that [redacted]'s diabetes was not well controlled while you were treating him;*

c. *you were aware, or should have been aware, that it would be dangerous for Mr. [redacted] to operate a motor vehicle;*

d. *Dr. Stewart telephoned you and discussed her concern that Mr. [redacted] should not have been driving in his medical condition;*

e. *you did not advise the administrator of the medical status of [redacted];*

f. *you did not advise [redacted] against operating a motor vehicle.*

The charges numbered 8 through 13 concern the treatment given by Dr. Huerto to Mr. [redacted].

Mr. [redacted] was 81 years old at the time he first consulted Dr. Huerto. Mr. [redacted] was suffering from peripheral vascular disease, a condition which had been previously addressed by vascular bypass surgery. In the early spring of 1997, Mr. [redacted] had been advised by a vascular surgeon to have one of his legs amputated in the near future; there was also the possibility that his other leg would also have to be amputated at some future time.

Not surprisingly, Mr. [redacted] was alarmed by this advice. In discussion with his family physician, Dr. Lois Stewart, he asked whether she would give him chelation therapy, which had been recommended to him by friends. Dr. Stewart said that she would not give him chelation therapy, as she did not believe it had any benefits, but she said that she would not try to prevent him obtaining it elsewhere.

Mr. [redacted] had heard about Dr. Huerto from friends, and

contacted him on March 4, 1997. Though Dr. Huerto made it clear that he did not provide chelation therapy at his clinic, Mr. [redacted] appears to have been under the illusion for some time that he was receiving chelation therapy from Dr. Huerto.

Dr. Huerto testified that Mr. [redacted] was extremely ill when he first attended the clinic. In addition to the peripheral vascular disease which had give rise to his concern about his legs, Mr. [redacted] had badly controlled diabetes and symptoms of congestive heart failure and arterial emboli. According to Dr. Huerto, he agreed with the assessment made by Dr. Ulmer, the vascular surgeon, that Mr. [redacted] would have to have his left leg amputated. He made every effort to convince Mr. [redacted] that he should be treated in a hospital. He also offered to contact specialists in other centres in Canada and the United States if Mr. [redacted] would agree. He even suggested to Mr. [redacted] that he could go to a chelation practitioner in Regina, thinking that another physician might be able to persuade Mr. [redacted] to follow the advice of Dr. Ulmer.

In his evidence, Dr. Huerto said that he knew that there would be significant difficulties attached to treating Mr. [redacted] in the clinic, and his staff were opposed to taking it on because of the heavy commitment of time and effort it would involve. Dr. Huerto stated, however, that he had decided to accept Mr. [redacted] as a patient because he feared that he would be without adequate medical care otherwise.

Charge 8: Treatment of [redacted]

a. Not arranging for treatment in hospital

As we have said, Mr. [redacted] was very ill when he first consulted Dr. Huerto, and he was suffering from a number of complicated medical conditions. It must be said that there is some discrepancy in the evidence over the extremity of his condition. Dr. Huerto testified that Mr. [redacted] was unable to walk unaided, that he was short of breath and of an unhealthy colour, that he had open sores on his feet and legs, that his feet and legs were oozing fluid and that there was a foul odour associated with these wounds. Mr. [redacted] did keep an appointment with Dr. Ulmer, his vascular surgeon, two days after he commenced his treatment with Dr. Huerto. In a letter which was included in the evidence before the

committee, Dr. Ulmer said that he did not recall symptoms of the dramatic severity described by Dr. Huerto, although he acknowledged, of course, that a condition which had led him to advise the amputation of a leg was a serious one.

A foot care specialist who was called in by the clinic to dress the wounds on Mr. [redacted]'s feet confirmed that he had quite serious sores, though she again did not describe her impressions of Mr. [redacted] in the extreme language used by Dr. Huerto.

It is clear, though there may be some difference as to the severity of the symptoms displayed by Mr. [redacted], that he was suffering from very serious medical conditions. It is further clear from the evidence, including the testimony of Mr. [redacted] himself, that he was adamantly opposed to the option of having his leg amputated, and that he did not wish to go into hospital as long as this was the primary option given to him.

As we have said in the case of Mr. [redacted], a physician cannot force a patient to take treatment which the patient does not wish to have. As long as the patient has sufficient information to make an informed choice, the physician should respect that choice.

We are satisfied that, in the early days of his dealings with Dr. Huerto, Mr. [redacted] was resistant to the idea of going into hospital because he anticipated that this would mean losing his leg, an option he refused to consider. The loss of his leg was a natural preoccupation of his at that time, and, according to Dr. Huerto, it was difficult to get him to consider other aspects of his medical condition.

Dr. Rodney Zimmerman, a cardiologist called as an expert witness by the College of Physicians and Surgeons, said that his review of the condition of Mr. [redacted] as described in the clinical notes of Dr. Huerto, led him to the conclusion that hospital care was the only reasonable choice. He said the particular concern with Mr. [redacted] would be that he would suffer a cardiac collapse. A patient in the condition of Mr. [redacted] should be receiving nursing care around the clock.

All witnesses at the hearing who addressed the case of Mr. [redacted] were in agreement that his condition was extremely serious and complicated, and that any plan for his treatment would

be a challenge. As we have said in relation to the treatment of Mr. [redacted], we are not of the opinion that offering a patient treatment outside a hospital setting is in itself a breach of the standards of the medical profession, provided that concerns of patient safety can be met.

We are satisfied that Mr. [redacted] resisted treatment in hospital because of his concern about having his legs amputated, and that when Dr. Huerto began treating him, Mr. [redacted] wanted to be treated at the clinic. In its general form, we do not think this aspect of the charge has been established.

As we will explain, this does not mean that we have no reservations about the treatment given to Mr. [redacted] in the clinic, or that we accept that Dr. Huerto was justified in interpreting the decision to undertake treatment at the clinic as giving him *carte blanche* to carry out procedures in an unsafe manner.

For various reasons, Dr. Huerto has become isolated from the normal collegial context in which medical specialists customarily exercise their medical judgment. His practice in recent years has been carried out in a climate in which he and his peers view each other with mutual distrust. The impression we formed of Dr. Huerto over his prolonged testimony before us is that, in formulating a justification and rationale for the way he practises his profession, he has found it necessary to establish that his methods are not only acceptable, but superior. This might, perhaps, be expected given the situation in which he has found himself.

In this respect at least his situation differs from that of Dr. Hughes, who not only enjoys the benefit of a large expert staff at his clinic, but who has easy access to other specialists and to hospitals.

In the conditions in which Dr. Huerto practices, it is difficult for us to believe that it is possible for him to give patients a genuinely balanced and dispassionate description of the options available to them.

b. Treatment with Primacor (milrinone) outside hospital

One of the treatments which Dr. Huerto instituted for Mr. [redacted] was the administration of Primacor (milrinone), an agent which is

used in part for its inotropic effects, in other words to increase the contractility of the heart muscle. It is also used as a vasodilator, to increase the size of the veins. Both of these features would clearly be of interest in a case such as that of Mr. [redacted], as the inotropic effect would strengthen the output of his heart, and the vasodilation effect would improve his circulation.

The major risk of milrinone therapy is that it will bring on arrhythmias, which are dangerous in a patient in an unstable cardiac condition. Dr. Zimmerman, a witness for the College, said that for this reason nearly all milrinone therapy is carried on in hospitals, so that the patient can be carefully monitored while the therapy is being given. He acknowledged that he is aware of milrinone therapy being given on an outpatient basis, but this occurs under strict protocols, and under specialized conditions.

Dr. Hughes, an expert called on behalf of Dr. Huerto, said that he was familiar with outpatient milrinone therapy, and that he was hoping that it would be available in the near future at the clinic with which he is associated in Peterborough, Ontario. He said that it is not necessary for milrinone to be administered in the hospital, provided proper protocols are followed, and that it shows promise as a means of shortening or eliminating hospital stays for some kinds of patients.

We are salsified that the administration of milrinone in an outpatient setting does not in itself represent a departure from the standards of the medical profession, and that this aspect of the charge has not been established.

c. Treatment with Primacor (milrinone) outside the standards of the profession

Though we have decided that the aspect of the charge which alleges that it was a violation of the standards of the medical profession to administer milrinone therapy in an outpatient setting has not been established, there remains the question of whether Dr. Huerto administered this therapy in a manner which was outside the accepted standards of the profession.

Dr. Zimmerman said that the literature suggests that outpatient milrinone therapy should only be used under specified conditions,

and that it should only be used in circumstances where the patient is as stable as possible. He provided this committee with a list of criteria which are suggested for use to determine the eligibility of patients for outpatient use of milrinone. These standards indicated the following criteria: that the patient should be assessed as having Class 3 or 4 heart failure; that the patient should be receiving maximized levels of oral therapy; that the patient should be able to carry out daily tasks; that the assessment of heart failure have been made in the hospital; and that the patient have undergone sox months of intermittent inpatient treatment with inotropic drugs. He pointed to one part of the suggested protocols which says that patients who are considered for milrinone therapy should be on maximized oral medications, such as diuretics; he questioned whether satisfying this aspect of the protocol would be possible, since Mr. [redacted] began receiving milrinone within two days of commencing his treatment with Dr. Huerto.

Dr. Huerto submitted to the committee an article describing the use of milrinone on an outpatient basis, and the criteria mentioned in this article differed somewhat from the standards alluded to by Dr. Zimmerman. The article suggested that the diagnosis of heart failure might take place in a hospital or a specialized heart clinic. It also mentioned only the requirement of diagnosis of Class 3 or 4 heart failure as a criterion for the selection of patients. We accept that there may be some variation in acceptable protocols - that, for example, a clinic devoted to the treatment of cardiac patients may be able to assess the level of heart failure. On the other hand, it should be noted that in the article referred to by Dr. Huerto, the focus was on nursing practice once patients had been selected for the administration of inotropic therapy in the home. We do not, in this connection, interpret the article as purporting to lay down a list of selection criteria comparable to the one mentioned by Dr. Zimmerman; the references to selection of patients were merely a prelude to the discussion of the nursing issues.

Dr. Hughes said that, although his clinic does not currently administer milrinone to outpatients, he is confident that it can be done safely under appropriate protocols. He had reviewed the written protocol produced by Dr. Huerto, and found it consistent with other protocols used for outpatient milrinone therapy. He acknowledged that he had never used milrinone under the

circumstances in which Dr. Huerto treated Mr. [redacted].

Both Dr. Huerto and Professor Heaslip gave evidence that they had obtained considerable information from physicians who are using milrinone on an outpatient basis, and that they had used these examples in formulating their own protocol.

Counsel for Dr. Huerto argued that, in the case of a seriously ill patient who has refused to go to hospital, a physician is justified in pursuing any course which holds out any hope at all for improvement in the medical status of the patient. He pointed to the following comment made by Dr. Bernard Dickens, a medical ethicist who testified at the hearing:

> The transcending ethical issue is whether patients are confined to receive care only that conforms to the standards of the profession. Professional assessments, professional judgments are impersonal judgments made in accordance with the ideals of the profession and they're very noble and practitioners are expected to be aware of them. They do not, however, constrain patients. Patients are entitled to indicated therapy outside the settings in which it may be preferable that the therapy be administered.

In these and other comments, Dr. Dickens made it clear that a patient can seek or refuse treatment in accordance with personal judgments, and that these choices may include a decision to seek or accept treatment which does not accord with the general assessment of the medical profession as to what the optimum conditions or modes of treatment might be. Dr. Dickens suggested here that an ethical physician will not let the best be the enemy of the good in these circumstances, and will try to provide the treatment chosen by the patient, even if it cannot be given under the ideal conditions. Thus, though the majority of physicians might think it safer to offer medical treatment to patients who are seriously ill in a hospital, a decision to accommodate a patient who is distrustful of hospitals may be an acceptable and ethical one.

We do not, however, interpret Dr. Dickens as saying that a physician is freed from the constraints placed on him or her arising from membership in a profession which has a strong

commitment to the maintenance of demanding standards of practice, and a strong sense of obligation to the protection of the public. It is certainly open to a patient to seek out whatever treatment that patient sees as being helpful, whether or not it would be viewed as having merit by the medical profession, and it behooves a physician to be as accommodating as possible in providing medical care of a kind which is considered desirable by a patient.

There comes a point, however, where a physician must surely conclude that the provision of a particular treatment under particular conditions cannot be done in a way which meets the standards to which the physician has declared allegiance by becoming a member of the profession. Notwithstanding the high degree of autonomy which individual physicians must enjoy, and the deference which must be accorded to their specialized medical judgment, the existence of the medical profession is based on a premise that, at the core, there is a body of standards, of expectations, which must be adhered to by its members, and that individual medical judgment cannot always trump those standards.

It is not, of course, easy to identify the line between those cases where a physician has been exercising his or her professional judgment where a complex assessment is required, and those where this judgment has carried the physician outside the line of acceptable medical practice. There are many unanswered questions in medicine, and physicians, particularly those in specialized areas, must be given extensive scope to interpret what is known and to extrapolate beyond it. This does not mean, however, that, because they are working in a field where not all the answers are known, it is open to them to do whatever they like, without any accountability to the standards established by the profession or to the assessment of their professional colleagues.

Dr. Huerto could point to no literature which supported the administration of milrinone therapy in the exact circumstances faced by [redacted]. Though Dr. Zimmerman accepted that there are circumstances under which milrinone therapy can be given on an outpatient basis, and Dr. Hughes might be described as enthusiastic about this option, neither of them had any experience of the use of milrinone under these conditions, and neither of them gave evidence which directly supported the use of milrinone under the circumstances with which Dr. Huerto was dealing.

Dr. Hughes said that the written protocol which Dr. Huerto and Professor Heaslip had formulated to be followed in the administration of milrinone therapy was consistent with the protocols he had seen for other outpatient milrinone therapy. We do not think this is in itself sufficient to establish the proposition that Dr. Huerto administered milrinone to [redacted] in accordance with the standards of the medical profession.

The written protocol formulated by Dr. Huerto may be consistent with the documentation used as guidance in other outpatient programs of milrinone treatment. It must be recalled, however, that comparable protocols address the use of inotropic therapy in connection with a hospital outpatient program, or in a situation such as that in which Dr. Hughes proposes to establish an outpatient service for milrinone treatment, that is, in an environment provided by a clinic with a staff of over thirty people.

The circumstances in which Dr. Huerto administered milrinone to Mr. [redacted] were quite different. Dr. Huerto has the assistance of only one nurse, Professor Heaslip, as well as that of Ms. Tiegen, who was not trained as a nurse. There was no suggestion that Mr. [redacted] had been "selected" for milrinone therapy in accordance with the kinds of criteria set out in the literature; the response of Dr. Huerto to this suggestion was that Mr. [redacted] was not like the patients described in the literature concerning outpatient administration of milrinone. This does not seem to us to be reassuring, as it suggests that Dr. Huerto was moving outside any guidelines for the safe administration of milrinone to outpatients, and establishing Mr. [redacted] as being in a class by himself. The fact that Mr. [redacted] was not the "usual" kind of patient to whom milrinone would be administered as an outpatient is not in itself fatal to the claim of Dr. Huerto that he was practising responsible medicine. It is necessary for him, however, to be able to point to some support, in the literature or in the practice of other physicians, for the use of milrinone with Mr. [redacted] under these circumstances. It would be ironic if the conclusion could be drawn that, the farther the case of an individual patient deviates from the available guidelines for safe practice, the more license would be given to a physician to ignore those guidelines.

It is clear from the examples of medical literature put forward by Dr. Huerto, as well as the evidence of Dr. Hughes and Dr.

Zimmerman, that there are appropriate circumstances for the administration of milrinone to outpatients, and that this therapy is successful in reducing or eliminating the need for hospitalization in many cases. Indeed, the evidence of Dr. Wells indicated that physicians at the Royal University Hospital are considering establishing an outpatient program for inotropic therapy. It is also clear from the literature, however, that there are certain risks attached to the therapy which need to be countered in the outpatient situation. We were not convinced by the speculation of Dr. Huerto that the only real danger to these patients is that they will feel so well that they will overexert themselves; he drew the conclusion that this would not be a problem which would be faced by Mr. [redacted].

When Dr. Huerto began to give milrinone, Mr. [redacted] had not been in his care long enough for his condition to become stabilized or for Dr. Huerto to be sure he conformed to the profile of a patient for whom the administration of this medication on an outpatient basis would be both safe and beneficial. Neither was Mr. [redacted] in a situation where monitoring or nursing care would be available to him once he left the clinic.

In his testimony, Dr. Huerto stressed that Mr. [redacted] was a patient who wished to take responsibility for his own care, and that he was not someone who would allow other people, including members of his family, to make decisions about his medical care. Mr. [redacted] himself testified at the hearing, and it was clear that he was a fairly forceful personality and a person used to doing things for himself.

On the other hand, members of the [redacted] family were present in the clinic on a number of occasions, as they often drove Mr. [redacted] there for his appointments. Ms. [redacted], Mr. [redacted]'s wife, gave evidence that she had been in the clinic, waiting for her husband. The evidence also showed that Mr. [redacted] consulted with one of his sons when he had questions about the bill presented by Dr. Huerto. Overall, the evidence, including the diary kept by Mr. [redacted], of which a section was put in evidence, suggest that Mr. [redacted] had a fairly close relationship with his wife and children.

There is, however, no evidence that Dr. Huerto communicated to any of them any details of the treatment which was being given to Mr.

[redacted] or enlisted their aid in monitoring his condition, with the exception of the occasion on which the question arose about his ability to drive, which we will address below. Ms. [redacted] said that Dr. Huerto gave her no information about the condition of her husband other than to say that he, Dr. Huerto, would be able to do something for Mr. [redacted].

Whatever strides are being made in connection with the administration of milrinone to patients outside a hospital setting, we do not think the milrinone therapy given to Mr. [redacted] by Dr. Huerto can be said to have been within the standards of the medical profession. We therefore find that this aspect of Charge 8 has been established.

d. Treatment with thrombolytic therapy

The allegation in this part of the charge is that Dr. Huerto administered thrombolytic therapy using the drugs streptokinase and rtPA in circumstances where the treatment provided was not within the standards of the medical profession.

These reason for giving these medications is described as follows in the CPS entry for Kabikinase (streptokinase):

> [Streptokinase] acts with plasminogen to form an activator complex which converts plasminogen to plasmin in both the blood and blood clots. Plasmin is a proteolytic enzyme with a special affinity for fibrin. It degrades fibrin clots as well as fibrinogen and other plasma proteins.

Thrombolytics such as streptokinase and rtPA are thus given with the aim of breaking up blood clots such as those which were creating poor circulation in the peripheral vessels of Mr. [redacted], which had led to the situation in which he faced having his leg amputated.

Dr. Zimmerman described the method by which thrombolytic agents are ordinarily used for the purpose of breaking up blood clots in peripheral vessels. A catheter is introduced as close as possible to the clot which is being addressed, and the thrombolytic agents are put directly into the clot, in an infusion lasting some time. In order to monitor the success of the thrombolysis, angiography is

used to show whether the clot has broken up and the blood flow improved.

There are a number of risks associated with thrombolysis, one being that the thrombolytic agents will have some effect on cardiac emboli, and that the breaking up of cardiac emboli will cause a stroke. Another risk is that of arterial or intercranial bleeding, because of the effect of the thrombolytic agents in reducing the clotting capacity of the blood.

Because of the risks, and because of the need for angiography to monitor the progress of thrombolysis, Dr. Zimmerman was fairly categorical in his opinion that thrombolysis is properly done in a hospital.

This opinion is supported by the CPS entry for streptokinase, which includes the following comment:

> **Streptokinase should only be used in hospitals where any necessary emergency care and the recommended diagnostic and monitoring techniques are available.**

Dr. Bruce DuVal, a vascular surgeon called as an expert by the College of Physicians and Surgeons, also testified about the use of thrombolytic therapy. He testified that thrombolytic therapy is ordinarily administered by an interventional rediologist after a vascular surgeon has recommended its use.

Dr. DuVal estimated the risk of some kind of bleeding as 10%, with 5-15% of the patients in whom bleeding occurs needing specific therapy for that. Dr. DuVal stressed the importance of monitoring the patient to ensure that this risk does not materialize. It should be noted that there was agreement that there is a limited risk of bleeding posed by the administration of thrombolytic agents, although there was some difference in the figures used to capture the size of the risk. Dr. DuVal said that the most significant risk in terms of size is that of bleeding near the point where the skin is punctured for the administration of the drug. The more significant risk in terms of seriousness is that of intercranial bleeding.

He said that streptokinase is ordinarily only used for a brief

period, because of the chance that it will develop antibodies in the patient which will negate its effect.

Dr. DuVal also testified that thrombolytic therapy was used in this circumstance to treat a condition which had taken some time to develop, and was not an emergency treatment. Because of this, the opinion of Dr. DuVal was that this therapy should not have been started until the overall medical condition of Mr. [redacted] was stabilized.

Dr. Huerto said that he used doppler imaging equipment to monitor the progress of the thrombolytic agents, and that the need for extensive monitoring was obviated by his practice of giving the medications in single small boluses rather than continuous infusions. The short half-life of the drugs would mean that there would be none of the medication remaining in the blood stream of the patient when they were released from the clinic.

Although Dr. Hughes had had no experience with the use of thrombolytic therapy under similar circumstances, he was of the view that the doppler imaging techniques are now an acceptable substitute for angiography in monitoring the results of thrombolysis.

In his testimony, Dr. Hughes stressed that Dr. Huerto was dealing with a patient suffering from a difficult and complex range of conditions, and that he was trying to find the best way to address these conditions under trying circumstances. Though he acknowledged that it is difficult to say what role the thrombolytic therapy played in the successful treatment of Mr. [redacted], he pointed out that Mr. [redacted] showed a remarkable recovery, and that he still has both of his legs to this date.

Dr. Tadros, another expert called on behalf of Dr. Huerto, made a similar point, arguing that the successful outcome should essentially be regarded as the test for whether the treatment given by Dr. Huerto was acceptable. We should note that we have placed relatively little weight on the testimony of Dr. Tadros, as he had not made a contribution to the medical literature or the development of clinical practice on this or related issues in recent years. Furthermore, he gave his opinions in a defensive manner which did not inspire confidence. Nonetheless, we take his point, and that made by Dr. Hughes, that the progress of Mr.

[redacted] was astonishing, and that there is little sign in the vigorous man who appeared before the committee of the seriously ill patient who first consulted Dr. Huerto.

The recovery of Mr. [redacted] cannot, however, be the only benchmark for the assessment of whether Dr. Huerto provided treatment in a manner which was consistent with the standards of the medical profession. There are elements of luck and of the unpredictable in the evolution of the health of any patient. Though the restoration to health of patients is an important criterion in the assessment of the standard of medical treatment which is being provided, it cannot be the only test of whether a physician has complied with the standards expected of members of the medical profession.

These standards are not inflexible; as we have noted, they are not based on the premise that physicians will be unanimous as to what diagnosis or mode of treatment is appropriate in any given situation. They take account of the fact that physicians must be able to move the boundaries of medical treatment forward, and they make room for new ideas and new forms of medical treatment.

Yet it is of the essence of a profession that there be some sort of consensus as to the appropriate standards of practice, however accommodating this consensus may be to the insights and imagination of individual practitioners. The profession must maintain some capacity to protect the overall safety of the public by excluding certain choices or methods of treatment which are accompanied by unreasonable risks or which are too untried, and by censuring physicians who make those choices, even if they have not occasioned harm to any specific patient. The fact that the standards of the medical profession accord considerable respect to the professional judgment of individual physicians, does not mean that a physician is entitled to practise without any constraints whatever, or to embark on a course of treatment which has no support in medical literature or in the practice of other responsible physicians.

The method described by Dr. Huerto for administering thrombolytic therapy differed considerably from that outlined by Dr. Zimmerman and Dr. Du Val. Because he does not have access to angiography, and therefore is not able to place a catheter directly into the clots in the peripheral vessels, Dr. Huerto injected the thrombolytic agent into the femoral artery, in the expectation that it would

travel through the blood stream and break up the clots as it reached them.

The testimony of Dr. Zimmerman was that the injection of thrombolytic agents into the femoral artery would be of questionable use. It was his opinion that in a patient with a severe gangrenous condition of the kind found in Mr. [redacted], the blood containing the thrombolytic agent would simply flow through proximate arteries and would avoid the occluded vessels. Though in some cases where it is impossible to introduce the thrombolytic agent directly into the clot, Dr. DuVal said that it is sometimes injected in close proximity to the clot, this is considered to be less desirable.

Dr. Tadros, a radiologist called on behalf of Dr. Huerto, said that he had heard of thrombolytic therapy being done by injection into the femoral artery, but he conceded that this occurred in circumstances where for some reason it was impossible to perform the therapy any other way.

The response of Dr. Huerto to the suggestion that it is necessary to provide close monitoring of a patient who is undergoing thrombolytic therapy was that it is not necessary when using the method he employed with Mr. [redacted]. Instead of using a continuous infusion of the kind described by Dr. Zimmerman and Dr. DuVal, Dr. Huerto administered the streptokinase and rtPA in single bolus injections, and, because of the short half-life of these agents, he was confident that there would not be any remnants of them in the bloodstream of Mr. [redacted] when he was released to go home from the clinic after each visit.

Dr. Huerto also responded in his testimony to the suggestion that thrombolytic therapy is appropriately carried out in a hospital setting. He said that Mr. [redacted] was adamantly opposed to going to hospital, and would not consent to go there under any circumstances. He also produced a consent form, signed by Mr. [redacted], which specifically addressed the risks associated with thrombolytic therapy, and in which the risk of death was explicitly mentioned. Dr. Huerto said that Mr. [redacted] had made it clear that he would rather die than go to hospital.

Dr. Dickens, the medical ethicist, commented on this consent form, and said that it was, in his experience, unusually clear and

graphic about the risks associated with this treatment. Supposing Mr. [redacted] to have been mentally competent when he signed the form, the opinion of Dr. Dickens was that the consent form was strong evidence that Mr. [redacted] had understood the full implications of undertaking this treatment outside a hospital, and had consented to it.

Mr. [redacted] acknowledged that the signature on the consent form was his, but he did not recollect ever reading the form, and did not recognize the terms set out in it. He testified that, when he first consulted Dr. Huerto, he was preoccupied with finding some way of saving his legs. Though he said he did not want to go to hospital to have his legs amputated, his answer to the question of whether he would rather have died than go to hospital was a revealing one. He said that he was not really thinking in those terms. Though, as he saw it in retrospect, he would probably rather have died than have his legs amputated, he was not really weighing the prospect of death at the time. This, and other aspects of his testimony, suggest that he took a different position than that described by Dr. Huerto.

Although it is evident that Mr. [redacted] was adamantly opposed to the amputation of his legs, we do not think that this can be interpreted as an opposition to going to hospital for any reason whatever. He had been in hospital on several occasions in the preceding years, and he did not react to these experiences in a hostile or dismissive way. His relationship with Dr. Ulmer, his vascular surgeon, continued to be a good one.

There is no evidence that any attempt was made to explain to Mr. [redacted] that he could go to hospital to have something done other than the amputation of his legs. Nor is there any indication that Dr. Huerto raised, or even proposed to raise, the question of thrombolytic therapy with Dr. Ulmer. This casts some doubt on the understanding Mr. [redacted] had of the contents of the consent form. Though to some extent a physician must be entitled to shift some of the onus to a patient to read and digest a consent form, it must be remembered that, according to Dr. Huerto, Mr. [redacted] was very gravely ill when he was given the form. Indeed, Dr. Huerto noted in his clinical record a question mark about the "higher mental functions" of Mr. [redacted] when he first started seeing him.

Our impression of Mr. [redacted] from his appearance before the committee, from his diary, and from the testimony of Dr. Huerto, is that he was always, at some level, capable of understanding his situation and giving instructions about his treatment. It seems doubtful to us, however, that he was in a position to understand fully a sophisticated and complex consent form of the kind which was presented to us, given the severity of his medical condition when he began seeing Dr. Huerto, and in the absence of clear and complete information about the treatment options available.

The interpretation by Dr. Huerto that Mr. [redacted] refused to go to hospital under any circumstances, and that he would rather face death than go to hospital, bears on another aspect of the argument made by Dr. Huerto. This was that, since his patient refused to have anything to do with a hospital, he was justified in using any form of treatment which had the slightest chance of success. Though a physician must clearly be given some latitude in treating a patient who refuses to go to hospital, and though the decision of a patient not to go to hospital should not mean that the patient is denied options outside the hospital setting, this does not lead to the corollary that a physician is entitled to carry out any treatment whatever, in whatever manner. Though a patient is entitled to make decisions which may be deleterious to his or her health, a physician must at some point refuse to carry out treatment which cannot be given without compromising the standards of acceptable medical practice.

As we have said, we do not see that as the choice which had to be made here, in the sense that we do not think the option of hospital treatment, without amputation, was presented adequately to Mr. [redacted].

One of the issues which arose during the hearing had to do with one of the measures taken by Dr. Huerto to decrease the risks posed by the thrombolytic therapy.

As the literature presented to the committee makes clear, notably the CPS entry for streptokinase, the risk of bleeding posed by thrombolytic agents is compounded when the patient is being given anticoagulants, such as Coumadin, which was being administered in this case to Mr. [redacted] to address his heart condition.

One of the ways of preparing a patient for the administration of

thrombolytic agents in these circumstances is to give injections of Vitamin K. According to the explanation given by Dr. Jeffrey Ginsberg, a hematologist called on behalf of Dr. Huerto, vitamin K acts with certain enzymes in the liver to produce clotting factors which assist in the clotting process in the blood. Without vitamin K, the clotting factors cannot function effectively because they lack certain residues, or "sticky patches", and the ability of the enzymes produced by the liver to form clotting factors is suppressed.

When a patient is receiving anticoagulants such as Coumadin, according to Dr. Ginsberg, the ability to create clotting factors is greatly reduced. It is this situation which must be addressed in order to make it safer to administer thrombolytic agents, and this is the basis on which vitamin K is administered.

The test which is used to determine how successful the administration of vitamin K has been in counteracting the effect of the anticoagulant is the measurement of INR levels.

The issues of the INR level which would be an appropriate threshold to indicate that thrombolytic agents could be administered, and of the rate at which vitamin K works to reduce high INR levels, became significant issues in relation to this aspect of the charge against Dr. Huerto.

It should be noted at this point that these issues were raised at the initiative of this committee, who perceived a discrepancy between the INR level indicated in one of the test results from the Medical Arts Laboratories on March 10, and the time of the commencement of the administration of thrombolytic agents on that date, as indicated in the clinic file for Mr. [redacted]. The committee asked for an explanation of this apparent anomaly at the end of the cross-examination of Dr. Huerto, to give him an opportunity to address this point.

Counsel for Dr. Huerto raised a strong objection to the introduction of this issue, arguing that it was contrary to the principles of natural justice, and that it had not been raised by either party prior to this point. Counsel used fairly strong terms to articulate his view that the committee had departed from its proper role, and had adopted a prosecutorial role in raising this question.

The committee considered this objection, and ruled that there had been nothing improper about raising this question. The evidence which has been put before the committee is voluminous and complex, and it includes medical files which cover a long time-span. We acknowledge that it would be highly improper for the committee to take advantage of our access to this information to raise issues which are entirely unconnected with the current set of charges, and for which the parties, and particularly Dr. Huerto, had no time to prepare.

This is not, however, an accurate characterization of what happened in this instance. The charge against Dr. Huerto concerned the alleged deviation from professional standards in his administration of a particular treatment, and arose from a concern that the risks of the treatment to the patient could not be properly addressed. The documentary evidence, including the files and notes of Dr. Huerto, and items of scientific literature, indicated that a common method of counteracting these risks in part is the administration of vitamin K, and that vitamin K had been administered to [redacted] in this case.

It is true that neither party had specifically drawn attention to this fact, or apparently attached any particular significance to it. Both parties had put before the committee evidence which raised these issues, issues which seem very closely connected to the question of whether Dr. Huerto should be faulted for the way he administered thrombolytic therapy to Mr. [redacted].

Furthermore, the committee intentionally raised the issue at a point in the hearing at which Dr. Huerto would have a full opportunity to consider and respond to the questions raised. The committee permitted both parties to consider the matter and call new expert witnesses to address these issues. Dr. Huerto himself was given permission to give further testimony some weeks after his examination, cross-examination and re-examination had been completed so that he would not be prejudiced by the introduction of this question.

We are cognizant of our responsibility to give a full and fair hearing to a physician whose practice is under attack as that of Dr. Huerto has been here. The question which we raised was one which we view as arising naturally from the issue of whether the administration of thrombolytic therapy by Dr. Huerto in these

circumstances fell outside the standards of the medical profession - surely the steps he took to counter known risks are directly relevant to that. We raised it at a time when Dr. Huerto would have an adequate opportunity to respond, and accommodated the reasonable requests of counsel for both parties to call further evidence in relation to the issue.

Dr. Sheila Rutledge Harding, a hematologist, was called as an expert witness by the College of Physicians and Surgeons. Dr. Harding has been involved in studies and consensus discussions concerning the effect of vitamin K on INR levels. She pointed out that vitamin K does not directly affect the clotting factors which are already at work in the blood, but operates in the liver to influence the future development of clotting factors. She said her estimate is that half of an intravenous dose of vitamin K will be in the liver within an hour. The studies to which she referred suggest that vitamin K will not have a significant effect on INR levels for about six hours, and most data has looked at the effect between 12 and 24 hours.

She acknowledged that there is really no data available to show how vitamin K operates in the first hour. Dr. Huerto submitted some studies, none of them as current as the studies referred to by Dr. Harding, showing that the effect of vitamin K on INR levels is markedly more pronounced shortly after its introduction; one of these studies purported to show quite dramatic drops in INR levels in the first hours after the administration of vitamin K.

It should also be noted that Dr. Ginsberg, though he could not point to any literature supporting a particular rate for the reduction of INR levels in a short time after the injection of vitamin K, thought it "perfectly biologically possible" that the INR levels could be reduced from 6.6 to 3.5 within an hour.

A further point of difference between the testimony of Dr. Harding and that of Dr. Ginsberg had to do with the testimony of Dr. Huerto that he had given larger doses of vitamin K in order to increase the rapidity and scale of the effect of vitamin K. Dr. Harding said that, in her opinion, a larger dose of vitamin K will not necessarily have this effect, as the physical process by which vitamin K works in producing clotting factors has physical and temporal limits; larger doses will not necessarily speed up this process or produce a more significant effect. Dr. Ginsberg conceded

that there is no information to demonstrate what the effects of vitamin K are at the higher doses given by Dr. Huerto; his response to this, however, was to say that, because the answers are not known, the assertion that the higher doses are more effective is as worthy of acceptance as the contrary.

Though Dr. Hughes said that a vascular surgeon would be in a better position to comment on thrombolytic therapy than he is, he did make some observations about the administration of thrombolytics in these circumstances. He said that the spectacular progress of Mr. [redacted] could probably be attributed in part to the thrombolysis.

He further said that his opinion would be that there was no urgency attached to the administration of thrombolytic therapy. He also said that he would expect the vitamin K to begin working in the liver immediately, and would expect it to have measurable results within a few hours. When asked to quantify this, he suggested that there would be detectable effect on INR levels within two hours, and a significant effect in six hours. He said that a reduction of INR level from 6.6 to 2.5 in twelve hours sounded reasonable. Counsel for the College asked Dr. Hughes to comment on a factual scenario in which the INR level was 6.6 a very short time before the administration of the thrombolytic agent, and Dr. Hughes conceded that, if this were the case, things turned out well for Mr. [redacted] in spite of a risk which was unacceptable.

In the medical file relating to the treatment of Mr. [redacted] which was presented to the committee, there is a document showing the result of a test done by Medical Arts Laboratories at 8:07; the INR level is registered in this document as 6.6.

In his initial response to questioning about the administration of the vitamin K and the INR levels, Dr. Huerto said that he was aiming to get INR levels down to 1.3 or 1.4 before beginning thrombolysis. When he was recalled, he said this was a mistake, and he attributed his answer to the stress of the hearing. He said that he is comfortable with a level starting about 5.0, but usually aims to get to 3.5 before administering thrombolytic agents. Dr. Huerto was unable to say exactly what the INR level had been at the time he began administering thrombolytic agents on March 10, but said that he "would not" have started it unless he was comfortable that the INR level was low enough.

The doctor's orders noted in the file show that kabikinase was administered at 8:30 a.m. and that an injection of vitamin K was given at the same time. The nursing notes differ slightly from this. They report that Mr. [redacted] first came to the clinic at 7:00 a.m., and that he went to the lab for tests at 8:10. They make no mention of the injection of vitamin K, and mark the beginning of thrombolysis at 9:00 a.m. As we have already noted, a report from the Medical Arts Laboratory shows INR levels as recorded at 8:07 a.m.

After the question of the timing of the vitamin K injections had been raised by the committee, and after Dr. Huerto had given his evidence on this point, Professor Heaslip produced for the committee a document which she said she had forgotten about up to that point. She said that it was part of a research study she was conducting, and that she had recorded all of the vitamin K injections and INR values for Mr. [redacted] during his treatment at the clinic. For March 10, this document shows that the INR level measured at the clinic at 7:30 a.m. was 6.8, and at 9:00, it was 3.5. The table also shows that vitamin K was administered at 7:55 a.m.

Having examined this document carefully, and considered the circumstances under which it was presented to the committee, we have concluded that it is entirely unreliable. Though the document covers the entire period during which Mr. [redacted] was being treated at the clinic, every entry in the document is written in exactly the same ink, and with handwriting which suggests uniform pressure. We do not find the explanation that this document was "forgotten" to be plausible, and find it entirely too coincidental that it should be recovered after the INR levels had become an issue at the hearing. We further find it puzzling that the values entered on this document do not exactly match the notations made in the nursing notes and the medication record with respect to Mr. [redacted], which were presumably made at the time of the treatment. We are not prepared to place any weight whatsoever on this document.

Though it is somewhat difficult to be sure what the exact interval was between the injections of vitamin K and the commencement of thrombolysis, it seems apparent that this period was not more than an hour in length. Dr. Huerto does not claim to have any direct memory of the INR levels at the time the thrombolytic agent was

administered on the morning of March 10, though he said he "would not have" administered the drugs unless the INR was registered at a level which he felt comfortable with. From his testimony, it is not clear what level this would be, exactly. We accept that he made an error in his initial statement that he would have as his goal an INR of 1.3 or 1.4, but we did not find convincing his explanation of why any level lower than 5.0 would be acceptable to him.

Dr. Harding testified to the effect that, though there are no recent data which directly indicate how fast vitamin K takes effect within the first hour after administration, the studies of its effects over a slightly longer period suggest that significant effects cannot be anticipated for well over an hour - the figure Dr. Harding herself was comfortable with was six hours. She presented the committee with a table she had prepared herself showing in graphic form the effect of vitamin K on INR levels over the hours after administration. This graph does show that the drop in INR levels is more rapid immediately after administration, but her extrapolation from the known data does not show that a drop from 6.6 to 3.5 in less than an hour would occur.

We found the evidence of Dr. Harding in this respect more persuasive and more coherent than that of Dr. Ginsberg, who was called on behalf of Dr. Huerto. Though Dr. Ginsberg is clearly an experienced and knowledgeable hematologist, he could not point to any support in the literature, in his experience, or in his consultations with colleagues, to support the assertion that the decrease in INR levels advanced by Dr. Huerto occurred, other than his statement that it was "perfectly biologically possible." We did not find this a helpful approach. The same statement can be made about many phenomena whose character is mysterious, but we do not think it is a reliable way of evaluating whether a particular diagnostic or treatment choice falls within the standards of practice which are expected of responsible physicians.

Dr. Huerto administered thrombolytic therapy to Mr. [redacted] using methods which had a very slim chance of being effective, in that there was no way of being certain that the thrombolytic agents would reach the occlusions in the peripheral vessels. We are also convinced that Dr. Huerto administered this therapy in a way which increased the risks to the patient, in that there was no provision for monitoring Mr. [redacted] once he left the clinic. Further, on at least one occasion, on March 10, we are convinced that Dr.

Huerto administered the thrombolytic agent without adequate attention to the INR levels which were registered for Mr. [redacted].

We thus find that this aspect of charge 8 against Dr. Huerto is established.

f. Prescription of certain drugs

In this part of the charge, it is alleged that Dr. Huerto prescribed a number of drugs to Mr. [redacted] in circumstances where the prescribing or provision of these drugs was not in the standards of the medical profession.

i. Adalat (nifedipine)

This medication is described as a calcium channel blocker which is generally prescribed for high blood pressure or angina. The CPS entry for Adalat indicates that it is necessary in using the medication to take precautions against hypotension, and to use lower doses in elderly patients.

In his evidence, Dr. Zimmerman said that the use of this particular type of medication has a negative inotropic effect on the heart, and that there are better drugs available to treat the conditions for which this medication is prescribed. He said that the danger of using Adalat in circumstances such as those in which Mr. [redacted] was being treated is that there will be a deterioration in the condition of the heart. There are also risks associated with the swift drop in blood pressure which may occur as a result of the drug.

The opinion of Dr. Zimmerman was that there was no indication he could identify in the file for the prescription of Adalat, and that it should not be prescribed without a good reason.

Under cross-examination, he answered that he had heard of Adalat being used for its vaso-dilator effects, though he had no experience with it in that context. Dr. Huerto asserted that his reason for using Adalat was that he hoped it would help to dilate the vessels, and this would help to address the critical leg ischemia suffered by Mr. [redacted].

Dr. Hughes testified that there is a body of medical opinion which would hold that Adalat is the "drug of choice" for preventing vascular spasm in the kind of situation which Dr. Huerto was facing here, and stated his opinion that there was nothing wrong with the provision of Adalat to Mr. [redacted].

We think that Dr. Huerto has met the test of showing that there is a body of responsible medical opinion to support his use of Adalat in these circumstances, and we therefore find that this aspect of the charge is not established.

ii. Lescol (fluvastatin sodium)

Lescol is a lipid metabolism regulator which has the effect of moderating blood cholesterol levels. Dr. Zimmerman commented that the dosage given to Mr. [redacted] was considerably higher than the doses normally prescribed. He said that he could not identify any conceivable benefit under these circumstances for prescribing this medication, and that it was not within the standards of the medical profession to prescribe drugs for which there was not a clear rationale. Though the risks of the drug are not serious, there is the possibility of annoying muscle pains, and some liver involvement.

Dr. Hughes said that it was clear that Dr. Huerto was using Lescol to lower lipid levels in the blood, and that there was nothing unreasonable about using a statin medication in this situation. He said that there is a debate within the profession over the appropriate target for cholesterol levels, with some physicians believing that it is desirable to lower cholesterol dramatically, and others believing that a moderate level of cholesterol is a safer goal. As Lescol is weaker than other statins, Dr. Hughes stated that there was nothing dangerous about the dosage given to Mr. [redacted].

Dr. Huerto testified that he felt it desirable in the case of Mr. [redacted] to reduce the level of cholesterol to "rock bottom."

We are of the view that Dr. Huerto has again succeeded in establishing that there is a body of responsible medical opinion to support his use of Lescol in these circumstances, and we therefore find that this aspect of the charge has not been established.

iii, iv, v. Primacor (milrinone), Streptokinase, rtPA

We have dealt with the administration of these drugs in earlier sections of this decision, and we do not feel it is necessary to comment on them further.

vi. Norvasc (amlodipine besylate)

Norvasc is a calcium channel blocker usually used to treat hypertension. The 1997 edition of the CPS contained a warning that the safety of its use in patients with congestive heart failure had not been established.

Dr. Hughes testified that further study had addressed this concern, and that the study referred to as the PRAISE trial indicated that there should be little concern about its safety for patients with congestive heart failure. Dr. Hughes conceded that, if the PRAISE trial was done after 1997, it would not affect the question of the judgment exercised by Dr. Huerto in 1997. After Dr. Hughes had completed his testimony, the committee was informed that the study had been available in 1997.

Dr. Hughes also expressed the opinion that Dr. Huerto had administered Norvasc in an appropriately cautious manner.

We do not think that the College has clearly established that the use of Norvasc by Dr. Huerto in the case of Mr. [redacted] in 1997 was outside the standards of the profession.

vii, viii. Morphine, MS Contin

MS Contin is a form of morphine which is used for its painkilling effect.

Dr. Zimmerman drew the inference from his review of the file that the narcotics had been prescribed because of the pain [redacted] was experiencing in his legs. Dr. Zimmerman said that Dr. Huerto had noted in the file that Mr. [redacted] was "feeling fine," and that this casts doubt on whether the prescription of the narcotics was necessary.

We do not think this testimony is sufficiently strong for us to conclude that Dr. Huerto was acting outside the standards of the

medical profession in prescribing morphine for Mr. [redacted].

ix. Digoxin (injectible)

There was no dispute among the witnesses testifying at the hearing that digoxin is a front line drug in the treatment of patients with congestive heart failure.

Dr. Zimmerman did raise the question, however, of whether it was necessary or desirable to continue to administer digoxin intravenously after the initial stages of the treatment. His opinion is that, though the administration of digoxin by this method is useful to give the patient an initial loading dose of the drug to stimulate the contractions of the heart, the patient is usually given digoxin in pill form after this.

Again, we do not think this evidence is sufficiently strong to establish that Dr. Huerto was acting outside the standards of the medical profession in this respect.

x. Gentamycin

Gentamycin is an antibiotic medication which Dr. Huerto was administering to address the sepsis he identified in Mr. [redacted]. Dr. Zimmerman testified that this is a somewhat toxic antibiotic, and that it can have a negative effect, among other things, on renal function. For this reason, Dr. Zimmerman said that it is desirable to carry out careful monitoring of patients taking gentamycin, and in particular to obtain "peak and trough" levels.

Dr. Hughes agreed that peak and trough levels are helpful in tracking the effect on a patient of gentamycin, and that they would be obtained under "ideal" conditions. On the other hand, he testified, there was no indication of any renal dysfunction at the time the gentamycin was being administered to Mr. [redacted].

We are not convinced that the administration of gentamycin was carried out in a way which fell outside the standards of the medical profession.

g. Erroneous ECG interpretations

In the case of all three patients whose treatment is the subject of

these proceedings, Dr. Huerto carried out frequent electrocardiograms on the equipment in his clinic, and their files contain numerous charts showing the results of the ECG testing. The equipment used by Dr. Huerto in his clinic provides not only the graph of the cardiac activity being measured, but a line or more of text which represents the assessment by the computer of what the graph shows.

These computerized evaluations of the ECG results are not always accurate, a fact acknowledged by Dr. Huerto. For example, on an ECG reading for April 4, 1997, the computerized comment is "tachycardia of undetermined origin" when a reading of the ECG graph itself shows that this is not the case.

The allegation in this part of the charge is that it was not consistent with his professional responsibilities for Dr. Huerto to allow these inaccurate statements to be retained in the file without correction or elaboration. Dr. Zimmerman testified that he would not leave such interpretations on the file, and that there needs to be some indication that the ECG reading has been reviewed, and a clear assessment of what the correct interpretation is.

The view of Dr. Zimmerman that it is desirable for the entries in a medical file to be as accurate as possible is, of course, a reasonable one. It is particularly important in the hospital setting where a number of health care providers are likely to be involved in the care of any one patient. It is essential in that context that those with responsibility for the care of the patient can rely on whatever appears in the file.

As Dr. Huerto pointed out, his situation is considerably different, and the interpretation of the ECG readings is a responsibility he does not share with anyone else. This is not an entirely satisfactory explanation, because physicians who subsequently treat patients who have consulted Dr. Huerto are also entitled to have access to records in which the entries are accurate.

On the other hand, as Dr. Zimmerman acknowledged, it is clear to anyone who knows anything about reading the ECG results that the computerized assessments do not always bear a clear relationship to the graphs. It is unlikely that a physician would be misled by the notations, and it seems more probable that physicians will rely on their own judgment.

Though we agree that it would probably be better if Dr. Huerto were careful to record accurate interpretations in the file, we do not think it has been established that retaining these particular computerized notations in the file falls outside the standards of responsible medical practice.

Charge 9: Excessive charges for IV circulatory support

This is the first of two charges dealing with the account presented to Mr. [redacted] in connection with the medications provided by Dr. Huerto at the clinic. In addition to allegations of violation of Section 46(o) and/or 46(p) of the *Medical Profession Act, 1981*, this charge alleges in the language of bylaw 51(2)(d) that Dr. Huerto charged "a fee that is excessive in relation to the services performed." It should perhaps be noted that it was uncertainty over this bill which first brought Mr. [redacted] into contact with the College of Physicians and Surgeons.

It is important in connection with both of these charges to have some understanding of the process by which the bill came into existence. Dr. Huerto, Professor Heaslip and Ms. Tiegen all testified about the way in which bills are drawn up in the clinic. The amount to be charged for medications is established by contacting the pharmacist and getting a quote for the current cost of medications. To this is added 10% as a handling fee.

The pharmacist who normally deals with the clinic, Ms. Laura Cholowski said that she has received these requests from the clinic on a number of occasions. She said they generally fax her a list, or telephone, asking the current price of medications. She calculates the current price, including the 10% handling fee, and sends back a list of the medications with the prices.

This practice, it should be noted, would not cover the specific item to which this charge relates, the "IV circulatory support." The evidence of Dr. Huerto and Professor Heaslip was that this item on the bill related to the intravenous nutritional material given to Mr. [redacted] during his visits to the clinic, referred to as total parenteral nutrition (TPN). Dr. Huerto said that this material was made up according to his specifications, and provided directly to the clinic by a medical supplier.

Professor Heaslip testified that she had been responsible for

making up the bill for Mr. [redacted]. It was clear from her testimony that Professor Heaslip did not like or trust Mr. [redacted], and she testified that she had, in fact, opposed treating him at the clinic.

She described Mr. [redacted] as being preoccupied with money, and reluctant to buy items needed for his treatment if he could obtain them for nothing at the clinic. She said, for example, that he was reluctant to use strips to test his blood sugar at home, but that he would do it if the clinic kept him supplied with the strips.

She said that she and Ms. Tiegen, as well as Dr. Huerto, had tried to make Mr. [redacted] realize that the medications which were provided to him would cost a considerable amount. She and Dr. Huerto said that Mr. [redacted] had indicated a number of times that he was concerned about spending too much money on his treatment. Dr. Huerto said that Mr. [redacted] raised the issue many times, and said that he was an "honourable man" who would pay what he owed.

Professor Heaslip said that her attitude to making up a bill as Mr. [redacted] requested was that it would be a waste of time, as she did not expect him to pay it. She said that she knew that whatever she put on a bill would not represent nearly the costs which had been incurred by the clinic for the medications supplied to Mr. [redacted]. She said that her view was that, therefore, it did not really matter what she put on the bill.

The evidence given by Professor Heaslip in this respect was somewhat disturbing to the committee, as it suggested a lack of concern about the accuracy of the written record which is not consistent with the responsibilities of a professional person. We must also say that her statements in this portion of her evidence undermined our confidence in the rest of her testimony, and led us to place relatively little weight on it.

It was clear from her evidence that Professor Heaslip is an admirer of the work of Dr. Huerto, and has committed much of her career to supporting it. She said that she was spending around fifty hours per week working at the clinic, for no remuneration. It was also clear that she feels strongly that Dr. Huerto has been unfairly pursued and victimized by the College of Physicians and Surgeons, and her response to counsel for the College was defensive and somewhat hostile.

We have taken into account that some of the sentiments expressed by Professor Heaslip are natural under the circumstances. This does not, however, persuade us that we are wrong in concluding that her evidence was not wholly reliable.

We have serious doubts about the figure of $3000 which was included in the bill given to Mr. [redacted], and attributed to "IV circulatory support." There is documentation in the file showing the elements which were included in the nutritional material administered intravenously to Mr. [redacted], and indicating how much of the TPN formula was given. There is no indication in the documentation before us what the cost of this material was, except in the final bill given to Mr. [redacted]. Neither did the College put forward any evidence to show what a normal cost for such material would be.

We have therefore come to the conclusion that, notwithstanding our doubts on the subject, the College has failed to provide us with clear evidence establishing that the cost charged to Mr. [redacted] was excessive.

Charge 10: Failure to provide information for informed decision

This charge is also related to the bill presented to Mr. [redacted], which included the charge of $3000 we have considered above, along with $11,150.68 for other medications. In addition to Section 46(o) and 46(p) of the *Medical Profession Act, 1981*, this charge alludes to bylaw 44(2), which makes it an infraction to breach the Code of Ethics which is reproduced in bylaw 44. The portion of the Code to which the charge refers is the obligation to "provide your patients with the information they need to make informed decisions about their medical care..."

We have earlier alluded to the notice which was on display at the reception desk in the clinic, which was intended to draw the attention of patients to the fact that they would be charged for the cost of their medications. The notice included samples of the costs which might be incurred, ranging from $5.00 for a xylocaine injection to $1900.00 for a TPA intravenous injection.

As we have already noted, Dr. Huerto testified that he also had a number of conversations with Mr. [redacted] on the subject of the costs of the treatment he was receiving. Dr. Huerto said that Mr.

[redacted] was clearly aware that there were costs attached to the treatment, and he assured Dr. Huerto that he intended to pay them. Dr. Huerto also noted that the consent form signed by Mr. [redacted] indicated that he understood he would have to pay "thousands of dollars" for the medications involved in the thrombolytic therapy.

Mr. [redacted] himself testified that he never understood the scale of the costs he would be asked to bear. The diary which he kept in which he noted the events of each day record that he was surprised when he received the bill prepared by Professor Heaslip.

Professor Heaslip testified that she made up the bill for Mr. [redacted] by copying the list of medications and prices received from the pharmacy by fax, and added to it the item for TPN. The total of the bill was thus $14,150.68.

Ms. Cholowksi testified that the list she provided contained a number of examples where she provided the price for medications given in different formats. Thus, the drug Lasix is entered three times, and the cost associated with different formats is noted. The evidence of Ms. Cholowski was that she was giving the price for these different formats for informational purposes, but that it would be necessary for the person making up the bill to use these figures to calculate the actual cost by relating it to the doses of the drugs given.

It is clear from this evidence that there are several items on the list which are "double counted" because they were used in a way not contemplated by Ms. Cholowski. On the other hand, it is possible that the cost of rtPA was underestimated, because the cost is given for one vial, and it is not clear whether Mr. [redacted] received more than one vial of the drug.

In our view, this charge has been established by the evidence put forward at the hearing. Professor Heaslip made no secret of the fact that the process she used for compiling the bill was more or less arbitrary, and she was not particularly concerned whether the figures on the bill bore an accurate relationship to the medications actually provided to Mr. [redacted]. The first version of the bill given to Mr. [redacted] contained merely the two figures - $11,150.58 and $3000 - attributed to medications and IV circulatory support. At the request of Mr. [redacted] and his son, an itemized bill was provided, based largely on the figures

supplied by Ms. Cholowski. As we have seen, these figures did not always bear a direct relationship to the costs of the medications administered.

Since the system used for assessing the costs to be borne by Mr. [redacted] was so arbitrary, it is hard to see how he could have been provided with accurate information about the cost of medication so that he could make whatever judgments he wished about his treatment. Though we are prepared to accept the testimony of Dr. Huerto that he and Mr. [redacted] had some general conversations about the obligation which would be imposed on Mr. [redacted] to pay for his medication, there is no indication that Dr. Huerto or his staff ever gave Mr. [redacted] any specific information with respect to the costs he was incurring as he went along. Indeed, Dr. Huerto relied in his evidence on the notice at the reception desk as fulfilling his obligation to provide information on this issue. Professor Heaslip provided an account to Mr. [redacted] only reluctantly, and after he had incurred significant costs; there were no interim accounts, and he was not provided with a running tally of the costs.

From the description given by Professor Heaslip of the importance of money to Mr. [redacted], it is entirely possible that information about the costs of the medications would have made a difference to the decisions he made about his treatment. This is not, of course, the test of whether such information should be provided, as the patient is entitled to adequate information even if, in the end, it does not affect the choices made. It is an indication, however, that Professor Heaslip and Dr. Huerto were aware of the significance of this issue to the patient, and they did not respond to it, in our view, in a way which was consistent with expected standards.

We have thus concluded that charge 10 has been established.

<u>Charge 11: Dispensing narcotics without prescription</u>

This is one of two charges dealing with the dispensing of narcotics in the treatment of Mr. [redacted].

Dr. Huerto described the general policy he uses with respect to the provision of medications, including narcotic substances. One method he commonly uses has already been described. He provides the

medications from his stock at the clinic, and then obtains from the pharmacy an indication of the costs and charges them back to the patient. There is another option, which is sometimes recommended to patients because of the subsidy available to senior citizens on prescription drugs. The drugs are provided to the patient at the clinic. Dr. Huerto then writes a prescription, which is filled and paid for by the patient at the pharmacy; the medications thus obtained are then returned to Dr. Huerto to replenish his stock.

Mr. [redacted] was supplied with narcotic substances at the clinic, notably MS Contin, a preparation of morphine, as well as morphine. There was no prescription written prior to the administration of the narcotics to Mr. [redacted].

Morphine is, of course, a controlled substance, and thus distinct from other kinds of prescription drugs. Though physicians are permitted to retain stocks of narcotics in their offices in order to deal with pain management for patients, it is expected that careful records will be kept of the administration of the narcotics to particular patients, and that all quantities of narcotics which are obtained will be accounted for.

It is not clear that Dr. Huerto made separate provision for accounting for the narcotic substances under his care. The medication records in the file for Mr. [redacted] do record the administration of morphine and MS Contin to him, but it is not apparent that there was any overall effort to keep accurate track of the administration of narcotics in the clinic.

Nonetheless, we do not find that the failure to write a prescription for narcotics is in itself a departure from the standards of the profession, as there are other methods for monitoring the consumption of narcotics, and for ensuring that there is a chain of responsibility which is clear.

Charge 12: Writing prescription for narcotics without intention that [redacted] should receive the medications

We have described above one of the methods by which Dr. Huerto dealt with the costs incurred by his patients in relation to the medications he provided. This was to make out a prescription which would be filled and paid for by the patient, with the drugs to be returned to the clinic to replenish the stock.

In the case of Mr. [redacted], this method was followed. He was given a prescription for morphine and MS Contin, and this prescription was presented to the PharmaSave pharmacy. Ms. Cholowski testified that she contacted the clinic because the prescription did not comply with the requirements of the triplicate prescription system, which governs prescriptions for narcotics; under this system, a number of copies of the prescription are made so that it is possible for the pharmacist, and ultimately the regulatory authorities, to monitor the consumption of narcotic medications. She testified that she did fill the prescription, but it was never collected by Mr. [redacted] or anyone acting on his behalf.

Dr. Huerto conceded that, under the system which has been described, it was not intended that the narcotic medications itemized in the prescription would be administered to Mr. [redacted] himself. The intention was that they would go back into the clinic stock, and would be used in future for some other patient. Dr. Huerto did not deny that he had acted in the manner alleged by the College, but he said that he did not realize that there was any requirement to proceed in any other way.

The medical profession has a legitimate interest in requiring physicians to exercise great care and to keep accurate records with respect to the administration of narcotics. It is clear that Dr. Huerto did not satisfy reasonable expectations in relation to this issue. Though we do not think he violated bylaw 51(2)(d), because we accept that he was not trying to charge Mr. [redacted] for drugs he had not received, we do think that he was guilty of unbecoming, improper, unprofessional or discreditable conduct by failing to maintain sufficiently careful records of the use of narcotics in the treatment of patients at the clinic.

Charge 13: Failing to alert the administrator under *The Vehicles Administration Act* of the dangers associated with the condition of Mr. [redacted]

Under this charge, reference is made to bylaw 51(2)(i) in addition to Sections 46(o) and 46(p) of *The Medical Profession Act, 1981*. Bylaw 51(2)(i) defines contravention of "any federal, provincial or municipal law" as unbecoming, improper, unprofessional or discreditable conduct. The allusion, in this context, is to the provision of *The Vehicles Administration Act* requiring qualified

medical practitioners to report to the administrator under the statute the name, address and clinical condition of any person who, in the opinion of the practitioner, is suffering from a condition which makes it dangerous for that person to continue to operate a motor vehicle.

Mr. [redacted] had been suffering from diabetes for some years when he began seeing Dr. Huerto, and his condition was not well-controlled. After the first few visits to Dr. Huerto, he drove himself to the clinic on a number of occasions. In one instance, he reported to Dr. Huerto that it had taken him over an hour to drive home because he had become disoriented and had difficulty remembering how to get home.

Dr. Huerto testified that he was concerned about this event, which he identified as a hypoglycemic episode. He said that he felt Mr. [redacted] should not be driving until his diabetic condition was more stable. He said he consulted with members of the [redacted] family and was assured that they would take turns driving Mr. [redacted] to his appointments at the clinic. Neither Ms. [redacted] nor Mr. [redacted], a son of Mr. [redacted], said that they had been involved in consultation with Dr. Huerto or agreeing to set up a rota for driving Mr. [redacted] to the clinic.

Dr. Huerto said that he did not report Mr. [redacted] to the administrator under *The Vehicles Administration Act*, as he conceded the statute required, because he felt that it would be an overreaction, on the basis of one episode, to put Mr. [redacted] in a position where he might be permanently barred from driving. He said that, in his experience, elderly patients find the prospect of having to give up driving to be humiliating, and he did not want to be responsible for bringing this about for Mr. [redacted].

Dr. Huerto also said that he felt it was the responsibility of Dr. Lois Stewart, who had been the family physician of Mr. [redacted], to make the report if she felt it was necessary. Dr. Stewart had been treating Mr. [redacted] at the time he decided he wanted to obtain chelation therapy in order to avoid having to face the amputation of his legs. She testified that, in addition to being the family physician of both Mr. [redacted] and his wife, she was a family friend. She said that she had told Mr. [redacted] that she would step back and not interfere in his treatment by other physicians if he chose to consult them. She said, however, that she

continued to be concerned about Mr. [redacted] on a personal basis, and she was at the [redacted] home on many occasions.

She acknowledged that she was aware of the episode when Mr. [redacted] became disoriented and had difficulty finding his way home, because his son had called her to ask her advice. She thought he was having an insulin reaction, and she telephoned Dr. Huerto to make sure he was aware of it. She suggested to him that he should telephone Saskatchewan Government Insurance as he was responsible for treating Mr. [redacted]; she said Dr. Huerto hung up on her.

In his evidence, Dr. Huerto displayed some antipathy towards Dr. Stewart, and he seems to have thought she was interfering in the treatment of Mr. [redacted], and criticizing the treatment prpvoded by Dr. Huerto to the [redacted] family. Our assessment of Dr. Stewart is that she was making sincere attempts to convey to the [redacted] family the distinction between her role as a friend and her role as their physician. Though she no doubt expressed herself fairly forcefully, we think that she did what she could to avoid influencing the [redacted] with respect to the treatment Mr. [redacted] was receiving from Dr. Huerto.

Mr. [redacted], one of the sons of Mr. [redacted], said that he had talked to Dr. Huerto about the occasion on which his father had difficulty finding his way home. He said that he thought he had also told Dr. Huerto about two other occasions on which his father had had apparent episodes of hypoglycemia, and his mother had called 911 to get help for him.

[redacted] also said that Dr. Huerto had explained to him that he was more concerned about the risk of hyperglycemia, despite the hypoglycemic episodes. Dr. Huerto confirmed in his own evidence that he had been aiming to achieve a very low blood sugar level in his treatment of Mr. [redacted] because he felt hyperglycemia posed the greater risk.

We have some sympathy for the position taken by Dr. Huerto that it is not consonant with the interest of elderly patients for a physician to be responsible for the removal of their ability to drive a car, which is closely tied to their sense of dignity and self-reliance. We would, in fact, have been inclined to overlook a technical violation of the obligation under *The Vehicles Administration Act* if we were confident that Dr. Huerto had taken

adequate steps to ensure that Mr. [redacted] would not be driving as long as his condition was unstable.

We are not convinced, however, that he did enter into the compact with the [redacted] family that he described. The members of the family who testified at the hearing did not recall being bound to such a responsibility. We also note that the treatment which was being given to Mr. [redacted] in relation to his diabetes was aimed at achieving the lowest possible blood sugar, to avoid hyperglycemia. Whatever the merits of this treatment, it is apparent that the treatment made further hypoglycemic episodes more rather than less likely, and made it further incumbent on Dr. Huerto to satisfy himself that Mr. [redacted] would not be posing a danger to the public or to himself by driving his car.

Finally, we would like to record our view that it was inappropriate for Dr. Huerto to try to shift onto the shoulders of Dr. Stewart the responsibility for reporting to the authorities concerning Mr. [redacted]'s driving. Under difficult circumstances, Dr. Stewart was trying to maintain an appropriate relationship with Mr. [redacted] and his family, to make it clear to them that she would not interfere in the treatment of Mr. [redacted], and to behave with professional decorum towards Dr. Huerto. It is possible that Dr. Huerto was under the illusion that Dr. Stewart was continuing to play a role as the family physician for Mr. [redacted], but this does not, in our view, relieve him of his own responsibilities toward Mr. [redacted] and the public, which are clear under the statute.

We find that this charge has been established.

Charge 14: Failing to maintain proper medical records

This charge reads as follows:

> *14. You Dr. Carlos Huerto are guilty of unbecoming, improper, unprofessional or discreditable conduct contrary to the provisions of* ***The Medical Profession Acrt, 1981, S.S. 1980-81, c. M-10.1 and/or Bylaw 51(2)(j), particulars of which are that you failed to maintain the standards of the profession in your medical records of*** [redacted] *and/or* [redacted] *and/or* [redacted].

The evidence which will be led in support of this particular will include that your medical charts did not include the information required by Bylaw 46(1) including:

a. the prescribing information and/or
b. professional advice given to the patients and/or
c. the treatment provided.

In this charge, the College alludes to bylaw 51(2)(j), which defines "failing to maintain the standards of the medical profession" as unbecoming, improper, unprofessional or discreditable conduct, and links these standards in part to the obligation laid out in bylaw 46(1), which requires a physician to maintain appropriate records. Bylaw 46(1) reads as follows:

46. Medical Records

All members of the College of Physicians and Surgeons of Saskatchewan shall keep, as a minimum requirement, the following records in connection with their practice:

1) In respect of each patient a legibly written or typewritten record setting out:
a) the name, address, birth date and Provincial Health Card Number of the patient;
b) the date that the member sees the patient;
c) a record of the assessment of the patient which includes the history obtained, particulars of the physical examination, the investigations ordered and where possible the diagnosis;
d) a record of the disposition of the patient including the treatment provided or prescriptions written by the member, professional advice given and particulars of any referral that may have been made. Prescribing information should include the name of medication, strength, dosage and any other directions for use.

The files of the three patients named in the charge were made available to the committee for review. The files contained the clinical notes made by Dr. Huerto, nursing progress notes,

medication records, test results and other documentation.

In general, Dr. Huerto made fairly extensive notes concerning each visit by a patient. These notes routinely included both a "working diagnosis" and a "plan", each so headed. We would interpret the "plan" section as being the portion of the notes where Dr. Huerto recorded the suggestions for treatment which occurred to him at the time of his consultation with the patient. It is not always clear in these notes what treatment was actually given to the patient.

Much of the information concerning treatment can, of course, be gleaned from the nursing progress notes, but the relationship between these often cryptic descriptions and the working diagnosis arrived at by Dr. Huerto is not always clear.

The clinical notes do not contain systematic indications of the prescription of medication by Dr. Huerto for patients. There are medication records in the files which show the drugs which were administered in the clinic, but there is not clear indication in the notes kept by Dr. Huerto which would shed light on his prescribing decisions.

We find that there have been some deviations from the standards required in Bylaw 46(1) in the records maintained by Dr. Huerto for these patients. In addition, as we have stated, we have some concerns about the preservation of the integrity of the original records. We find that this charge has been established.

SUMMARY OF FINDINGS

For the convenience of those reading this decision, we are including here a summary of our findings with respect to the charges. The exact wording of the charges and the details of our findings can be found above.

Charge 1: Failing to respect the privacy of [redacted]

We found that the College failed to establish this charge.

Charge 2: Failure to maintain professional standards in the treatment of [redacted]

a. Use of Synvisc

The committee found that this part of Charge 2 was not established, because of a related finding that Synvisc was not administered.

b. Failure to provide appropriate treatment for migraine

The committee found that this part of charge 2 was not established.

c. Failure to strongly advise discontinuation of birth control medication

The committee found that this part of Charge 2 had been established.

d.,e. and f. Initiation of anticoagulation therapy

The committee found that these parts of charge 2 were not established.

g. Failure to achieve an INR level in the therapeutic range for anticoagulation

The committee found that this part of Charge 2 was established.

Charge 3: Injection with Fluanxol, Synvisc or Betaseron

The committee found that this charge was not established.

Charge 4: Conflict of interest - providing Fluanxol, Betaseron or Synvisc at a profit

Though the committee did not find that Dr. Huerto intended to profit from the charges assessed for these medications, we did find that there was an instance of unbecoming, improper, unprofessional or discreditable conduct in relation to the composition and presentation of the account given to the [redacted] family.

Charge 5: Invoice with respect to Synvisc

As the committee concluded that Synvisc had not been injected, we found that this charge was established.

Charge 5A: Falsification of medical records of [redacted]

1. Falsification of hand-written notes

The committee upheld this part of the charge.

2. Falsification of typed transcripts

The committee upheld this part of the charge.

3. Removal of medication list from file

The committee upheld this part of the charge.

Charge 6: Failing to arrange appropriate medical treatment for [redacted]

The committee found that this charge was not established.

Charge 7: Treatment of [redacted] **on June 5, 1997**

a. Failing to transport to hospital without delay

We found that this aspect of the charge was not established.

b. Provision of aggressive treatment, including Lasix, morphine, aminophylline, sodium bicarbonate and dopamine

The committee found that this part of Charge 7 was not established.

c. Prescription of aminophylline and sodium bicarbonate

The committee found that this part of the charge was not established.

d. Advising the family of Mr. [redacted] **that he was in stable condition**

The committee found that this part of the charge was established.

Charge 8: Treatment of [redacted]

a. Not arranging for treatment in hospital

The committee found that this part of the charge was not

established.

b. Treatment with Primacor (milrinone) outside hospital

The committee found that this part of the charge was not established.

c. Treatment with Primacor (milrinone) outside the standards of the profession

The committee upheld this part of the charge.

d. Treatment with thrombolytic therapy

We found that this aspect of Charge 8 was established.

f. [sic] Prescription of certain drugs

i. Adalat (nifedipine)

We found that this aspect of the charge was not established.

ii. Lescol (fluvastatin sodium)

We found that this aspect of the charge was not established.

iii., iv., v. Primacor (milrinone), Streptokinase, rtPA

The committee referred to earlier parts of the decision.

vi. Norvasc (amlodipine besylate)

We found that this part of the charge was not established.

vii., viii. Morphine, MS Contin

We found that this aspect of the charge was not established.

ix. Digoxin (injectible)

We found that this aspect of the charge was not established.

x. Gentamycin

We found that this aspect of the charge was not established.

g. Erroneous ECG interpretations

We found that this aspect of Charge 8 was not established.

Charge 9: Excessive charges for IV circulatory support

The committee found that this charge had not been established.

Charge 10: Failure to provide information for informed decision

The committee found that this charge had been established.

Charge 11: Dispensing narcotics without prescription

The committee found that this charge was not established.

Charge 12: Writing prescription for narcotics without intention that [redacted] should receive the medications

The committee found that this charge should be upheld.

Charge 13: Failing to alert the administrator under *The Vehicles Administration Act* to the dangers associated with the condition of [redacted]

The committee found that this charge had been established.

Charge 14: Failing to maintain proper medical records

The committee found that this charge was established.

PENALTY

Counsel for the College of Physicians and Surgeons, in his argument, urged this committee to make some recommendations concerning the penalty which would be appropriate in the event there are charges which the committee finds to have been well-founded. Although we are aware that any comments we make in this connection are not binding on the Council of the College, which makes the decision as to penalty based on our report, it may be helpful for us to make some observations about the relationship

between the findings we have made and possible penalties.

We have concluded that a number of the charges should be upheld, on the basis of evidence which we found to be clear and compelling. It goes without saying that some of the charges are more serious than others, and that the degree of deviation from the standards of the profession is not uniform. One would expect the appropriate penalty to vary accordingly.

The charges which have been established against Dr. Huerto are not all of the same kind. In some cases, the allegations were addressed to particular instances of conduct on his part; in other cases, the charges were that the treatment he carried out fell outside the standards of the medical profession.

In our view, the most serious of the findings we have made which fall into the latter category are our conclusions that his administration of inotropic therapy (milrinone) and thrombolytic therapy fell outside the standards of the profession.

It is our opinion that a lengthy suspension from practice is warranted in connection with these charges. An interim suspension was ordered by the Council of the College, and Dr. Huerto has been absent from his practice for a considerable length of time already; this should be taken into account in considering the penalty, though the length of suspension up to this point should not necessarily dictate the total period.

In the case of the administration of milrinone therapy by Dr. Huerto, we have drawn a distinction between the question of whether inotropic therapy should ever be used outside a hospital setting, and the actual use by Dr. Huerto of milrinone in the case of Mr. [redacted]. Though we have found that there is respectable support in the medical community for outpatient use of milrinone, we also found that Dr. Huerto administered milrinone to Mr. [redacted] in a way which fell outside the standards of the profession. In the event that the council decides Dr. Huerto should be able to use inotropic therapy in his clinic in the future, we would suggest that certain conditions be attached to this. These would include having the protocol formulated by Dr. Huerto and Professor Heaslip reviewed by medical practitioners experienced in the use of inotropic therapy, as well as requiring a review which would ensure that the administration of milrinone therapy which is carried on in

the clinic is actually consistent with an acceptable protocol.

The charges relating to the treatment of Mr. [redacted] also raised the issue of the administration of thrombolytic therapy by Dr. Huerto. We would suggest that the council prohibit the use of thrombolytic therapy by Dr. Huerto in his clinic, pending the development of some kind of acceptable standards in the medical community for the use of thrombolytics under circumstances similar to the ones which exist at the clinic.

Our review of the many charges laid against Dr. Huerto on this occasion has given us considerable concern about the extent to which he has been practising in isolation from the kind of collegial consultation which we see as an essential component of medical practice, and, in particular, of the practice of medical specialists.

We would recommend that the College consider some strategy for bringing about some way in which Dr. Huerto could be given the benefit of access to this body of collegial support and guidance. As we have pointed out, though the choice to practise outside a hospital setting is not objectionable in itself, there is a vast difference between the kind of clinical setting in which Dr. Hughes, for example, carries out his practice, and that exemplified by Dr. Huerto's clinic, in which he must rely exclusively on his own medical judgment, and where he has virtually no expert staff. It is our view that consideration should be given to finding some mechanism for improving the level of consultation between Dr. Huerto and other medical specialists.

As an aside - and acknowledging that such advice lies entirely outside our mandate - we would urge the College to consider formulating standards for the operation of stand-alone clinics of the kind operated by Dr. Huerto, as it is likely that this model of medical care will become more, not less, widespread as changes occur in the general system for the delivery of medical care.

The most serious of the charges relating to the specific conduct of Dr. Huerto is that in which it is alleged that he falsified the medical records of [redacted]. In upholding this charge, and at other points in our decision, we have emphasized the importance of accurate medical records, and the seriousness of deviating from strict and meticulous honesty in compiling and maintaining the

records. We think this conduct should be included as one of the matters justifying a period of suspension from practice. As with the charges which concerned the administration of inotropic and thrombolytic therapy, we recognize that the period for which Dr. Huerto has already been suspended from his practice should be taken into account.

With respect to the remaining charges, such as that pertaining to the advice given to the [redacted] family at the Royal University Hospital, or the failure to report Mr. [redacted] under *The Vehicles Administration Act*, we think they warrant a reprimand or warning.

We hope these comments will be of some assistance to the College in deciding on the penalties which should be imposed on Dr. Huerto in respect of the charges we have been asked to consider.

DATED the 24th day of January, 2000.

Beth Bilson

Beth Bilson, Chair

Brenda Hookenson

Dr. Brenda Hookenson

K. Ogle MD, CCFP

Dr. Keith Ogle