

# **INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO**

*In the matter of the Public Inquiries Act, R.S.O. 1990, c. P.41*

*And in the matter of Order-in-Council 826/2007 and the  
Commission issued effective April 25, 2007, appointing the  
Honourable Stephen Goudge as a Commissioner*

## **WRITTEN SUBMISSIONS OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

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# TABLE OF CONTENTS

<b>I.</b>	<b>OVERVIEW .....</b>	<b>1</b>
<b>II.</b>	<b>SYSTEMIC ISSUES .....</b>	<b>3</b>
	ISSUE #1: QUALIFICATIONS REQUIRED TO PRACTICE FORENSIC PEDIATRIC PATHOLOGY IN ONTARIO .....	3
	<i>Problem Identified re: Systemic Issue #1 .....</i>	5
	<i>Evidence re: Qualifications of Forensic Pathologists .....</i>	5
	<i>Recommendation #1 .....</i>	10
	ISSUE #2: CPSO'S ABILITY TO INVESTIGATE AND ADDRESS CONCERNS RAISED ABOUT PEDIATRIC FORENSIC PATHOLOGISTS' PRACTICE.....	10
	<i>Problems Identified re: Systemic Issue #2: .....</i>	13
	(1) Lack of Information Sharing .....	13
	Failure to Report Clinical Concerns to the CPSO.....	13
	Legislation .....	14
	Evidence re: HSC's Failure to Share Concerns with CPSO.....	18
	Evidence re: OCCO's Failure to Report Concerns to CPSO.....	23
	Failure of Police to Share Information with CPSO.....	28
	Failure of HSC and OCCO to Share Information with Each Other .....	29
	Reluctance of Other Physicians to Share Information with Professional Regulatory Body.....	30
	Significance of Physicians' Reluctance to Report .....	31
	<i>Recommendation #2 .....</i>	32
	<i>Recommendation #3 .....</i>	32
	(2) CPSO's Use of and Access to Expertise in Forensic Pathology .....	32
	<i>Recommendation #4 .....</i>	37
	ISSUE #3: MAINTAINING STANDARD OF PRACTICE.....	37
	<i>Problem Identified re: Systemic Issue #3: .....</i>	37
	Registry for Pathologists Available to Perform Coroner's Cases.....	37
	<i>Recommendation #5: .....</i>	38
	Standards and Guidelines .....	38
	<i>Recommendation #6: .....</i>	39
<b>III.</b>	<b>FACTUAL FINDINGS REQUESTED.....</b>	<b>39</b>
	CPSO Relinquishes Jurisdiction to OCCO.....	39
	CPSO Assumes Jurisdiction and Investigates Complaints .....	41
<b>IV.</b>	<b>FINAL SUBMISSIONS .....</b>	<b>42</b>
	Final Submissions Regarding Findings of Fact .....	42
	Final Submissions Regarding Regulation and Systemic Issues.....	43
<b>V.</b>	<b>FORMAL SYSTEMIC RECOMMENDATIONS.....</b>	<b>44</b>

## I. OVERVIEW

1. The College of Physicians and Surgeons of Ontario (the “CPSO”) submits that the evidence at the inquiry has raised many systemic issues regarding the regulation of pediatric forensic pathology in Ontario. Those that are most relevant to the CPSO, as the self-regulating body for the medical profession in the Province of Ontario,<sup>1</sup> are as follows:
  - (i) The qualifications required to practice pediatric forensic pathology in Ontario;
  - (ii) The CPSO’s ability to investigate and address concerns raised about the practice of pediatric forensic pathology; and
  - (iii) Setting and maintaining standards of practice for pediatric forensic pathology.
2. The CPSO submits that it is best situated to address all of these concerns, as it has the legislative authority to:
  - (i) issue certificates of registration to doctors (through its registration committee),<sup>2</sup> thereby addressing the issue of the appropriate qualifications that should be required to practice pediatric forensic pathology;

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<sup>1</sup> The role and authority of the CPSO is set out in the *Regulated Health Professions Act* S.O. 1991, C. 18, as am. (the “*RHPA*”), the Health Professions Procedural Code which is Schedule 2 to the *RHPA* (the “*HPPC*”) and the *Medicine Act, 1991*, S.O. 1991, C. 30 (the “*Medicine Act*”). This system of self-regulation is based on the premise that the CPSO must act first and foremost in the public interest.

<sup>2</sup> The Registration Committee reviews the applications of physicians who wish to become members of the CPSO, but do not fulfill the requirements for the issuance of a certificate of registration. The Registration Committee is also responsible for the development of policies and regulatory changes pertaining to registration requirements for entry to practice, whether they are for training programs or for independent registration.

- (ii) investigate complaints and other information received (through its complaints committee<sup>3</sup> and executive committee<sup>4</sup>) and discipline doctors (through its discipline committee<sup>5</sup>) who may have committed an act of professional misconduct or displayed incompetence, thereby enabling it to address concerns it receives about the practice of pediatric forensic pathology;
- (iii) monitor and maintain standards of practice through peer assessment, education and remediation (through its education and quality assurance committees),<sup>6</sup> thereby maintaining the standards of practice of the profession.<sup>7</sup>

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<sup>3</sup> The Complaints Committee investigates matters and complaints about physicians' practice and conduct, reviewing all relevant records and submission of the physicians. The potential outcomes of a review by the Complaints Committee include taking no further action, cautioning the doctor, directing the doctor to the Quality Assurance Committee where he or she may be assessed and/or required to participate in educational programs, or referring the doctor to the Discipline Committee (CPSO Institutional Report, PFP302481, at p. 11).

<sup>4</sup> The Executive Committee is the body that oversees the administration of the CPSO and also approves investigations of a member's practice where there are allegations of professional misconduct and incompetence (CPSO Institutional Report, PFP302481, at p. 8).

<sup>5</sup> The Discipline Committee hears matters of alleged professional misconduct or incompetence. A discipline panel is comprised of at least three members, at least two members must be public members and one must be a physician member of Council. There are two routes by which a matter may come before the discipline committee: a referral by the complaints committee or a referral by the executive committee. The complaints committee route is used when a formal complaint has been filed. The executive committee route is used whenever allegations of professional misconduct or incompetence come to the attention of that committee. The discipline committee can make a variety of orders including the revocation or suspension of the physician's certificate of registration or the imposition of specified terms, conditions or limitations on the physician's certificate (CPSO Institutional Report, PFP302481, at p. 8).

<sup>6</sup> The Quality Assurance Committee develops, establishes and maintains programs and standards of practice to assure the quality of practice of the profession, and standards of knowledge and skill, and programs to promote continuing competence among physicians (CPSO Institutional Report, PFP302481, at pp. 10-11).

<sup>7</sup> Under Bill 171, the powers of the new Inquires, Complaints and Reports Committee ("ICR Committee"), that will replace the CC and EC committees, will expand to enable that Committee to require education and remediation, a power that neither the Executive nor the Complaints Committee currently has. The new legislation will be in force no later than June 2009.

## II. SYSTEMIC ISSUES

### ***Issue #1: Qualifications Required to Practice Forensic Pediatric Pathology in Ontario***

3. All doctors in Ontario must be members of the CPSO in order to practice medicine in the province.<sup>8</sup> The CPSO regulates all physicians in Ontario regardless of their specialty, including physicians engaged in work outside the traditional doctor/patient relationship, such as physicians engaged in research, academics, administration, those providing expert testimony, and those who conduct various types of assessments (e.g. custody and psychiatric assessments and independent medical examinations), and the coroners and pathologists who provide services to the Office of the Chief Coroner for Ontario (“OCCO”).
4. A certificate of registration for Independent Practice authorizes the holder to engage in independent, unsupervised medical practice, subject to the terms, condition and limitation that the holder of the certificate only practise in the areas in which he or she is educated and experienced.<sup>9</sup> The CPSO is moving forward on its initiative to issue scope specific certificates of registration that specifically restrict physicians from practising outside of the speciality in which they are trained.
5. As noted in the CPSO’s Institutional Report,<sup>10</sup> the Royal College of Physicians and Surgeons of Canada (the “RCPSC”) provides accreditation for specialties such as Pathology. The RCPSC is the national examining and certifying body for medical specialists in Canada and also accredits Canadian specialty training programs. Access to

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<sup>8</sup> CPSO Website ([http://www.cpso.on.ca/About\\_the\\_CPSO/geninfo.htm](http://www.cpso.on.ca/About_the_CPSO/geninfo.htm)), *Medicine Act*, s.9

<sup>9</sup> *Ibid.*

<sup>10</sup> PFP302481 at pp. 12 -13.

the RCPSC examinations is gained through completion of an RCPSC-accredited residency program in Canada or through completion of an RCPSC-recognized residency program in the United States. Limited access is available through completion of certain international specialty training programs that have been previously assessed and approved by the RCPSC.<sup>11</sup>

6. Physicians may receive accreditation from the RCPSC in areas including anatomical pathology, general pathology and neuropathology.<sup>12</sup> Forensic pathology was officially recognized by the RCPSC as a one-year subspecialty of anatomical or general pathology in September 2003 but no programs in forensic pathology have yet been accredited.<sup>13</sup> The RCPSC is to begin this program this year.

7. The CPSO will recognize as specialists those physicians who:

- a) are certified by the RCPSC in the specialty they are practising; or
- b) have trained in a RCPSC program, practised as an uncertified specialist for the prescribed period, participated in a relevant CPSO assessment and successfully completed it at their own expense; or
- c) have specialty training and hold certification as a specialist from the recognized specialty certifying body of another country and meet five other criteria set out in the CPSO policy.<sup>14</sup>

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<sup>11</sup> The CPSO Council criteria for specialist recognition is set out in a policy entitled "Recognition of Non-Family Medicine Specialists." CPSO Website ([http://www.cpso.on.ca/Info\\_physicians/applicants/regist.htm](http://www.cpso.on.ca/Info_physicians/applicants/regist.htm))

<sup>12</sup> RCPSC Website ([http://rcpsc.medical.org/residency/accreditation/arps/arp\\_e.php](http://rcpsc.medical.org/residency/accreditation/arps/arp_e.php))

<sup>13</sup> RCPSC Website ([http://rcpsc.medical.org/residency/accreditation/arps/forensic\\_e.php](http://rcpsc.medical.org/residency/accreditation/arps/forensic_e.php))

<sup>14</sup> CPSO Website ([http://www.cpso.on.ca/Info\\_physicians/regpol/nonfamspec.htm](http://www.cpso.on.ca/Info_physicians/regpol/nonfamspec.htm))

***Problem Identified re: Systemic Issue #1***

8. There is little consensus as to the appropriate qualifications for physicians to practice pediatric forensic pathology safely and effectively.

***Evidence re: Qualifications of Forensic Pathologists***

9. The Inquiry heard evidence regarding the qualifications and training which is available for those Pathologists wishing to practice forensic or, more specifically, pediatric forensic pathology in Ontario. In particular:

- The RCPSC provides for certification in anatomical pathology and general pathology. Recently the RCPSC has identified forensic pathology as a subspecialty after certification in either of anatomical or general pathology. However, no one in Canada, to date, has obtained this subspecialty designation.<sup>15</sup>
- Most forensic pathologists in Commonwealth countries therefore write the examination from the Society of Apothecaries in the United Kingdom. That is the standard path for forensic pathology qualification for certification for the Commonwealth countries. This certification is called the Diploma in Medical Jurisprudence in Pathology (the “DMJ path”).<sup>16</sup>
- This route involves training in recognized centres and a process of examination which includes written tests, the formation of a case book, an oral examination and finally the performance of an autopsy in front of examiners.<sup>17</sup>

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<sup>15</sup> Evidence of Dr. Pollanen, 11/12/2007, p. 45, lines 10 to 25; and p. 46, lines 1 to 6.

<sup>16</sup> Evidence of Dr. Pollanen, 11/12/2007, p. 46, lines 13 to 22.

<sup>17</sup> Evidence of Dr. Pollanen, 11/12/2007, p. 46, lines 23 to 25; and p. 47, lines 1 to 8.

10. With respect to training in forensic pathology in other jurisdictions, the Inquiry heard that:

- In England and Wales one can obtain specialty qualification in forensic pathology either by: a) training first in histopathology (anatomic pathology) and then obtaining a recognized diploma in forensic pathology (from the Worshipful Society of Apothecaries or the Royal College of Pathologists); or b) training first in histopathology and then obtaining membership in the Royal College of Pathologists in forensic pathology.<sup>18</sup> One must spend at least six months in each of pediatric pathology and neuropathology during training.<sup>19</sup>
- In Finland forensic medicine has been a specialty since 1955. It consists of five years of training. This includes three and a half years spent in specific training at the Department of Forensic Medicine, a minimum of six months at the Department of Histopathology, nine months of general practice and the rest in different other specialties (e.g. internal medicine, surgery).<sup>20</sup>
- To become board certified in forensic pathology in the United States a minimum of four years of training is required (this would consist of a combined certification program).<sup>21</sup> One would combine anatomical and clinical pathology (which has rotations through the standard areas in clinical pathology, microbiology, immunology etc.) and then completing one forensic year. Alternatively, one can complete a combined program of two years

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<sup>18</sup> Evidence of Dr. Milroy, 11/19/07, p. 9 to 10.

<sup>19</sup> Evidence of Dr. Milroy, 11/19/07, p. 10, line 25; and p. 11, lines 1 to 21.

<sup>20</sup> Evidence of Dr. Saukko, 12/12/07, p. 24, lines 23 to 25; and p. 25, lines 1 to 13.

<sup>21</sup> Evidence of Dr. Hanzlick, 2/11/2008, p. 14, lines 19 to 25; and p. 15, lines 1 to 3.



anatomic pathology, one year in a specialty area (such as toxicology) and then a year of forensic pathology.<sup>22</sup> Since 1999, all training must be completed in an Accreditation Council on Graduate Medical Education Accredited program. Accreditation means that a training program is required to meet specific criteria to become accredited, so that accredited programs have common training goals and objectives and meet minimum standards as evaluated by a formal inspection.<sup>23</sup>

11. More importantly perhaps, the Inquiry heard significant evidence regarding the current training of those practicing forensic pathology or pediatric forensic pathology in Ontario, and what would be recommended as the most appropriate qualifications and training. In particular:

- Currently across the province, out of 190 pathologists who perform autopsies for the OCCO, there are only twenty-five pathologists completing autopsies in homicide and criminally suspicious cases.<sup>24</sup> Not all of these pathologists have formal training in forensic pathology.<sup>25</sup>
- There are two elements to formal training in forensic pathology, the training (which is usually vocational experiential) and the certification. Dr. Pollanen's view is that both are very important. The issue right now is that there are some people who may take the training but elect not to sit the examinations.<sup>26</sup>

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<sup>22</sup> Evidence of Dr. Hanzlick, 2/11/2008, p. 102, lines 20 to 25; p. 103, lines 1 to 16.

<sup>23</sup> R. Hanzlick, "Options for Modernizing the Ontario Coroner System" (November 12, 2007) at pp. 7-8.

<sup>24</sup> Evidence of Dr. Pollanen, 11/12/2007, p. 83, lines 5 to 25; and p. 84, lines 1 to 19.

<sup>25</sup> Evidence of Dr. Pollanen, 11/12/2007, p. 241, line 25; and p. 242, lines 1 to 8.

<sup>26</sup> Evidence of Dr. Pollanen, 11/12/2007, p. 242, lines 8 to 25.

- Dr. Pollanen prepared a document entitled “Review of the Pediatric Forensic Pathology Overview Reports: Ten Systemic Issues.”<sup>27</sup> One of the issues set out in that document was the absence of specialized education, standards and certification in forensic pathology in Canada<sup>28</sup>:

Canadian forensic pathology has been neglected for decades. The national development of forensic pathology has been hampered by the lack of action by Faculties of Medicine in Canadian Universities, the RCPSC and the Canadian Association of Pathologists.<sup>29</sup>

- In Dr. Pollanen’s view, Canada has lagged behind about forty years in comparison to other jurisdictions and this has had a ripple effect throughout the system. Lack of certification encourages different mechanisms to develop within systems to fill in the gaps (including for example, being self taught or developing informal networks of training).<sup>30</sup> Self-taught sub-specialists have a higher chance of getting into difficulties with misdiagnosis compared to a sub-specialist who is trained and certified.<sup>31</sup> In his view, the system may produce isolated highly competent forensic pathologists, but it is hardly a systemic approach to education and certification or a commitment to professional quality.<sup>32</sup> Dr. Pollanen suspects that there are many people who would have opted for training and examination had it been available domestically. This is improving because next summer RCPSC will have training programs and an exam in forensic pathology.<sup>33</sup>

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<sup>27</sup> PFP301189.

<sup>28</sup> PFP301189 at p. 1.

<sup>29</sup> PFP301189 at p. 2.

<sup>30</sup> Evidence of Dr. Pollanen, 12/5/2007, p. 14, lines 6 to 23.

<sup>31</sup> Evidence of Dr. Pollanen, 12/6/2007, p. 44, lines 20 to 25.

<sup>32</sup> Evidence of Dr. Pollanen, 12/5/2007, p. 14, lines 24 to 25; and p. 15, lines 1 to 7.

<sup>33</sup> Evidence of Dr. Pollanen, 11/12/2007, p. 243, lines 1 to 11.

- Dr. McLellan's notes that pediatric forensic pathology is currently done by a combination of forensic pathologists who have pediatric knowledge and experience and pediatric pathologists who have some additional forensic knowledge or training. He expects in the future, because of the number of pathologists, it will be dealt with by a combination of the two.<sup>34</sup>
- However, for cases involving homicide and criminally suspicious matters, Dr. Pollanen favours the forensic approach because it forms a better framework or structure upon which to deal with issues related to the violent death of children.<sup>35</sup> Dr. McLellan testified that a forensic pathologist should be involved because they have the most expertise in dealing with that kind of case.<sup>36</sup> In his view, the best match for a homicide or criminally suspicious case is the forensic pathologist who has additional pediatric expertise.<sup>37</sup>
- Specialized training in pediatric pathology prior to commencing pediatric forensic cases may be helpful in some cases but there is a very large spectrum from cases that are clearly homicidal to those that are natural or undetermined.<sup>38</sup> One approach that's been used in the United Kingdom and to some extent Australia, is a hybridization of the two approaches where the autopsy is done essentially by two pathologists collaborating together.<sup>39</sup> Dr. Pollanen feels that there are many benefits to double doctoring. It allows both

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<sup>34</sup> Evidence of Dr. McLellan, 11/14/2007, p. 148, lines 1 to 9.

<sup>35</sup> Evidence of Dr. Pollanen, 11/12/2007, p. 243, lines 12 to 25; and p. 244, lines 1 to 11.

<sup>36</sup> Evidence of Dr. McLellan, 11/14/2007, p. 148, lines 9 to 16.

<sup>37</sup> Evidence of Dr. McLellan, 11/14/2007, p. 148, lines 17 to 25; and p. 149, lines 1 to 4.

<sup>38</sup> Evidence of Dr. Pollanen, 11/13/2007, p. 7, lines 7 to 25; and p. 8, lines 1 to 7.

<sup>39</sup> Evidence of Dr. Pollanen, 11/13/2007, p. 8, lines 8 to 25; and p. 9, lines 1 to 12.

perspectives to come out in the first instance and is a good way of navigating pitfalls and ensuring completeness of examination.<sup>40</sup>

- A special course has been developed, and held on two occasions, focusing on expert testimony for pathology experts emphasizing the importance of balanced and fair testimony. It includes mock-examination and cross-examination.<sup>41</sup>

### ***Recommendation #1***

12. **Specified education, training and certification should be required to ensure the safe and effective practice of pediatric forensic pathology. The CPSO should participate with other interested parties to determine what should be required, and endeavour to implement any recommendations from this Honourable Commission in this regard.**

### ***Issue #2: CPSO's Ability to Investigate and Address Concerns Raised about Pediatric Forensic Pathologists' Practice***

13. In its role as the self-governing body for all physicians in Ontario, the CPSO is uniquely situated to investigate and adjudicate all matters of physician regulation. In fulfilling its mandate of public protection, the CPSO is not as hindered by internal resource considerations, such as those mentioned by the OCCO and HSC in this case.
14. The CPSO exercises its oversight of physicians, including coroners and pathologists, both in response to formal complaints and in response to information received from other sources.

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<sup>40</sup> Evidence of Dr. McLellan, 11/14/2007, p. 149, lines 22 to 25; and p. 150, lines 1 to 8.

<sup>41</sup> Evidence of Dr. McLellan, 11/14/2007, p. 120, lines 22 to 25; and p. 121, lines 1 to 9.

15. The Executive Committee, with the authority provided to it under s. 75 of the *Health Professions Procedural Code*, which is Schedule 2 to the *Regulated Health Professions Act*<sup>42</sup>, routinely approves broad-based investigations into a physician's entire practice. These investigations are conducted pursuant to the authority set out in s. 75(a) of the HPPC. It also routinely refers such members to the discipline committee on the basis of these investigations. Section 75(1)(a) investigations may be initiated on the basis of information provided to the Executive Committee from the Registrar, the Complaints

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<sup>42</sup> Section 75 of the HPPC reads as follows:

75. The Registrar may appoint one or more investigators to determine whether a member has committed an act of professional misconduct or is incompetent if,
- (a) the Registrar believes on reasonable and probable grounds that the member has committed an act of professional misconduct or is incompetent and the Executive Committee approves of the appointment;
  - (b) the Executive Committee has received a report from the Quality Assurance Committee with respect to the member and has requested the Registrar to conduct an investigation; or
  - (c) the Complaints Committee has received a written complaint about the member and has requested the Registrar to conduct an investigation.

Effective June 4, 2009, the section will read as follows:

75. (1) The Registrar may appoint one or more investigators to determine whether a member has committed an act of professional misconduct or is incompetent if,
- (a) the Registrar believes on reasonable and probable grounds that the member has committed an act of professional misconduct or is incompetent and the Inquiries, Complaints and Reports Committee approves of the appointment;
  - (b) the Inquiries, Complaints and Reports Committee has received information about a member from the Quality Assurance Committee under paragraph 4 of subsection 80.2 (1) and has requested the Registrar to conduct an investigation; or
  - (c) the Inquiries, Complaints and Reports Committee has received a written complaint about the member and has requested the Registrar to conduct an investigation.

#### **Emergencies**

- (2) The Registrar may appoint an investigator if,
  - (a) the Registrar believes on reasonable and probable grounds that the conduct of the member exposes or is likely to expose his or her patients to harm or injury, and that the investigator should be appointed immediately; and
  - (b) there is not time to seek approval from the Inquiries, Complaints and Reports Committee.

#### **Report**

- (3) Where an investigator has been appointed under subsection (2), the Registrar shall report the appointment of the investigator to the Inquiries, Complaints and Reports Committee within five days.

Committee, or from Quality Assurance Committee. However other sources that lead to investigations under s. 75 of the HPPC and consequent referrals include hospital reports and reports from colleagues, administrators and other health professionals. The CPSO may even act upon anonymous and media reports.

16. Since the CPSO's jurisdiction is, under the legislation, only partly complaint-based, the more information the CPSO obtains, for instance through hospital reports and coroners reporting problematic cases, the more likely it is to be able to commence a broad based investigation under s. 75(1)(a) instead of a complaints investigation (which will have narrower options for referrals).
17. Since 2001, the CPSO has increased the number of investigations undertaken under s. 75(a)<sup>43</sup>:

<b>New</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Registrar's Investigations	27	25	41	66	36	62	123

<b>Disposed</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Registrar's Investigations EC Decisions	61	66	75	73	74	79	101

18. Had the CPSO received notice of the concerns from both the HSC and the OCCO back in the mid to late 1990's regarding Dr. Smith, in addition to the three complaints it received in the [REDACTED] Gagnon and Waudby cases, it would likely have sought to conduct an investigation under s. 75(a) of the HPPC. Today it would certainly do so.

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<sup>43</sup> stats not kept prior to 2001

***Problems Identified re: Systemic Issue #2:***

1. Lack of information sharing with CPSO and between other bodies;
2. CPSO use of and access to expertise in forensic pathology.

**1) Lack of Information Sharing**

*Failure to Report Clinical Concerns to the CPSO*

19. The CPSO has experienced what appears to be a general trend against reporting. In a recent arbitration agreement between a physician and an Ontario hospital, the physician was provided with an opportunity to “voluntarily resign” so that reporting to the CPSO was not necessary, failing which his privileges would be terminated.
20. The evidence provided to the Inquiry has further highlighted the hesitancy of members to report behaviour – even when it is arguably egregious. This specific evidence is discussed in further detail below.
21. The CPSO cannot determine the exact extent to which failure to report occurs - though it appears to be quite pervasive. It also appears as though rigorous negotiations occur at the hospital level between hospital counsel and physician counsel to negotiate a quiet departure from a hospital in exchange for not reporting to the CPSO. That doctor then moves to another hospital and puts patients at risk. That is contrary, if not to the letter of the law, than to the spirit of it and is clearly not in the public interest.<sup>44</sup>
22. It was clear from the testimony heard by the Commissioner that many bodies that had long-standing concerns about Dr. Smith and were aware of deficiencies in his work.

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<sup>44</sup> Evidence of Dr. Gerace, 2/20/2008, p. 56, lines 13 to 25; and p. 57, lines 1 to 19.

Other than the complaints received from individual family members, however, the CPSO was not advised of any of these concerns.

23. One shortcoming of a complaints-based system is articulated in the paper prepared by Professor Sossin for the Inquiry. He states as follows: "... it may be challenging for an aggrieved party has the requisite knowledge and disclosure to have the basis for a complaint."<sup>45</sup> The CPSO can and does act on information it receives from various sources that possess this knowledge including hospitals, colleagues, administrators and other health professionals. It is therefore of the utmost importance that there is good communication between these entities and the CPSO as well as strict adherence to both legislative and professional reporting requirements.

### *Legislation*

24. As set out above under Part I under the Section entitled "CPSO's Powers of Investigation" the CPSO can investigate and act upon matters which it becomes aware of through reports from its members, other institutions, hospitals, the media, the public or otherwise. Currently, reporting to the CPSO regarding clinical concerns is legislatively imposed by law through two statutes, the *Public Hospitals Act* and the *Regulated Health Professions Act*. The relevant sections of these Acts (including all impending amendments) are set out below:

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**Public Hospitals Act, R.S.O. 1990, CHAPTER P.40**

**Notice to college of disciplinary action against physician**

**33. Where,**

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<sup>45</sup> L. Sossin, "Accountability and Oversight for death Investigations in Ontario" (January 20, 2008) at p. 30.



- (a) the application of a physician for appointment or reappointment to a medical staff of a hospital is rejected by reason of his or her incompetence, negligence or misconduct;
- (b) the privileges of a member of a medical staff of a hospital are restricted or cancelled by reason of his or her incompetence, negligence or misconduct; or
- (c) a physician voluntarily or involuntarily resigns from a medical staff of a hospital during the course of an investigation into his or her competence, negligence or conduct,

the administrator of such hospital shall prepare and forward a detailed report to The College of Physicians and Surgeons of Ontario. R.S.O. 1990, c. P.40, s. 33.

**Regulated Health Professions Act, S.O. 1991, c. 18, as amended**

**Reporting by employers, etc.**

**85.5** (1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges of a member or who dissolves a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Registrar within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons. 1993, c. 37, s. 23; 2000, c. 42, Sched., s. 36.

**Same**

(2) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the Registrar within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act. 1993, c. 37, s. 23.

**Application**

(3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services. 1993, c. 37, s. 23.

**Immunity for reports**

**85.6** No action or other proceeding shall be instituted against a person for filing a report in good faith under section 85.1, 85.2, 85.4 or 85.5. 1993, c. 37, s. 23.

**Note: Effective June 4, 2009 or on an earlier day to be named by proclamation of the Lieutenant Governor, Schedule 2 is amended by the Statutes of Ontario, 2007, chapter 10, Schedule M, section 63 by adding the following sections:**

**Reporting by members re: offences**

**85.6.1** (1) A member shall file a report in writing if the member has been found guilty of an offence. 2007, c. 10, Sched. M, s. 63.

**Timing of report**

(2) The report must be filed as soon as reasonably practicable after the member receives notice of the finding of guilt. 2007, c. 10, Sched. M, s. 63.

**Contents of report**

(3) The report must contain,

- (a) the name of the member filing the report;

- (b) the nature of, and a description of the offence;
- (c) the date the member was found guilty of the offence;
- (d) the name and location of the court that found the member guilty of the offence; and
- (e) the status of any appeal initiated respecting the finding of guilt. 2007, c. 10, Sched. M, s. 63.

**Publication ban**

- (4) The report shall not contain any information that violates a publication ban. 2007, c. 10, Sched. M, s. 63.

**Same**

- (5) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban. 2007, c. 10, Sched. M, s. 63.

**Additional reports**

- (6) A member who files a report under subsection (1) shall file an additional report if there is a change in status of the finding of guilt as the result of an appeal. 2007, c. 10, Sched. M, s. 63.

**Reporting by members re: professional negligence and malpractice**

- 85.6.2** (1) A member shall file a report in writing if there has been a finding of professional negligence or malpractice made against the member. 2007, c. 10, Sched. M, s. 63.

**Timing of report**

- (2) The report must be filed as soon as reasonably practicable after the member receives notice of the finding made against the member. 2007, c. 10, Sched. M, s. 63.

**Contents of report**

- (3) The report must contain,
- (a) the name of the member filing the report;
  - (b) the nature of, and a description of the finding;
  - (c) the date that the finding was made against the member;
  - (d) the name and location of the court that made the finding against the member; and
  - (e) the status of any appeal initiated respecting the finding made against the member. 2007, c. 10, Sched. M, s. 63.

**Publication ban**

- (4) The report shall not contain any information that violates a publication ban. 2007, c. 10, Sched. M, s. 63.

**Same**

- (5) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban. 2007, c. 10, Sched. M, s. 63.

**Additional reports**

(6) A member who files a report under subsection (1) shall file an additional report if there is a change in status of the finding made against the member as the result of an appeal. 2007, c. 10, Sched. M, s. 63.

**See: 2007, c. 10, Sched. M, ss. 63, 75 (1).**

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25. There is statutory mandatory reporting of sexual abuse in the HPPC, as follows:

**Regulated Health Professions Act, 1991, S.O. 1991, c. 18**

**Reporting by members**

**85.1** (1) A member shall file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient.

**Reporting by facilities**

**85.2** (1) A person who operates a facility where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds to believe that a member who practises at the facility has sexually abused a patient. 1993, c. 37, s. 23.

Note: Effective June 4, 2009 or on an earlier day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule M, section 61 by striking out "has sexually abused a patient" at the end and substituting "is incompetent, incapacitated, or has sexually abused a patient". See: 2007, c. 10, Sched. M, ss. 61, 75 (1).

26. In April, 2007 the Health Professions Regulatory Advisory Council ("HPRAC") submitted certain recommendations to the Minister of Health and Long-Term Care in response to his request for advice with respect to the regulation of health professions under the *RHPA*. HPRAC recommended various changes to the legislation including that mandatory reporting of professional misconduct, incompetence or incapacity (in addition to sexual abuse) be added to ss. 85.1 (Reporting by Members) and 85.2 (Reporting of Facilities) of the HPPC. The CPSO supported the broadening of the requirement of the mandatory reporting of sexual abuse to include incapacity and incompetence. As set out

above, the proposed amendment in this regard was accepted only for s. 85.2, so that mandatory reporting of incompetence is now required for facilities.

*Evidence re: HSC's Failure to Share Concerns with CPSO*

27. The evidence at the Inquiry established that HSC had information regarding significant concerns with Dr. Smith both with respect to his pediatric forensic and surgical pathology practices, but failed to share this information with the CPSO.

28. In particular, HSC gave the following evidence:

- There were at least four instances where Dr. Cutz and Dr. Smith disagreed on a post-mortem diagnosis.<sup>46</sup>
- Dr. Thorner testified that Dr. Smith had the longest list of incomplete cases and the ones that were incomplete for the greatest period of time. He had difficulty completing cases in all areas, including surgical cases, hospital autopsies and medicolegal autopsies.<sup>47</sup> His office was generally disorganized and it seemed that he had a problem with the work practice and just how to get down to doing the work.<sup>48</sup> Dr. Becker introduced standard turnaround times of 80 percent completion within four working days with the additional 20 percent which were more complicated, expected to take longer. Dr. Smith did very poorly at meeting these goals whereas most of his colleagues met the goals.<sup>49</sup> In addition, with respect to autopsy cases, Dr. Smith was behind on the expected completion time of 3 months for those cases as

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<sup>46</sup> Evidence of Dr. Cutz, 12/18/2007, p. 89, lines 7 to 25; p. 90 to 92; p. 94 to 98; p. 100 to 106.

<sup>47</sup> Evidence of Dr. Thorner, 1/11/2008, p. 32, lines 15 to 25; and p. 33, lines 1 to 7.

<sup>48</sup> Evidence of Dr. Thorner, 1/11/2008, p. 33, lines 12 to 21.

<sup>49</sup> Evidence of Dr. Thorner, 1/11/2008, p. 34, lines 2 to 25; and p. 35, lines 1 to 19.

well. He was behind on more cases and for longer periods of time than his colleagues.<sup>50</sup> Dr. Smith was also equally slow on medicolegal autopsy reports.<sup>51</sup>

- The ongoing concern about Dr. Smith's backlog of cases and his failure to complete reports on time spanned approximately 8 years (from at least 1995 to 2002). Dr. Thorner found it to be a frustrating problem.<sup>52</sup> There is a relationship between being disorganized (which Dr. Smith was) and late reporting. It is possible that because Dr. Smith was under pressure to catch up on his work he may not have been as thorough as he should have been. Further, a certain length of time between writing a report and reviewing the slides might cause an inaccurate report. There is a relationship between organization and quality of work product.<sup>53</sup> Dr. Becker absolutely understood that disorganization and late reporting could have an impact on patient care.<sup>54</sup>
- After Dr. Taylor returned to HSC in 2003, and at some point prior to July 2004, it was decided by someone above Dr. Taylor, possibly the Vice President or Dr. Phillips who was the acting DPLM Chief, to take Dr. Smith off the autopsy service altogether and have him focus on doing surgical pathology.<sup>55</sup> Dr. Taylor thinks that he was taken off hospital autopsies because of the publicity being generated and to try to "cool things down a little bit."<sup>56</sup> Dr. Taylor had no concerns about Dr. Smith's administrative function as the Director of the OPFPU did find it a bit strange that he would still be in that position if he was not engaged in Coroner's cases. However,

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<sup>50</sup> Evidence of Dr. Thorner, 1/11/2008, p. 35, lines 21 to 25; and p. 36, lines 1 to 9.

<sup>51</sup> Evidence of Dr. Thorner, 1/11/2008, p. 37, lines 3 to 24.

<sup>52</sup> Evidence of Dr. Thorner, 1/11/2008, p. 142, lines 3 to 20.

<sup>53</sup> Evidence of Dr. Thorner, 1/11/2008, p. 142, lines 21 to 25; p. 143; and p. 144, lines 1 to 6.

<sup>54</sup> Evidence of Dr. Thorner, 1/11/2008, p. 145, lines 6 to 15.

<sup>55</sup> Evidence of Dr. Taylor, 12/18/2007, p. 292, lines 8 to 25; p. 293; and p. 294, lines 1 to 18.

<sup>56</sup> Evidence of Dr. Taylor, 12/18/2007, p. 294, lines 21 to 25; and p. 295, line 1.

Dr. Taylor notes that this was not his call at the time.<sup>57</sup> He did speak to the OCCO about the concern he had prior to Dr. Smith's resignation in 2004 and the discussions, with Dr. McLellan, were basically whether Dr. Taylor would be interested in taking over the Directorship.<sup>58</sup>

- Both Dr. Taylor and Dr. Phillips filled out a form, like a reference, with respect to Dr. Smith's application to the College of Physicians and Surgeons of Saskatchewan (the "CPSS") in 2005<sup>59</sup> which stated that they considered Dr. Smith to be reliable, ethical and of good character. Dr. Taylor states that he did have information at the time from the OCCO that would deal directly with Dr. Smith's credibility and that he made mention of that on "the form."<sup>60</sup> It is the CPSO's understanding from Dr. Taylor's counsel that Dr. Taylor was referring to a document dated July 18, 2005 entitled "Request for Confidential Evaluation of Applicant to Saskatoon Health Region Medical-Dental Staff"<sup>61</sup> when he gave this evidence. The only criticism of Dr. Smith contained on this form reads as follows:

"Issues with regards to Dr. Smith having delinquent reports were identified and addressed shortly after I became Division Head of Pathology, two years ago. His report turnaround time was subsequently satisfactory."<sup>62</sup>

...

The College of Physicians and Surgeons investigated some complaints related to Dr. Smith's forensic pathology practice – I believe these have been resolved.<sup>63</sup>

Dr. Taylor then goes on to state as follows:

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<sup>57</sup> Evidence of Dr. Taylor, 12/18/2007, p. 295, lines 6 to 17.

<sup>58</sup> Evidence of Dr. Taylor, 12/18/2007, p. 295, lines 18 to 25; p. 296; and p. 297 lines 1 to 4.

<sup>59</sup> PFP118666 and PFP170426.

<sup>60</sup> Evidence of Dr. Taylor, 12/19/2007, p. 86, lines 14 to 25; and p. 87

<sup>61</sup> PFP170423.

<sup>62</sup> PFP170423 at p. 2.

<sup>63</sup> PFP170423 at p. 3.

Dr. Smith's diagnostic pathology work and abilities related to pediatric pathology have been up to the standard expected by the Hospital for Sick Children ...<sup>64</sup>

- Dr. Taylor agrees that it would have been very useful to have had some kind of bridge between OCCO and HSC where issues could be freely discussed and perhaps acted upon. Sharing of information between the institutions (in both directions) was clearly a problem and Dr. Taylor agrees that there should have been some kind of route for transmission of important information between the two institutions.<sup>65</sup>

29. During cross-examination by the CPSO, HSC acknowledged the following:

- There were concerns with Dr. Smith's surgical pathology and forensic pathology, and about the timeliness of his reports.<sup>66</sup> Some of these concerns were brought up with Dr. Smith in correspondence by the hospital and at rounds but was not shared with the OCCO or the CPSO.<sup>67</sup>
- On July 20, 1995, Dr. Becker wrote a letter to Dr. Smith<sup>68</sup> advising Dr. Smith that he failed to meet departmental standards. This was a significant letter because it related to patient care.<sup>69</sup>
- On April 18, 1997, Dr. Becker wrote Dr. Smith a letter<sup>70</sup> where Dr. Smith was advised his responsibilities would be curtailed. This letter also raised serious concerns about Dr. Smith's work both in terms of the reporting time and the accuracy of his reports. These problems had persisted since 1995, and there was no

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<sup>64</sup> PFP170423 at p. 3

<sup>65</sup> Evidence of Dr. Taylor, 12/19/2007, p. 88, lines 9 to 25; and p. 89, lines 1 to 19.

<sup>66</sup> Evidence of Dr. Taylor, 12/19/2007, p. 160, lines 17 to 25; and p. 162, lines 1 to 14.

<sup>67</sup> Evidence of Dr. Taylor, 12/19/2007, p. 161, lines 15 to 22; p. 162, lines 1 to 10; and p. 175, lines 20 to 25.

<sup>68</sup> PFP137837.

<sup>69</sup> Evidence of Dr. Taylor, 12/19/2007, p. 163, lines 4 to 25; and p. 164, line 1.

<sup>70</sup> PFP137850.

improvement in either reporting time or accuracy of his reports.<sup>71</sup> About this letter

Dr. Chaisson made the following comment:

... I would consider this to be a very serious matter, that the Chief is writing and making ... these indications and ... especially issues of docking salary. I mean, that's ... a very serious degree ... of problem here.<sup>72</sup>

- In the email of March 12, 2002 to Dr. Smith<sup>73</sup> which also dealt with delays in Dr. Smith's reports, he was told by HSC that this represented a fall below the standard of care that was expected at HSC. This demonstrated that the problems with Dr. Smith were still ongoing in, at least, March of 2002.<sup>74</sup>
- As far as both Drs. Cutz and Taylor are aware, the information with respect to Dr. Smith's work at HSC was not shared with the CPSO.<sup>75</sup>
- When Dr. Taylor was asked by the CPSO whether or not he felt that, whatever the legal obligation, there was a professional obligation on the part of HSC to notify the CPSO that they had a physician who had been identified as falling below the standard of practice, he testified as follows:

"Well, notification of the College, in my opinion, is a very serious matter. And - and I'm speaking for myself. I can't speak for Dr. Becker who was the Division Head and Department Chief at that time. *My approach would be to try to rectify the situation as best I can before resorting to calling the Col -- calling the College. And especially in the context of -- of late reports.* [emphasis added]

If the late reports hadn't been impacting upon patient care, meaning that there hadn't been lots of complaints being registered by the families or the Coroner's Office with regards to that, then I may have given it a little bit less -- although it's still an important issue -- less importance than what might be required to call -- contact the College. So, you know, it's a difficult assessment to make. I mean, it's a very serious matter to contact the College.

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<sup>71</sup> Evidence of Dr. Taylor, 12/19/2007, p. 164, lines 17 to 25; and p. 165, lines 1 to 6.

<sup>72</sup> Evidence of Dr. Chaisson, 12/7/2007, p. 169, lines 14 to 25.

<sup>73</sup> PFP137707.

<sup>74</sup> Evidence of Dr. Taylor, 12/19/2007, p. 169, lines 2 to 22.

<sup>75</sup> Evidence of Drs. Taylor and Cutz, 12/19/2007, p. 175, lines 19 to 25.



On the other hand, if I felt, with all the information that was available to me, that the practitioner was dangerous to patients, I would have called the College. I'm not sure -- looking at all of these -- all of these things which we've gone through, especially the surgical side of things, which is something I think that is directly under the responsibility of the Division or Department Head -- whether they require contacting the College.

The issues with regards to late times on the coroner's cases; when it comes down to the bottom line, I think that's an issue with the Office of the Chief Coroner because those reports are being created for the Office of the Chief Coroner under coroner's warrants.

Issues related to hospital autopsy delinquency is another matter, and that comes back to the Chief of the Service.

So I'd have -- you know, I'm kind of walking around this, but it is a bit of a tough call so I'm not sure what I would have done in those circumstances unless I had all of this stuff in front of me.”<sup>76</sup>

### *Evidence re: OCCO's Failure to Report Concerns to CPSO*

30. It is also clear that the OCCO knew of significant problems with the timeliness of Dr. Smith's reports and with his clinical work, but, like HSC, failed to share this information with the CPSO.

31. In particular, OCCO gave the following evidence:

- There were concerns about the timeliness of Dr. Smith's reports going back as far as 1992 and the OCCO was aware of this fact at least as early as 1994.<sup>77</sup> The concerns about timeliness were being addressed by Dr. Cairns and Dr. Chiasson by meeting with Drs. Becker and Smith.<sup>78</sup> Dr. Young was aware that there were concerns about Dr. Smith's timeliness and responsiveness and would have been aware that Dr. Cairns and Dr. Chiasson were having a series of meetings with Dr. Becker to see what could

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<sup>76</sup> Evidence of Dr. Taylor, 12/19/2007, p. 173, lines 16 to 25; p. 174; and p. 175, lines 1 to 17.

<sup>77</sup> Evidence of Dr. Cairns, 11/26/2007, p. 62, lines 1 to 10; p. 63, lines 14 to 18; and Evidence of Dr. Young, 11/30/2007, p. 46, lines 8 to 19.

<sup>78</sup> Evidence of Dr. Cairns, 11/26/2007, p. 84, lines 11 to 23.

be done about that.<sup>79</sup> Further, Dr. Chaisson testified that he had an ongoing concern about the timeliness of Dr. Smith's reports and that he started to hear about that concern from regional coroners. He also recalls Dr. Wilson writing memos to him indicating major delays in reports of Dr. Smith.<sup>80</sup>

- It would be both unusual<sup>81</sup> and viewed as a serious problem if a pathologist had to be summonsed in order to compel production of a post-mortem report.<sup>82</sup> It came to the OCCO's attention that Dr. Smith did have to be summonsed in order to compel his post-mortem reports.<sup>83</sup>
- By the Spring of 1998, Dr. Cairns was giving advice to the Regional Coroners to seriously consider whether they wanted to give consultations to Dr. Smith in light of the associated significant delays.<sup>84</sup>
- In light of the fact that Dr. Smith's delayed reports were affecting the need for a reasonable trial in a reasonable period of time, the OCCO should have done more sooner to address the problems that it knew about in respect of Dr. Smith's delayed reports.<sup>85</sup>
- When Dr. Young met with Dr. Smith about the Nicholas case in the early Spring of 1999,<sup>86</sup> he expressed concern that Dr. Smith's report in that case had gone too far (the

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<sup>79</sup> Evidence of Dr. Cairns, 11/27/2007, p. 11, lines 5 to 22; and Evidence of Dr. Young, 11/30/2007, p. 46, lines 20 to 25; pg. 47, lines 1 to 7; p. 88, lines 19 to 25; and p. 89, lines 1 to 3.

<sup>80</sup> Evidence of Dr. Chaisson, 12/7/2007, p. 162, lines 16 to 25; and p. 163, lines 1 to 20.

<sup>81</sup> Evidence of Dr. Young, 11/30/2007, p. 54, lines 20 to 25; and p. 55, line 1.

<sup>82</sup> Evidence of Dr. Cairns, 11/26/2007, p. 66, lines 9 to 19.

<sup>83</sup> Evidence of Dr. Cairns, 11/26/2007, p. 217, lines 17 to 25; and p. 218, lines 1 to 10.

<sup>84</sup> Evidence of Dr. Cairns, 11/26/2007, p. 80, lines 4 to 18.

<sup>85</sup> Evidence of Dr. Cairns, 11/26/2007, p. 120, lines 21 to 25; and p. 121, lines 1 to 8.

<sup>86</sup> Evidence of Dr. Young, 11/30/2007, p. 141, lines 17 to 24.

analogy he gave was that of a tree: Dr. Smith was far out on one branch and Dr. Young wanted him hugging the trunk)<sup>87</sup> he discussed the need to document corridor consultations, and he discussed the need for Dr. Smith to improve the timeliness of his reports.<sup>88</sup> Finally, Dr. Young told Dr. Smith that all these things would appear in a memo in the near future.<sup>89</sup> Ultimately, these issues did form the nucleus of the memo produced by the OCCO called “Forensic Pathology Pitfalls.”<sup>90</sup>

- In early January, 2001, Dr. Young and Dr. Cairns met with Dr. Smith and the message to him was, essentially, that he either resign from doing medicolegal autopsies or the OCCO would withdraw his privileges (would not allow him to do anymore autopsies).<sup>91</sup> Dr. Young gave Dr. Smith the option to withdraw and suggested that it was the best thing to do in terms of his long term reputation.<sup>92</sup> Dr. Smith subsequently wrote a letter resigning from medico-legal autopsies<sup>93</sup> within an hour or so.<sup>94</sup>
- Dr. Cairns did not believe any aspect of Dr. Smith’s description of the events surrounding the removal and subsequent handling of the hair in Jenna’s case as Dr. Smith explained it during a meeting attended by Dr. Smith’s wife in the Spring of 2002.<sup>95</sup> After this meeting, he thought that Dr. Smith’s time as a forensic pathologist

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<sup>87</sup> Evidence of Dr. Young, 11/30/2007, p. 143, lines 17 to 25.

<sup>88</sup> Evidence of Dr. Young, 11/30/2007, p. 144, lines 3 to 11.

<sup>89</sup> Evidence of Dr. Young, 11/30/2007, p. 144, lines 11 to 15.

<sup>90</sup> Evidence of Dr. Young, 11/30/2007, p. 144, lines 13 to 20; PFP133660.

<sup>91</sup> Evidence of Dr. Cairns, 11/27/2007, p. 36, lines 11 to 25; and p. 37, lines 1 to 13.

<sup>92</sup> Evidence of Dr. Young, 11/30/2007, p. 204, lines 22 to 25; and p. 205, lines 1 to 11.

<sup>93</sup> PFP127457, Evidence of Dr. Cairns, 11/27/2007, p. 36, lines 17 to 21.

<sup>94</sup> Evidence of Dr. Young, 11/30/2007, p. 205, lines 14 to 19.

<sup>95</sup> Evidence of Dr. Cairns, 11/27/2007, p. 83, p. 84; and p. 91, lines 6 to 13.

“was gone.”<sup>96</sup> Despite this fact, and the fact that the content of the meeting was discussed with other members of the OCCO, nothing changed - Dr. Smith continued to do non-criminally suspicious coroner’s autopsies, continued to sit on the Pediatric Death Review Committee and the Death Under Two Committee and he continued to hold his title as the Director of Ontario’s OPFPU.<sup>97</sup>

- Despite all of the shortcomings of Dr. Smith known to the OCCO, Dr. Cairns testified that it was not until he had the conversation with Dr. Smith in the Spring of 2002 regarding the issues surrounding the hair in Jenna’s case that Dr. Cairns first concluded that some form of disciplinary proceeding should be taken by the CPSO.<sup>98</sup> Likewise, Dr. Young testified that it was at the point when he learned of Dr. Cairn’s meeting with Dr. Smith regarding the hair that he had “no difficulty” with the College being involved and being aware of this matter.<sup>99</sup>
- In April 2004, Dr. Young had an exchange of emails with Dr. Smith about whether or not he would remain in the positions he held on the Committees and as Director of the OPFPU.<sup>100</sup> However, Dr. Young did provide some grace to accommodate the fact that there was an outstanding CPSO proceeding.<sup>101</sup> Dr. Smith actually resigned after Dr. Young left as Chief Coroner in 2004.<sup>102</sup>

32. In addition, the Inquiry heard significant evidence regarding another pathologist practicing in Ottawa (the “Ottawa pathologist”) about whom there were significant

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<sup>96</sup> Evidence of Dr. Cairns, 11/27/2007, p. 91, lines 13 to 19.

<sup>97</sup> Evidence of Dr. Cairns, 11/27/2007, p. 93, lines 4 to 25.

<sup>98</sup> Evidence of Dr. Cairns, 11/27/2007, p. 107, lines 17 to 25; and p. 108, lines 1 to 5.

<sup>99</sup> Evidence of Dr. Young, 11/30/2007, p. 247, lines 7 to 25; and p. 248, line 1.

<sup>100</sup> Evidence of Dr. Young, 12/13/2007, p. 42, lines 19 to 25; and p. 43, lines 1 to 2.

<sup>101</sup> Evidence of Dr. Young, 12/13/2007, p. 43, lines 3 to 14.

<sup>102</sup> Evidence of Dr. Young, 12/13/2007, p. 43, lines 15 to 19.

concerns on the part of Dr. Chaisson and others. These were significant forensic pathology issues and the concerns were about the fundamentals of the forensic pathology the Ottawa pathologist was doing.<sup>103</sup> Dr. Chaisson took several steps in an attempt to address these concerns including meeting with the pathologist, suggesting remedial activities and trying to recruit someone to oversee the Ottawa pathologist's work and act in a supervisory role.<sup>104</sup> Dr. Chaisson also went to some pains to draw these concerns to the attention of the Chief Coroner<sup>105</sup> and was clear to both Dr. Cairns and Dr. Young that the concerns he had were about the fundamentals of forensic pathology being completed by the Ottawa Pathologist.<sup>106</sup> At no time did Dr. Chaisson, Dr. Young, Dr. Cairns or any of the regional coroners notify the CPSO about their concerns regarding the Ottawa Pathologist.<sup>107</sup>

33. It was also clear from the evidence at the Inquiry that resources were a major consideration of the OCCO when dealing with the problematic work of pathologists. Dr. Young testified that one of the main reasons he took the position that the CPSO had no jurisdiction to deal with complaints "about the actions, findings, or opinions of a pathologist acting pursuant to the Coroners Act" was out of a concern about retaining pathologists to do this kind of work.<sup>108</sup> Dr. Cairns also testified that even though Dr. Smith's late reports and unresponsiveness were warning signs, he was "an invaluable resource" and therefore it was considered inappropriate to stop using him.<sup>109</sup> Similarly, the reason Dr. Chaisson did not remove the Ottawa pathologist from doing forensic

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<sup>103</sup> Evidence of Dr. Chaisson, 12/11/2007, p. 168, lines 6 to 20.

<sup>104</sup> Evidence of Dr. Chaisson, 12/11/2007, p. 168, lines 21 to 25; and p. 169, lines 1 to 15.

<sup>105</sup> Evidence of Dr. Chaisson, 12/10/2007, p. 242, lines 7 to 25; and p. 243, line 1.

<sup>106</sup> Evidence of Dr. Chaisson, 12/11/2007, p. 123, lines 6 to 25; and p. 124, line 1.

<sup>107</sup> Evidence of Dr. Chaisson, 12/11/2007, p. 169, lines 16 to 25; and p. 170, lines 1 to 8.

<sup>108</sup> Evidence of Dr. Young, 4/12/1007, p. 180, lines 22 to 35; p. 181; p. 182, line 1; and p. 185, lines 7 to 16.

<sup>109</sup> Evidence of Dr. Cairns, 11/26/2007, p. 93, lines 12 to 25; and p. 94, lines 1 to 5.

pathology altogether was because it would have created a “major human resource problem” and “there was nobody to take up the slack.”<sup>110</sup>

### *Failure of Police to Share Information with CPSO*

34. The Inquiry heard evidence that the Police deliberately gave the CPSO misleading information. Detective Charmley testified that, on January 10, 2002,<sup>111</sup> he told an investigator at the CPSO that (with respect to the Jenna case) to the best of his knowledge, no scrapings or swabs or hair samples were taken.<sup>112</sup> This was despite the fact that Detective Charmley knew that Dr. Smith had retained a hair sample from Jenna’s body. He acknowledged that well prior to his January 2002 conversation with the CPSO’s Investigator he had met with Dr. Smith (on November 15, 2001) and obtained an envelope with “hair from pubic area” written on the outside.<sup>113</sup> Detective Charmley is not sure why he told the investigator that no hair sample was taken but it might have been because it was an issue that they didn’t want public, though he doesn’t remember if it was public or not.<sup>114</sup>

35. On August 9, 2001, Dr. Cairns wrote to the CPSO to advise that the OCCO would not co-operate with the CPSO’s investigation:<sup>115</sup>

“Thank you for your letter of August 3, 2001 requesting a copy of our reports with regards to the death of [Jenna].

For your information, at the present time this case has been re-activated and a further investigation is presently underway. Therefore, I am unable to furnish you with the requested documents until the investigation is completed.

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<sup>110</sup> Evidence of Dr. Chaisson, 12/11/2007, p. 129, lines 12 to 25.

<sup>111</sup> Evidence of Detective Charmley, 1/15/2008, p. 189, lines 11 to 25; and p. 190, lines 1 to 7.

<sup>112</sup> Evidence of Detective Charmley, 1/15/2008, p. 191, lines 15 to 25; and p. 192, line 1.

<sup>113</sup> Evidence of Detective Charmley, 1/15/2008, p. 192; and p. 193, lines 1 to 19.

<sup>114</sup> Evidence of Detective Charmley, 1/15/2008, p. 193, lines 23 to 25; p. 194, and p. 195, lines 1 to 3.

<sup>115</sup> PFP147185.

Please be assured that our reports will be forwarded to you once we have closed the case.”<sup>116</sup>

*Failure of HSC and OCCO to Share Information with Each Other*

36. In addition, the OCCO noted that HSC had not made it aware, until this Inquiry, that HSC also had fairly significant concerns about Dr. Smith’s non-coroner pathology work, and specifically his surgical pathology work.<sup>117</sup> Dr. Cairns testified that this information would have been both relevant<sup>118</sup> and “very very helpful” to the OCCO and noted his disappointment that Dr. Becker hadn’t shared HSC’s concerns about Dr. Smith with the OCCO.<sup>119</sup> This was particularly the case here because the criticism that HSC was leveling dealt with histopathology – an area critical to Dr. Smith’s performance as a forensic pathologist.<sup>120</sup> Such communication would have been helpful regardless of whether or not the HSC correspondence critical of Dr. Smith<sup>121</sup> was actually given to Dr. Smith.<sup>122</sup> Dr. Cairns further testified that the lack of information-sharing between the OCCO and those hospitals employing pathologists doing coroner’s work is a systemic issue that deserves serious consideration by the Commissioner.<sup>123</sup> Similarly, Dr. Chaisson testified that it certainly would have been of interest to know that “... at least in a general way ... there were problems on the clinical side.”<sup>124</sup>

37. HSC testified that the concerns it had with the OCCO were probably considered by Dr. Becker as something not worth reporting to the Coroner. The forensic work and hospital

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<sup>116</sup> Evidence of Elizabeth Doris, 1/16/2008, p. 108, lines 12 to 25; p. 109, lines 1 to 7.

<sup>117</sup> Evidence of Dr. Cairns, 11/26/2007, p. 102, lines 19 to 25; and p. 103, lines 1 to 10.

<sup>118</sup> Evidence of Dr. Cairns, 11/26/2007, p. 108, lines 24 to 25; and p. 109, lines 1 to 5.

<sup>119</sup> Evidence of Dr. Cairns, 11/29/2007, p. 59, lines 16 to 25; and p. 60, lines 1 to 7.

<sup>120</sup> Evidence of Dr. Cairns, 11/29/2007, p. 64, lines 8 to 13; and p. 81, lines 2 to 25.

<sup>121</sup> PFP137850.

<sup>122</sup> Evidence of Dr. Cairns, 11/29/2007, p. 83, lines 6 to 21.

<sup>123</sup> Evidence of Dr. Cairns, 11/26/2007, p. 112, lines 21 to 25; and p. 113, lines 1 to 11.

<sup>124</sup> Evidence of Dr. Chaisson, 12/7/2007, p. 170, lines 1 to 16.

work were separate jobs and Dr. Becker's responsibility was for the hospital and issues that were related to maintaining excellence in patient care. He had no responsibility over the coroner's work which he viewed as a separate job. He probably assumed that was being evaluated by the coroner's office and the impression that Dr. Smith was doing such a good job implied that the problem that Dr. Becker had with Dr. Smith was probably hospital-limited.<sup>125</sup>

### *Reluctance of Other Physicians to Share Information with Professional Regulatory Body*

38. The hesitancy to report concerns about a physician to the professional regulatory body was expressed not only by the physicians who gave evidence on behalf of the OCCO and HSC, but other physicians who gave evidence at the Inquiry. Dr. Cordner, Director of the Victorian Institute of Forensic Medicine in Melbourne, Australia,<sup>126</sup> was asked about reporting to his licensing body. He testified as follows:

MS. CAROLYN SILVER: ... You were discussing with Ms. Rothstein the fact that the licensing body in your jurisdiction is able to deal with concerns about forensic pathologists and you discussed a case.

My question is: If, in the course of doing a review, you find that a forensic pathologist is not meeting the standard of practice, would you notify your regulatory body?

DR. STEPHEN CORDNER: I would, but I have -- as I mentioned in my paper, I've never come across a case where I felt the standard of practice was such that I felt any ethical or professional obligation to blow the whistle.

MS. CAROLYN SILVER: But if you came across that case you would notify the regulatory body?

DR. STEPHEN CORDNER: Yes, and that would be -- well, there's two (2) issues. You're talking about individual cases. I quite often get asked by people, Oh you must have known that so-and-so was incompetent; why didn't you do something about it?

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<sup>125</sup> Evidence of Dr. Thorner, 1/11/2008, p. 167, lines 8 to 25; and p. 168, lines 1 to 17.

<sup>126</sup> Evidence of Dr. Cordner, 2/11/2008, p. 8, lines 14 to 25; and p. 9, lines 1 to 4.



And my usual answer is, and I think it's a fair answer is, Well, look, I don't know enough in detail about a sufficient number of cases to come to a conclusion that a particular individual is incompetent.

Now, it might be the performance in a single case might actually mean that that's a reasonable conclusion and I've never had the experience of that in a single case.

MS. CAROLYN SILVER: But you're saying if you reached that –

DR. STEPHEN CORDNER: Yeah.

MS. CAROLYN SILVER: -- conclusion, ultimately you would notify the licensing body?

DR. STEPHEN CORDNER: Yeah. I'd have an obligation to do so, yes.<sup>127</sup>

39. Even Dr. Pollanen, who acknowledged the CPSO's role in regulating physicians giving testimony in court since this is "within the scope of the professional aspect of what the pathologist does", expressed uncertainty about the OCCO's obligation to report to the CPSO when it receives information about a forensic pathologist, for example, giving perjured evidence in court. He candidly stated "I don't know what our obligations would be in that regard." Later, he acknowledged that while there would be some cases where the OCCO would need to report that to the CPSO, his concern was "that there is no bright line here."<sup>128</sup>

### *Significance of Physicians' Reluctance to Report*

40. The CPSO submits that there is clearly an attitude that notification to a licensing body of behaviour or practice falling below an acceptable standard is "whistle blowing" of a very serious nature and that one should contact the CPSO only as a last resort.

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<sup>127</sup> Evidence of Dr. Corder, 2/13/2008, p. 189, lines 23 to 25; p. 190; and p. 191, lines 1 to 7.

<sup>128</sup> Evidence of Dr. Pollanen, 11/15/2007, p. 112, lines 1 to 12; 12/5/1997, p. 282, lines 21 to 25; p. 283; and p. 284, lines 1 to 17

41. The CPSO submits that although the extreme hesitancy of physicians to report to the CPSO concerns about other physicians is very troubling from a practical point of view, it is nonetheless a strong indicator of the CPSO's status as an objective, professional body which is both capable of and willing to impose serious consequences on physicians when necessary.
42. While the CPSO submits that information sharing with the CPSO has been inadequate in the past, it is hopeful that the impending amendments to the *RHPA*, which require institutions to report incompetence, will assist in addressing this issue.

***Recommendation #2***

43. **Reporting requirements under the *RHPA* must be properly adhered to so that the CPSO receives appropriate information when there are concerns regarding physicians' competence.**

***Recommendation #3***

44. **Policy talks should be instigated between the CPSO, the OCCO, Hospitals, facilities and other bodies not governed by the *RHPA* in an effort to agree on reasonable and practical communication strategies to ensure the CPSO receives appropriate information when there are concerns regarding physicians' competence.**

**(2) CPSO's Use of and Access to Expertise in Forensic Pathology**

45. There was concern expressed at the Inquiry that the CPSO may not be able to retain peer specialists (for forensic pathology in particular, but presumably this would apply to any

specialty).<sup>129</sup> Professor Sossin expressed a concern about the complaints committee obtaining the expertise to deal with complaints against coroners:

“... given the shortage of forensic pathologists, the CPSO may not always have access to expertise it needs to conduct an investigation into misconduct by a coroner or pathologist ...”<sup>130</sup>

46. The CPSO has always been able to obtain the appropriate specialty experts it requires.

While there are certainly times when the retaining of experts is a lengthy and costly endeavour, this does not deter the College from obtaining the requisite expertise. The CPSO always considers the necessity for expertise and, whenever there is a case that raises serious clinical concerns in any discipline, retains well-respected and highly qualified experts to assist it with areas of medicine that members of the panel are not qualified or experienced in.<sup>131</sup>

47. Dr. Gerace noted, in his evidence, that the CPSO frequently faces issues with respect to highly specialized work since the practice of medicine is broad-based and multi-specialty and no single panel is able to know everything about every area in medicine. The CPSO therefore utilizes the profession to provide expertise in a particular subject area. For instance, the CPSO has issues that, not infrequently, involve obstetrical concerns. As such, it has a standing obstetrical panel made up of academics, specialists, community specialists and family doctors engaged in the practice who consider those focused concerns. If there are other, even more specialized areas, the CPSO will go to experts in

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<sup>129</sup> Evidence of Dr. Young, 12/4/2007, p. 182, lines 8 to 25; p. 183 to 185; and p. 186, lines 1 to 7.

<sup>130</sup> L. Sossin, “Accountability and Oversight for death Investigations in Ontario” (February 20, 2008) at p. 30.

<sup>131</sup> Evidence of Dr. Gerace, 2/20/2008, p. 20, lines 15 to 25; p. 21 to 22; and p. 23, lines 1 to 6; see also examples in Appendix A.

the field and, occasionally, with a very small community, it will go outside the jurisdiction to get the expertise required to provide an opinion to the panel.<sup>132</sup>

48. In the cases involving Dr. Smith which were before this Inquiry, once the issue of jurisdiction was settled, the CPSO retained three qualified out of province experts to sit as an independent panel and advise the CPSO Complaints Committee regarding the highly specialized area in which Dr. Smith worked and whether or not his work met the standard of practice.
49. Further, in its current investigation regarding Dr. Smith, the CPSO has retained three experts, Dr. Jack Crane, Dr. Christopher Milroy and Dr. Helen Whitwell to provide an opinion with respect to Dr. Smith's standard of practice and put its own investigation of Dr. Smith on hold at the request of this Commission of Inquiry in order to allow them to first assist the Inquiry.
50. One of the concerns raised during the Inquiry by various individuals and bodies has been that forensic pathology is different than the rest of medicine in that, traditionally, medicine revolves around the patient. In fact, S. Cordner et al., in their paper for the Inquiry entitled "A Model Forensic Pathology Service" at p. 18, states as follows:
- ... Doctors' obligations to patients are central. This culture, imbued during medical training, survives intact through the practice of virtually every branch of medicine, including all the disciplines within pathology, with the exception of forensic pathology. In forensic pathology there is no traditional patient.
51. Although this is true of forensic pathology, it is also true of a long list of other areas within which physicians practice. The CPSO regulates all physicians, regardless of area

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<sup>132</sup> Evidence of Dr. Gerace, 2/20/2008, p. 21, lines 4 to 23; see also examples in Appendix A.

of practice, professional capacity and whether or not there is direct patient contact. The CPSO has jurisdiction over physicians practicing in areas where there is no traditional doctor/patient relationship, including those engaged as physician administrators, coroners, academics and researchers.<sup>133</sup> The CPSO also frequently takes jurisdiction in complaints about physicians acting as experts, for instance, in the case of a child custody issues or independent medical examinations.<sup>134</sup> Dr. Gerace gave a recent example of a coroner's investigation where the College assumed jurisdiction and conducted an investigation.<sup>135</sup> As Dr. Gerace testified at the Inquiry, if a complaint was received by the CPSO today about a pathologist doing work for the OCCO the CPSO would take jurisdiction.<sup>136</sup>

52. Dr. Cordner expanded on this concern, in his evidence at the inquiry, in opining that a regulatory board such as the CPSO is not the most appropriate regulatory mechanism for forensic medical practice since it is a "different paradigm which is poorly understood by general medical practice" and because medical boards deal primarily with the obligations of doctors to patients, which is "quite a long way away from where forensic pathologists are practicing." As Dr. Cordner stated in his evidence:

DR. STEPHEN CORDNER: -- any legal proceeding. So we had, what I regard, as a very unfortunate and inappropriate use of the Medical Board against one (1) of our pathologists and -- and -- which resulted in an adverse, but at the lowest level of adverse, finding for that pathologist which completely turned that pathologist off -- a very good pathologist in my view -- off the practice in forensic pathology.  
So I've got a little bit of a view about the adequacy of the general medical regulatory mechanisms and their applicability to -- and what I think is a different paradigm which is poorly understood by general medicine, which is forensic medical practice

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<sup>133</sup> Details of cases contained in Appendix A.

<sup>134</sup> Evidence of Dr. Gerace, 1/16/2008, p. 175, lines 11 to 25; and p. 176, lines 1 to 16. See Appendix A for examples.

<sup>135</sup> Evidence of Dr. Gerace, 1/16/2008, p. 176, lines 17 to 25; and p. 177, lines 1 to 2.

<sup>136</sup> Evidence of Dr. Gerace, 1/16/2008, p. 175, lines 5 to 10.

MS. LINDA ROTHSTEIN: Help us understand, with a little more detail if you would, Dr. Cordner, why you say they got it wrong.

DR. STEPHEN CORDNER: Well, that -- that would mean going into the details of the particular case, but let me just say that -- I mean Medical Boards and medical counsels (sic) are obviously an extremely important organ -- group for the protection of the public; the protection of the public from medical practitioners who, for a whole range of reasons, ought not to be practicing medicine or ought to be brought to account for some falling below the -- the acceptable standards, so that is absolutely right.

Forensic pathologists need disciplinary mechanisms, not getting away from that for one (1) moment. The General Medical Counsel (sic) or the Medical Board type approach is there for the protection of patients, okay? That's dealing with the primary obligation of virtually all doctors to look after patients. That is quite a long way away from where forensic pathologists are practicing.

So, you've got a whole system here, which is geared to protecting the public and evaluating a doctor's observation of his or her duties to patients, evaluating a forensic pathologist who's operating in a completely different paradigm.

So unless that disciplinary mechanism goes to some lengths to accommodate this different paradigm, then I think there needs to be a separate disciplinary mechanism for forensic pathologists which would have, at least, perhaps, a wider level of support amongst forensic pathologists.

In the particular case, there was no effort to engage forensic pathologists from another discipline -- from another --

DR. DAVID RANSON: Jurisdiction

DR. STEPHEN CORDNER: -- jurisdiction in a Medical Board process to evaluate their performance. That was a problem, I believe, with the way Professor Meadow was evaluated by the GMC.

MS. LINDA ROTHSTEIN: Right.

DR. STEPHEN CORDNER: There were three (3) medical practitioners and three (3) lay people on that -- on that board that suspended his registration; none of whom had any particular understanding or knowledge of what it's like to be a witness operating in a completely different paradigm.

So -- and we've written a little bit about it in the paper, but I actually think the Home Office mechanism -- at least, they've gone to the trouble of setting up a particular mechanism to evaluate the performance of forensic pathologists, but to what extent that is recognized by the GMC as sort of doing for their work for them, I think that's still a body of work to be done.

COMMISSIONER STEPHEN GOUDGE: I take it, at the very least, you would say when the regulatory body purports to engage in this sort of regulation, they ought to come at it through the eyes of forensic pathology.

DR. STEPHEN CORDNER: Well, to recognize that it's a different paradigm. It's not to do with the medical management of patients which is what the whole system is designed for; to protect patients from doctors who have fallen below some standard of medical practice.

Now, forensic pathologists are practicing a form of medicine, but it is so different. I know this is pleading a special cause, but it is so different that it needs recognition in the way that it's evaluated.<sup>137</sup>

53. With all due respect to Dr. Cordner, as Ms Rothstein put to him in her questions during that roundtable discussion on February 13, 2008, the model used in most adjudicative forums is that the decision maker does not possess expert knowledge in any specialized area, but obtains that requisite expertise from expert witnesses. The CPSO submits that, as suggested by Ms Rothstein, the CPSO is an appropriate regulatory model for forensic pathology since it can obtain qualified forensic pathologists to provide expert evidence to the decision makers with respect to the standard of practice.<sup>138</sup>

#### ***Recommendation #4***

54. **The CPSO should continue to rely on expertise of independent experts (where required) to assist it in investigating and responding to complaints and other information received about pediatric forensic pathologists.**

### ***ISSUE #3: Maintaining Standard of Practice***

#### ***Problem Identified re: Systemic Issue #3:***

55. Concern was raised at the Inquiry regarding the lack of practice guidelines for pediatric forensic pathology, including the provision of expert testimony in this area.

#### ***Registry for Pathologists Available to Perform Coroner's Cases***

56. There has been some suggestion at the inquiry that an approved registry, analogous to the Home Office list in the UK, of pathologists available to perform coroner's cases might be

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<sup>137</sup> Evidence of Dr. Cordner, 2/13/2008, pp. 114-117.

<sup>138</sup> Evidence of Dr. Cordner, 2/13/2008, pp. 117-118.

a positive step.<sup>139</sup> It was further suggested that the requirements or mechanisms of the registry (selection criteria, a mechanism at regular intervals for reappointment and a mechanism for removal<sup>140</sup>) might be best managed by a board.<sup>141</sup> In addition, it was recognized that there might be some overlapping jurisdiction with CPSO with respect to some aspects of the maintenance or governance of this registry.<sup>142</sup>

57. The CPSO agrees that such a registry could assist in ensuring the quality of the work performed by pediatric forensic pathologists.<sup>143</sup> The CPSO submits that the management of this registry should not in any way impede the CPSO's jurisdiction to effectively and appropriately oversee the physicians who are members of the registry. To this end the CPSO would be pleased to engage in discussions with the relevant member organizations involved in the formation and/or maintenance of such a registry.

***Recommendation #5:***

58. **If a registry system is recommended for pathologists, it should be a condition of registration that a physician consent to information being shared between the CPSO and the organization maintaining the registry prior to and during registration.**

***Standards and Guidelines***

59. The CPSO endeavours to provide its membership with guidelines, including those related to clinical practice.<sup>144</sup> It also provides its membership with a guide setting out the principles of practice and duties expected by the membership. This document, entitled

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<sup>139</sup> Evidence of Dr. Pollanen, 12/5/2007, p. 274, lines 12 to 25; and 275, lines 1 to 12.

<sup>140</sup> Evidence of Dr. Pollanen, 12/5/2007, p. 275, lines 13 to 25.

<sup>141</sup> Evidence of Dr. Pollanen, 12/6/2007, p. 33, lines 9 to 25; and 34, lines 1 to 5.

<sup>142</sup> Evidence of Dr. Pollanen, 12/5/2007, p. 276, lines 21 to 25; and 277, lines 1 to 21.

<sup>143</sup> Evidence of Dr. Gerace, 2/20/2008, p. 54, lines 3 to 25; and p. 55, lines 1 to 6.

<sup>144</sup> <http://www.cpso.on.ca/Publications/publications.htm>. The CPSO notes there is debate in almost all areas of medical practice as to what the appropriate standards are, having regard to various guidelines in the area.



“The Practice Guide, Medical Professionalism and College Policies” is available to the public.<sup>145</sup>

60. The CPSO is continually adding to and updating the “policies, position statements and regulations” section of its website<sup>146</sup> which provides physicians with easy access to additional guidance in specific areas already covered by the general practice guide referenced above. For instance, the CPSO has published policies with respect to Third Party Reports<sup>147</sup> as well as Professional Responsibility in Undergraduate<sup>148</sup> and Postgraduate<sup>149</sup> Medical Education.

***Recommendation #6:***

61. **The CPSO should endeavour to implement any guidelines or protocols recommended with respect to standards of practice for pediatric forensic pathology, including with respect to expert testimony by physicians.**<sup>150</sup>

### **III. FACTUAL FINDINGS REQUESTED**

***CPSO Relinquishes Jurisdiction to OCCO***

62. The factual circumstances which lead to the ultimate decision of the Executive Committee in 1998 to allow the OCCO to assume jurisdiction over Coroner’s

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<sup>145</sup> <http://www.cpso.on.ca/Policies/PracticeGuideSept07.pdf>.

<sup>146</sup> <http://www.cpso.on.ca/Policies/policy.htm>.

<sup>147</sup> Policy #8-02 (<http://www.cpso.on.ca/Policies/third.htm>).

<sup>148</sup> Policy #2-03 ([http://www.cpso.on.ca/Policies/resp\\_ug.htm](http://www.cpso.on.ca/Policies/resp_ug.htm)).

<sup>149</sup> Policy #3-03 ([http://www.cpso.on.ca/Policies/resp\\_ug.htm](http://www.cpso.on.ca/Policies/resp_ug.htm)).

<sup>150</sup> as Dr. Gerace testified at the Inquiry, it would be useful to have written standards about the way in which physicians are to provide expert opinions to any court or tribunal or third party and the need for objectivity (Evidence of Dr. Gerace, 2/20/2008, p. 23, lines 14 to 25; and p. 24, lines 1 to 17).

Pathologists has been the subject of evidence at the Inquiry and is set out in detail in the CPSO's Institutional Report.<sup>151</sup>

63. The OCCO told the CPSO that its office, more specifically Coroner's Council, would (and, with respect to the Gagnon complaint, the OCCO asserted it did) complete a thorough investigation into the complaints brought against Dr. Smith and that it would litigate over the issue of jurisdiction should the CPSO attempt to assume it over the complaints.<sup>152</sup> Believing that it would not serve the public interest to litigate with the OCCO over the issue of jurisdiction, and relying on the OCCO's assurance that it would properly investigate and respond to the complaints, the CPSO relinquished jurisdiction.<sup>153</sup>
64. At the Inquiry, Dr. Gerace testified that, although the CPSO was not afraid of litigating with the OCCO, the deliberation by the CPSO at the time was "... why expend resources to determine who was going to do it, but rather ensure that it was done and – and assuming it would be done appropriately."<sup>154</sup> Dr. Gerace further testified that the assumption was that if the OCCO was going to investigate a complaint, it would be a full investigation utilizing whatever was necessary to ensure that the standard was being met.<sup>155</sup> The understanding was that there were a variety of venues where a complaint against Dr. Smith could be dealt with – either through the Complaints Committee or Coroners' Council, and it was Dr. Gerace's assumption that the responsibility of the

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<sup>151</sup> PFP302481 at pp. 22-26.

<sup>152</sup> Evidence of Dr. Young, 12/4/2007, p. 180, lines 15 to 25; and p. 181, lines 1 to 10.

<sup>153</sup> See, also Evidence of Dr. Gerace, 1/16/2008, p. 178, lines 1 to 16 for instance, Dr. Carlisle's memo to the Registrar of October 29, 1997 (PFP170427 at p. 2) where Dr. Carlisle states: "The College and the Chief Coroner were clear in their understanding that neither wished to end up in Divisional Court opposing the other over the question of jurisdiction. This would be an inappropriate application of public funds and would not serve to protect the public interest in any way."

<sup>154</sup> Evidence of Dr. Gerace, 1/16/2008, p. 178, lines 1 to 16.

<sup>155</sup> Evidence of Dr. Gerace, 1/16/2008, p. 178, lines 17 to 23.

Coroner's Office in carrying out its activity is similar to the primary responsibility of the CPSO under the RHPA – to ensure public protection.<sup>156</sup>

65. In his evidence, Dr. Young agreed that by telling the CPSO to let the OCCO take jurisdiction, Dr. Young was telling the College that it could rely on his office to properly address and investigate complaints about pathologists.<sup>157</sup> In his letter to Mr. Gagnon of May 6, 1999,<sup>158</sup> which he forwarded to the CPSO, Dr. Young states that he had “read [the] brief in detail and considered it very carefully.”<sup>159</sup>
66. Although the CPSO had every reason to believe that the OCCO would investigate the complaints properly<sup>160</sup>, as a result of the evidence at the Inquiry, it is clear that there was little or no investigation completed by the OCCO and that, in fact, the complaints were not even read in their entirety.<sup>161</sup>

### ***CPSO Assumes Jurisdiction and Investigates Complaints***

67. In contrast to the paucity of attention paid by the OCCO to the Gagnon complaint, once the CPSO assumed jurisdiction, its investigations into the three complaints against Dr. Smith before it were detailed and comprehensive. The CPSO went outside the province to obtain a panel of three respected and qualified independent experts in the same field as Dr. Smith. Its investigators provided detailed materials to the experts and to the deciding Committee (in this case the Complaints Committee).<sup>162</sup> With respect to the Gagnon

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<sup>156</sup> Evidence of Dr. Gerace, 1/16/2008, p. 178, lines 22 to 25; and p. 179, lines 1 to 22.

<sup>157</sup> Evidence of Dr. Young, 12/4/2007, p. 191, lines 14 to 25; and p. 192, lines 1 to 14.

<sup>158</sup> PFP007885.

<sup>159</sup> Evidence of Dr. Young, 12/4/2007, p. 196, lines 2 to 18.

<sup>160</sup> Evidence of Dr. Gerace, 1/16/2008, p. 179, lines 23 to 25; p. 180, line 1.

<sup>161</sup> Evidence of Dr. Young, 12/4/2007, p. 197, lines 5 to 18.

<sup>162</sup> CPSO Institutional Report PFP302481 and Evidence of Dr. Gerace, Michelle Mann and Elizabeth Doris, 1/16/2008.

complaint, the CPSO experts addressed the specific concerns raised by Mr. Gagnon. This was in stark contrast to the OCCO's general response. Dr. Young acknowledged that when the CPSO took jurisdiction, it did a better job than the OCCO in responding to the Gagnon complaint.<sup>163</sup>

68. Even when the CPSO ultimately took jurisdiction in the three complaints, Dr. Young continued to attempt to influence the CPSO's investigation. On April 10, 2002, he sent a letter to the CPSO, drafted by legal counsel for Dr. Smith, that stated, in part:

I trust the College will, in the course of its investigation of Dr. Smith, be cautious that it is not used to discourage expert participation in the work of the coroner by encouraging parties dissatisfied with the opinions of coroner's experts to make complaints of professional misconduct. There are other far more appropriate forums for challenging the substance or methodology of an opinion.<sup>164</sup>

69. The Complaints Committee provided detailed reasons for its decision<sup>165</sup> and sanctioned Dr. Smith commensurate with its findings. Two of the three decisions were appealed to HPARB and both were dismissed by the Board.<sup>166</sup>

## IV. FINAL SUBMISSIONS

### *Final Submissions Regarding Findings of Fact*

70. The CPSO recognizes, with the benefit of hindsight, that its decision not to assume jurisdiction over pathologists acting in their capacity as agents of the coroner's office in the late 1990s was regrettable and ultimately led to a delay in its investigation. However, the CPSO submits, as set out above, that the decision was made in good faith in what was, at the time, perceived to be in the best public interest. The CPSO had no way of

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<sup>163</sup> Evidence of Dr. Young, 12/4/2007, p. 204, lines 9 to 25; and p. 205, lines 1 to 5.

<sup>164</sup> PFP144922.

<sup>165</sup> PFP074293, PFP029060 and PFP029044.

<sup>166</sup> PFP146400 and PFP146982.

knowing that the Coroner's Council (or, when it was disbanded, Dr. Young) would fail to conduct a proper and adequate investigation.

71. As also indicated above in, it is the CPSO's position that once it did assume jurisdiction for the complaints against Dr. Smith, it completed a thorough and detailed investigation.

***Final Submissions Regarding Regulation and Systemic Issues***

72. It is the CPSO's view that regulation is most effective when viewed as a continuum rather than entities each with their own mandate. In fact, it appears that this lack of communication and isolated approach to the regulation and oversight of Dr. Smith by the three main bodies responsible for that oversight, namely HSC, the OCCO and the CPSO, is one factor that prevented earlier detection of the serious problems with Dr. Smith's practice.
73. Instead of working together and communicating with the CPSO, both HSC and the OCCO tried to "fix the problem in-house." While there are certainly some complaints that can be handled at a local level<sup>167</sup>, the breakdown occurs when there is a pattern of behaviour that is not reported to the CPSO.<sup>168</sup> Without reporting, the CPSO has no way of knowing whether or not a problem is systemic.<sup>169</sup> The only way to recognize a systemic problem is if there is free communication between the various parties involved (i.e. the unit, the regulator, the hospital, etc.). When that communication doesn't happen, it creates problems,<sup>170</sup> as it did in this case.

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<sup>167</sup> Evidence of Dr. Gerace, 2/20/2008, p. 14, lines 24 to 25; and p. 15, lines 1 to 20.

<sup>168</sup> Evidence of Dr. Gerace, 2/12/2008, p. 45, lines 1 to 4.

<sup>169</sup> Evidence of Dr. Gerace, 2/12/2008, p. 45, lines 4 to 10.

<sup>170</sup> Evidence of Dr. Gerace, 2/12/2008, p. 45, lines 11 to 17.

**V. FORMAL SYSTEMIC RECOMMENDATIONS**

- (1) Specified education, training and certification should be required to ensure the safe and effective practice of pediatric forensic pathology. The CPSO should participate with other interested parties to determine what should be required, and endeavour to implement any recommendations from this Honourable Commission in this regard.**
- (2) Reporting requirements under the *RHPA* must be properly adhered to so that the CPSO receives appropriate information when there are concerns regarding physicians' competence.**
- (3) Policy talks should be instigated between the CPSO, the OCCO, Hospitals, facilities and other bodies not governed by the *RHPA* in an effort to agree on reasonable and practical communication strategies to ensure the CPSO receives appropriate information when there are concerns regarding physicians' competence.**
- (4) The CPSO should continue to rely on expertise of independent experts (where required) to assist it in investigating and responding to complaints and other information received about pediatric forensic pathologists.**
- (5) If a registry system is recommended for pathologists, it should be a condition of registration that a physician consent to information being shared between the CPSO and the organization maintaining the registry prior to and during registration.**

- (6) The CPSO should endeavour to implement any guidelines or protocols recommended with respect to standards of practice for pediatric forensic pathology, including with respect to expert testimony by physicians.<sup>171</sup>**

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<sup>171</sup> as Dr. Gerace testified at the Inquiry, it would be useful to have written standards about the way in which physicians are to provide expert opinions to any court or tribunal or third party and the need for objectivity (Evidence of Dr. Gerace, 2/20/2008, p. 23, lines 14 to 25; and p. 24, lines 1 to 17).

## Appendix A

### Surgeons

#### **Dr. A (broad investigation based on three complaints)**

1. On December 7, 2006, the College's Executive Committee approved a broad investigation into Dr. A's practice based on three complaints filed against Dr. A regarding his surgical skills. The Committee was assisted in its review by the independent opinion of an assessor who had the same specialty qualification (obstetrics and gynaecology) as Dr. A, and who practiced in another Ontario centre in an environment similar to that in which Dr. A was practicing at the time of the events in these cases. The Committee noted that in reaching its decisions it benefited from the analysis and conclusions arrived at by the qualified and experienced assessor.

### Physicians engaged as Expert Witnesses

#### **Dr. W**

2. Dr. W, a psychiatrist, gave sworn evidence in two matters, one criminal and one civil, in December of 1997 and October of 1998 respectively. Dr. W acknowledges that in both matters he made a number of errors in his evidence and in his filed curriculum vitae. The parties agree that Dr. W committed an unprofessional act when he made the above-noted errors in the criminal and civil matters referred to above. The Discipline Committee directed the Registrar to suspend Dr. W's certificate of registration for 30 days; and directed Dr. W to appear before the panel to be reprimanded.



## Physicians Performing Independent Medical Examinations of a Non-Patient

### **Dr. H**

3. Dr. H received various complaints about his conduct in performing IMEs for insureds who were collecting disability coverage. The CPSO obtained assistance from an independent opinion of an assessor orthopaedic surgeon who also performs independent medical examinations, who identified serious deficiencies with respect to the adequacy of Dr. H's report. The Committee concluded that, in its view, Dr. H's IME report was judgmental and biased and further noted that this was not the first occasion on which it had had concerns regarding inappropriate bias and inaccuracy in IME reports prepared by Dr. H. The Committee required Dr. H to attend at the College to appear before a panel of the Committee to be cautioned in this matter. Furthermore, the Committee was sufficiently concerned about Dr. H that it believed a further review of his knowledge and skills in the conduct of IME and preparations of such reports was required. As such it directed the matter to the attention of the CPSO's Quality assurance Committee. HPARB confirmed the Committee's decision.

## Physicians Who Engage in Assessments for Child Custody Applications

### **Dr. P**

4. Complaint to the College regarding a custody and access assessment, ordered by the Ontario Court (General Division), performed by Dr. P. Part of the complaint was that Dr. P. provided a biased, superficial and inaccurate report, containing statements known to be false, misleading and improper, and that Dr. P breached

confidentiality by gathering information without the proper authorization. The complaints committee decision to caution the physician was upheld by HPARB.

**Dr. A**

5. Complaint to the College about an assessment carried out by Dr. A in relation to arrangements for custody and access as between complainant and her husband.

The Committee was assisted in its review of this complex matter by the independent opinion of an assessor who had the same specialty qualification (psychiatry) as Dr. A and who practiced and taught in another Ontario centre, in an environment similar to that in which Dr. A practiced. The committee noted that it benefited from the analysis and conclusions arrived at by the qualified and experience assessor and attached a copy of his report (edited to maintain anonymity) to the decision.

6. The assessor thoroughly reviewed the College's investigative file (including correspondence, all medical charts, records and consultation reports and audiotapes of the interviews conducted) and set out a detailed history of the matter. The assessor concluded that Dr. A showed poor judgment, erred in several areas of his assessment and did not meet the standard of the practice of the profession. The Committee relied on the comprehensive reasoning and opinions outlined by the assessor and concluded that the care provided by Dr. A in the present case was inadequate in a number of respects. The Committee directed the case to the Quality Assurance Committee of the College.

7. In another complaint against Dr. A regarding a court ordered assessment he conducted in a Family Court matter regarding the complainant's request that he be allowed unsupervised access to his daughter, the complaints committee acknowledged that Dr. A practices in a very complex and difficult area. It further noted that frequently, given the very adversarial nature of the context in which Dr. A operates, there will be individuals who are unhappy with the conclusions reached in his assessments. In that case, after carefully reviewing the record, the Committee concluded that Dr. A's assessment and report were reasonable and adequate and that no further action was warranted against him.

#### Physician Administrators

##### **Dr. J**

8. Dr. J was retained by the Coroner's Office to provide an expert opinion further to that Office's review of the death of a 25 year-old insulin dependent diabetic, who suffered cardiac arrest and died in the Emergency Department.
9. The deceased's mother complained to the College about the medical conclusions Dr. J. had reached. In that matter the Committee took no action against the physicians complained of and stated that it agreed with Dr. J's analysis of the clinical issues relating to the death.

##### **Drs. X, Y and Z**

10. This was a complaint regarding the investigation conducted by the OCCO into the death of a 22 year-old who was found dead lying in the parking lot of his

apartment building in Toronto. The investigating coroner determined that the deceased had committed suicide and, after reviewing additional reports, conducting a full autopsy and completing multiple investigations into the tragic incident, the OCCO confirmed this conclusion. The deceased's family, the complainants, disagreed with this conclusion – they believed that he had been murdered.

11. The Complaints Committee investigated the matter but ultimately took no action.

### Research Physicians

#### **Dr. K**

12. Dr. K admitted to writing harassing letters to a colleague after a dispute over a research project. The Discipline Committee found that Dr. K committed acts of professional misconduct. The Committee directed that Dr. K appear before the panel to be reprimanded, and Dr. K pay the College's costs in the amount of \$2,500.

### Physicians in Academic Roles

#### **Dr. H**

13. Dr. H was the principal investigator of a medical research project and author of the related research application. The complainant received a package from a certain medical center inviting him to participate in a research study because he had "been identified as having at least one [risk factor for a certain condition]." The Complainant complained to the CPSO that, among other things, certain of his

private information had been gathered and used by Dr. H and the medical center for the purposes of the study. The Committee identified three ways in which Dr. H failed to adhere scrupulously to acceptable research and/or privacy practices. Dr. H's conduct in this case was addressed by means of a written caution.

### Physician Politicians

#### **Dr. B**

14. The complainant complained to the CPSO that the support of Dr. B, a Liberal Member of Parliament, for Canada's military mission in Afghanistan "endangers the lives of many Canadians, contrary to her oath and duty as a medical doctor." The Committee, after considering the matter at two separate meetings and accepting further written submissions from the complainant, ultimately decided to take no further action with respect to this complaint.

### Physician Behaviour Constituting "Conduct Unbecoming"

#### **Dr. F**

15. On April 13, 2006, Dr. F entered a plea of guilty to a charge of common assault arising from a traffic incident. Dr. F admitted that he struck several blows to the lip area and shoulder of another driver.
16. Dr. F admitted that during the incident he committed an act of professional misconduct in that he engaged in conduct unbecoming a physician. Dr. F was required to appear before a panel of the Discipline Committee to be reprimanded and was ordered to pay costs to the College.

**Dr. S**

17. In March, 2004, Dr. S, of his own volition, called the Police Department in Michigan and provided sensitive personal information about the complainant's character and physical and mental health, some of which was unverified and disparaging. When he did so, Dr. S did not identify himself as a physician, and stated that he was acting in the capacity of a concerned person. Dr. S was not the complainant's physician, rather, the complainant was a former member of Dr. S's family.
18. The Discipline Committee ordered that Dr. S appear before the panel to be reprimanded.