Indexed as: **Wilson (Re)**

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed
by the Complaints Committee of The College of Physicians
and Surgeons of Ontario, pursuant to Section 26(2)
of the ***Health Professions Procedural Code***,
being Schedule 2 to the
Regulated Health Professions Act, 1991,
S.O. 1991, c.18, as amended

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. RONALD HAROLD WILSON

PANEL MEMBERS: DR. C. HILL (CHAIR)
DR. D. BRADEN
R. SANDERS
J. FREDERICK

Hearing Dates: January 21 – 25, 2002
February 4 – 6, 2002
March 4 – 7, 2002

Decision/Released Date: August 21, 2002

PUBLICATION BAN

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

DECISION AND REASONS FOR DECISION

This matter came before the Discipline Committee of the College of Physicians and Surgeons of Ontario for hearing on January 21 though to 25, February 4 though to 6, March 4 though to 7, 2002.

THE ALLEGATIONS

In the Amended Notice of Hearing it was alleged that Dr. Ronald Harold Wilson is guilty of professional misconduct as defined:

1. under clause 1(1)2 of Ontario Regulation 856/93 ("O.Reg. 856/93"), made under the *Medicine Act, 1991*, under paragraph 29.22 of Ontario Regulation 548/90 ("O.Reg.548/90") and under paragraph 27.21 of Ontario Regulation 448/80 ("O.Reg.448/80"), in that he failed to maintain the standard of practice of the profession;

2. under clause 1(1)27 of O.Reg. 856/93, paragraph 29.3 of O. Reg. 548/90 and paragraph 27.3 of O.Reg. 448/80, in that he contravened the regulations under the Medicine Act, 1991, by failing to maintain the records required under Part V of O. Reg. 241/94;

3. under paragraph 29.3 of O. Reg. 548/90, in that he failed to maintain the records required to be kept respecting a member's practice; and

4. under clause 1(1)33 of O. Reg. 856/93, paragraph 29.33 of O. Reg. 548/90 and paragraph 27.32 of O. Reg. 448/80, in that he committed an act or was guilty of an omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

It was also alleged that Dr. Wilson is incompetent, as defined in section 52 of the *Health Profession Procedural Code* which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 and in subsection 61(4) of the *Health Disciplines Act*, in that his professional care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of patients, of a nature or to an extent that demonstrates that he is unfit to continue to practice or that his practice should be restricted.

The allegations detailed in items 2 and 3 above were withdrawn during the course of the hearing.

The Amended Notice of Hearing sets out particulars of the allegations as follows:

There were 19 complainants who were patients of Dr. Wilson during the period of 1990 to 1996. Specific allegations were made with respect to each patient. In addition is was alleged that Dr. Wilson failed to maintain the standard of practice of the profession in the operation of his EEG laboratory as follows:

a. he did not implement or ensure that appropriate infection control measures were practised in the EEG laboratory from 1989 to 1996, including the following:
    i. failing to ensure the use of gloves in the performance of the insertion of needle electrodes when exposure to blood and bodily fluids occurred;
    ii. failing to ensure the use of gloves during the cleaning and disinfection procedure under direct observation;
    iii. prior to December 1996, there was no protocol regarding the cleaning, disinfection and sterilization procedures;
    iv. did not implement a monitoring process to ensure the adequacy of the sterilization procedure;
    v. failed to ensure that the personnel responsible for the cleaning, disinfection and sterilization process were adequately educated, trained and competent in the areas of prevention and control of blood borne pathogens;

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

vi. allowing needle electrodes to be reused on patients without being subjected to any cleaning, disinfection or sterilization procedure.

It was also alleged that, during this period, Dr. Wilson caused unnecessary EEGs to be performed.

PLEA

Dr. Ronald Harold Wilson pleaded not guilty to all allegations.

PUBLICATION BAN

The Discipline Committee ordered under section 45 (3) of the *Health Professions Procedural Code* that neither the names of the complainants nor any information by which they, or any patient of Dr. Wilson, may be identified, published or broadcast.

THE EVIDENCE

AGREED STATEMENT OF FACTS

An Agreed Statement of Facts was filed concerning professional activities in various EEG clinics in the Toronto area. Dr. Wilson was a specialist in Neurology who owned and directed these clinics. Mr. K. was the EEG technologist who performed all EEGs in these clinics from 1970 to 1996. In 1996 a major Hepatitis B outbreak was identified by the Public Health Department. The source was traced to Dr. Wilson's EEG clinics. It was agreed that:

1. Dr. Wilson was the medical director of various EEG clinics at the relevant times.
2. Mr. K. performed subdermal (henceforth "needle") EEGs at Dr. Wilson's clinics to the knowledge and approval of Dr. Wilson. Mr. K. does not have a medical degree and Dr. Wilson was aware of this fact.
3. Dr. Wilson was the medical director of the EEG clinics. He was responsible for the supervision of Mr. K. and the conduct of the EEGs.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

4. There was a Hepatitis B outbreak in Dr. Wilson's clinics from 1992 to 1996.
5. Mr. K. would, on occasion, take all the needle electrodes and pull them out at once from the scalp of the patient. Dr. Wilson became aware of this.
6. There was no written protocol regarding the cleaning, disinfection and sterilization process for the needle electrodes at Dr. Wilson's clinics during the relevant time period. Dr. Wilson was aware of this.
7. Two dry heat sterilizers were used in the clinics – Dak Model 652 and Model 652T. Dr. Wilson purchased a steam autoclave in and around October 15, 1995. This steam autoclave did not work initially and was returned. A replacement steam autoclave became fully operational on or around November 10, 1995.
8. The two dry heat sterilizers were not serviced or checked by anyone other than Mr. K. until February 23, 1996 when they were checked by Starkman Surgical Supply.
9. There was no biological indicator testing done for the sterilization process of the needle electrodes.
10. There were no logs or other documentation kept at Dr. Wilson's clinics for the monitoring, maintenance or testing of the dry heat sterilizers or the sterilization process for the needle electrodes. Dr. Wilson was aware of this.
11. Mr. K. tested positive on February 22, 1996 for e-antigen hepatitis B.
12. It is likely that Mr. K. was the source of the Hepatitis B outbreak at Dr. Wilson's clinics, however only in cases where there is a DNA match can one say with certainty that a patient contracted Hepatitis B from Mr. K..
13. Seventy-five cases of Hepatitis B patients who received needle EEGs at Dr. Wilson's clinic met the outbreak case definition in the investigation by the Public Health Department.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

WITNESSES - Public Health Department

Ms. R.

Ms. R. was a senior Public Health Inspector for the Scarborough Public Health Department in 1995 – 96.

Mr. B.

Mr. B. is a senior Public Health Inspector for the Communicable Diseases Control Unit, Scarborough Public Health Department from 1990 to the present. Mr. B. was involved in the investigation of the Hepatitis B outbreak beginning in January 1996, along with Ms. R. and Mr. L.

Mr. L.

Mr. L. is an infection control officer for Mount Sinai Hospital. He is a certified Public Health Inspector and was associated with disease surveillance with the North York Public Health Department in early January 1996. This branch had noticed a possible link between cases of Hepatitis B and the EEG labs run by Dr. Wilson.

Ms. R. was approached in late 1995 by two women who had concerns about Hepatitis B and another whose husband had contracted Hepatitis B. Ms. R. became aware that these three patients had EEGs performed at one of Dr. Wilson's EEG labs within a few months of contracting the disease. A preliminary investigation was begun and included the participation of Mr. B. and Mr. L.

During a telephone conversation held January 19, 1996, Dr. Wilson told Ms. R. that he had decided to discontinue the use of needle electrodes for the performance of EEGs. Dr. Wilson also informed Ms. R. that he had purchased a new steam autoclave in the fall of 1995 and they discussed biological test monitoring.

Dr. Wilson and Ms. R. met on January 24, 1996 at his office and laboratory with two other investigators, an intern and Mr. B. Dr. Wilson was cooperative and seemed very

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

concerned about the Hepatitis B cases. Dr. Wilson stated that he was aware of three hepatitis B cases of patients who had also attended his laboratory for EEGs. These were not the same cases that the Public Health Department was then aware of.

Dr. Wilson also stated that he was taking blood samples to test for Hepatitis B from other patients who had EEGs during the same time period as the identified cases. Dr. Wilson told Ms. R. that he was telling patients that the blood tests were 'routine' and that he did not tell them he was testing for Hepatitis B. Dr. Wilson was made aware of the infected patients by the patients themselves or by family physicians who called to ask for advice about the use of anticonvulsant drugs in epileptic patients with liver disease. Dr. Wilson did not himself report these cases to the Public Health Department.

Dr. Wilson then introduced the investigators to Mr. K. in the EEG lab. Ms. R. and Mr. B. remember a long room with a desk, a 'lazy boy' type chair, a counter with a sink, shelves and a dry heat sterilizer as well as a steam autoclave. Mr. L. attended on a subsequent occasion and described the room in the same way. There were no needle electrodes available to view on either occasion.

Both Ms. R. and Mr. B. testified that Mr. K. proceeded to demonstrate the processing of electrodes using the disc electrodes available. Mr. K. first soaked the electrodes in a mixture of soap and Javex, then in glutaraldehyde. Mr. K. did not wear gloves during this demonstration. Ms Richardson asked for written documentation for the use of the dry heat sterilizer, the use of the steam autoclave, and a written protocol for the processing of needle electrodes. Mr. K. was unable to produce such documents. Mr. B. noticed a small dry heat sterilizer but no procedure books documenting that the sterilizer had been tested or any written protocol for use. There were no temperature logs in evidence, no records of biological testing and no temperature gauge on the autoclave. Mr. K. was subsequently unable to provide these documents to Mr. L. when requested.

On January 26, 1996, Mr. B. tested the DAK 652 dry heat autoclave and the steam autoclave in Dr. Wilson's office. The disc electrodes were wrapped around a cloth core

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

then wrapped in cloth with a spore test included inside the cloth. Both sterilizers passed the test. Another sterilizer at the Fairview office site, a DAK 652T, was tested by placing thermometers inside the machine. The autoclave was capable of reaching the temperature required for sterilization. The temperature gauge on the machine itself was not working at the time of this inspection. Photographs of the sterilizers taken at the time of the investigation were entered into evidence, along with a receipt for the steam autoclave dated November 10, 1995.

At the end of the hearing, the actual dry heat sterilizers that had been in use in Dr. Wilson's clinics were produced for inspection by the Panel. Both the DAK 652 and DAK 652T models appeared to be the size of a small toaster oven. It was apparent that three to four bundles of electrodes as described could be sterilized at one time. Both had instructions for use on the casing and a pilot light. There were no temperature indicators or means of recording such temperatures.

When Mr. L. visited the clinic, he asked Mr. K. how he tested the sharpness of the needles. Mr. K. demonstrated by rubbing his thumb and fingers together. He also told Mr. L. that no thermometer was used when the sterilizer was in use.

On cross-examination, Ms. R. confirmed that immunization against Hepatitis B was not mandatory for health care workers. She also confirmed that, generally speaking, a doctor's office is not considered a risk factor for the transmission of Hepatitis B. Her impression was that Dr. Wilson was cooperative, professional and open to discussion of system changes in his office. He also agreed to shut down his EEG lab until a better degree of understanding was reached. Dr. Wilson seemed to be deeply shocked when he learned that 20 hepatitis B patients had been matched to his office.

WITNESS - Ms. W.

Ms. W. was the Infection Control Officer at the Centenary Hospital from February 1988 to March 1994. She testified that Centenary Hospital started using disc electrodes only for the performance of EEGs in 1989 because needle electrodes were not considered safe.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

Dr. Wilson called her twice in the fall of 1995 to ask advice. He informed her that he was a member of a task force that was looking at the procedures of EEG clinics in the area. Dr. Wilson did not mention to her that he was the Medical Director of several EEG labs. She strongly recommended to him that needle electrodes not be used and subsequently sent him a copy of Dr. Brian Young's article in the Canadian Medical Association Journal in 1991 entitled "Minimal standards for electroencephalographic laboratories."

The second conversation was related to sterilization procedures and they discussed steam versus dry sterilization. Ms. W. told Dr. Wilson that steam sterilization was better but dry heat was acceptable providing the user followed the manufacturer's recommendations, and that the process was monitored and audited. She stated that she particularly remembered these conversations because a doctor had initiated them.

WITNESSES – PATIENTS and/or COMPLAINANTS

There were nineteen complainants, sixteen of whom testified in this capacity. All had been patients of Dr. Wilson during the period of 1990 – 1995. The original presenting complaints included headaches, dizziness, blurred vision and numbness of the arm. All had EEG testing at a clinic in which Dr. Wilson was the Medical Director and Mr. K. was the EEG technologist. Only one witness testified that Dr. Wilson himself performed the EEG. There was otherwise general agreement that Mr. K. performed all other EEGs. All the EEGs were performed using needle electrodes. Eight patients subsequently developed Hepatitis B. With the exception of complainant 1, Dr. Wilson acknowledged that the Hepatitis B was contracted at one of his clinics.

Several witnesses indicated that Dr. Wilson's manner was professional and polite and that he was sympathetic, supportive and concerned.

Questions were asked of these witnesses regarding the EEG experience that they had at that time. Several described the waiting room at the clinic as full, quite full or packed, although they did not know whether all the people there were patients or accompanying persons. Nor did they know whether these people were waiting for an appointment with

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

Dr. Wilson or for EEG testing. Patients were not asked if they were suffering from any skin lesions or communicable diseases. Patients were not offered a choice in the type of EEG to be performed i.e. needle or disc electrode technique. There was no evidence that Mr. K. wore gloves at any time while performing EEGs. The average length of the procedure was consistently reported as ten to fifteen minutes with the exception of one patient who thought the procedure took thirty to sixty minutes. Most patients had only one EEG. Three patients had two to four and one had twelve over a period of several years, including two sleep EEGs.

Two patients reported that Mr. K. removed the needle electrodes at the end of the test by removing them all at the same time or by pulling them all out at once, like "a bunch of carrots". The father of one of the patients (patient X), who was waiting for his son in the waiting room at the time, corroborated his son's testimony. The father stated that he saw blood running down the side of his son's face when he left the EEG lab. He was upset enough to speak to Mr. K., who then took his son back into the lab and wiped off his face with a gauze. Mr. K. did not wear gloves while doing this. They reported this episode to Dr. Wilson. Dr. Wilson listened to the complaint and agreed that this was unacceptable behaviour. Dr. Wilson stated that he would talk to Mr. K. and tell him to stop removing the electrodes in bunches.

Complainant 2 is currently a 54-year-old retired teacher. She presented to Dr. Wilson in March of 1991 with numbness in the left side of her face. Asked about the EEG, she described the experience in the same terms as set out above. Between April and August 1991, she began experiencing double vision. On the Thursday before the Labour Day weekend, Dr. Wilson admitted her to the Centenary Hospital for further tests (a second EEG had been done in his lab just prior to this admission). During the week she had another EEG, which she describes as a much different experience from the one that Mr. K. performed. She stated that the procedure took much longer to perform, there were no needles used and her scalp was measured. Dr. Wilson then ordered an MRI study, which confirmed a diagnosis of Multiple Sclerosis.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

The Panel found all these witnesses credible. They testified in a straightforward manner. They were able to describe the events and surroundings in detail and were careful to indicate if they did not recall the details.

WITNESSES - Employees

There were two witnesses who worked at the one of Dr. Wilson's clinic as sleep lab technicians; Mr. A., who was employed for about one year in 1990 –1991, and Mr. M., who worked there for one year in 1989. Mr. A. was trained for his position on site at the clinic. The sleep EEGs were performed using disc electrodes, which were applied after cleaning the skin, and held to the scalp with glue. Mr. A. stated that during his training he was told to scratch the scalp with a blunt needle through a small hole in the electrode to enhance electrode reception of the electrical brain waves. He stated that he never did this as he had concerns about potential infections. He also stated that the blunt needle was never washed between patients. Mr. M. confirmed this. He wore gloves while performing the procedure.

Mr. A. entered the regular EEG lab on a daily basis to pick up supplies for the Sleep Lab, which was on the floor above. He stated that he did not see any wrapped bundles or a sterilizer in that lab. Mr. A. was quite firm that neither lab had an Infection Control Manual. At no time during his employment was there information given to the staff about needle stick injuries. Hepatitis B vaccination protection was not offered to the staff. Mr. M. concurred with all these points in his testimony.

Sometime in 1991, Mr. A., at his own request, witnessed an EEG performed by Mr. K.. He stated the test took fifteen minutes to perform. Mr. K. did not measure the patient's scalp. At the end of the test Mr. K. removed the needle electrodes all at once. There was blood trickling down the patient's right temple. Mr. K. placed the electrodes on a table behind the examining chair. On one further occasion Mr. A. was passing the EEG lab when a patient was leaving and saw blood trickling down the patient's temple to the cheek. The patient was upset and Mr. A. asked him to speak to Dr. Wilson about this. After several of such episodes Mr. A. spoke with Dr. Wilson about his concerns. He

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

stated that seeing the blood made him concerned about sterilization and he asked Dr. Wilson if the electrodes were being sterilized. Dr. Wilson told him that this was Mr. K.'s job and that Mr. K. knew what he was doing. Mr. A. was satisfied that "something was in place".

Mr. M. also witnessed EEGs performed by Mr. K.. He stated that he was standing right beside Mr. K. when he saw him remove the needle electrodes from one patient and reinsert them into the next with no cleaning or sterilization.

The Panel considered both Mr. A. and Mr. M. to be credible witnesses who did not overstate their recollections. Both were cross-examined at length and did not alter their evidence. They were balanced and fair in their testimony.

EXPERT WITNESSES

DR. JOHN CONLY

The College called two expert witnesses. The first was Dr. John Conly, who is currently Professor, Department of Pathology & Laboratory Medicine, Medicine and Microbiology & Infectious Diseases, University of Calgary. The Panel accepted Dr. Conly as an expert witness in the field of Infectious Diseases.

In Dr. Conly's opinion, based on a review of all relevant documents that were provided to him, Dr. Wilson's conduct failed to meet the standard of practice. Dr. Conly gave the panel an excellent and comprehensive review of the characteristics of the Hepatitis B virus. The Hepatitis B virus was first discovered in 1964 and was well known to the medical profession from the mid 1970s. The existence of blood borne pathogens generally became even more prominent with the advent of AIDS in the mid 1980s. Reports of blood borne transmission in laboratory workers and dialysis units were widely published in the mid 1970s. In Dr. Conly's opinion, an ordinary and competent physician should have been aware of the existence of the virus and its mode of transmission in the period of 1989 to 1996. Standards for Universal Precautions with respect to AIDS were developed by the Centers for Disease Control in Atlanta Georgia and published in the

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

Canada Diseases Weekly Report in November 1987. These same standards were subsequently modified to apply to all blood borne pathogens, including specifically Hepatitis B virus, in July 1988.

Dr. Conly also reviewed the principles of sterilization, which cover cleaning, disinfection and sterilization. Sterilization is the most effective method of removing all disease-related pathogens. The principles have been well understood since the 1970s. The process of sterilization must be documented and validated every time. Biological indicators must be used to ensure full sterilization. Standards, written in 1995, had been in place for two decades by then. With these standards in place all health care settings, including hospitals and clinics, would be able to deal with both known and unknown pathogen risks during any procedure. Dr. Conly also stated that gloves should be worn in all health care settings when there is patient or instrument contact even though gloves will not prevent needle stick injuries.

In Dr. Conly's opinion, the Medical Director of an EEG clinic is ultimately responsible for procedures performed there and the potential outcomes of such procedures.

Based on his review of the relevant documents relating to Dr. Wilson's practice, Dr. Conly testified that Dr. Wilson would have failed to meet the standard of practice in:

- No use of gloves in the presence of blood and/or bodily fluids;
- No hand washing between patients;
- Unorthodox and probably ineffective cleaning method for the electrodes;
- Failure to autoclave electrodes;
- Lack of monitoring to ensure sterility of electrodes;
- Lack of requirement for specific infection control training for persons performing the sterilization;
- Lack of information given to employees about Hepatitis B; and
- Reuse of electrodes for successive patients with no cleaning.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

The Panel considered Dr. Conly's evidence to be helpful. Dr. Conly was very knowledgeable in his field and presented his views in an objective and reasoned fashion.

DR. DONALD GEORGE BRUNET

Dr. Brunet is Professor, Department of Medicine, Queen's University and Acting Head Department of Medicine. He holds a certification from The Royal College of Physicians and Surgeons of Canada in Neurology. The Panel accepted Dr. Brunet as an expert witness in the field of EEGs. He stated that they are currently indicated for the diagnosis of seizure disorders and certain mental functions. He testified that EEGs are done in all types of health care settings, usually by a technologist and then read by a physician. The usual performance of an EEG requires that the technologist take a five to ten minute history from the patient. It then takes ten to twenty minutes to measure the head and place the leads appropriately. The EEG test itself takes twenty to thirty minutes. There is no possibility of doing twenty one to twenty six EEGs in a day using this method.

It was Dr. Brunet's opinion that needle electrode EEGs are not as accurately diagnostic as disc electrodes for the following reasons: the needles are directional and must be placed very carefully; the needles tend to fall out; the needles are more prone to artifact; patient cooperation is required; insertion of the needles causes pain; and there is a potential for infection. Also the potential for needle stick injuries is unusually high.

In Dr. Brunet's opinion Dr. Wilson as the Medical Director of the EEG labs in question bore full responsibility for supervising the technologist performing the procedure. Dr. Wilson was responsible for the care and safety of his patients and staff. Dr. Wilson was also responsible for the quality of the recordings and the interpretation of the results. Dr. Wilson was responsible for dealing with any complaints appropriately. Dr. Wilson was responsible for the choice of the type of electrodes used for the procedure. The technologist was responsible for the day-to-day operation of the EEG lab.

In Dr. Brunet's opinion, the number of EEGs performed in the case of complainant 3 was excessive in a patient with no seizures. Also, he stated that ambulatory EEGs are not

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

considered a screening test and should be performed only after a negative routine EEG. In Dr. Brunet's opinion, the most appropriate test for many of Dr. Wilson's patients would have been a CT scan. In his opinion, Dr. Wilson failed to meet the standard of care in his ordering of EEGs for at least six patients.

The panel considered Dr. Brunet a credible, knowledgeable expert witness who responded to questioning in a balanced fashion.

Dr. Wilson called three expert witnesses.

DR. DICK ERIC ZOUTMAN

Dr. Zoutman is Associate Professor, Departments of Pathology and of Community Health & Epidemiology at Queen's University. He is currently the Medical Director, Infection Control Service, Kingston General, Hotel Dieu and St. Mary's of the Lake Hospitals. Dr. Zoutman was accepted by the Panel as an expert witness in the field of Infectious Diseases. Dr. Zoutman reviewed the epidemiology of Hepatitis B in detail. In particular, he confirmed that, while the rates of the disease can be up to fifty percent in some areas of the world, the rates in Toronto are approximately two to three percent. He also reviewed the serology of Hepatitis B in detail and stated that the infectivity of e-antigen positive virus is very high, in the range of thirty percent for needle stick injuries in the presence of the virus. In Dr. Zoutman's opinion, Mr. K. was the source of the Hepatitis B outbreak. He agreed with the Public Health report that this outbreak was not caused by patient-to-patient transmission of the Hepatitis B virus. It was his opinion that, because of this, the EEG needle electrodes were not the mode of transmission.

In Dr. Zoutman's opinion, Dr. Wilson was acting as Medical Director of the EEG clinics and was responsible for the nature of the practice and procedures used. This would include: assessing the potential for infectious diseases; instituting appropriate procedures to minimize the risk to patients; and awareness of actual practices in the clinics. Mr. K. would be expected to be aware of the maintenance of general hygiene of himself and the equipment used, especially when contact with the patient was expected. In Dr. Zoutman's

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

opinion it was appropriate for Dr. Wilson to delegate daily routine activities to Mr. K. and to present new policies and technologies to Mr. K. for implementation.

A great deal of Dr. Zoutman's testimony concerned infection control standards in general use in the period from 1990 to 1995. In his opinion, the use of gloves would not have prevented transmission of Hepatitis B in the EEG clinics and were not mandatory to use in the cleaning of equipment in circumstances where the skin of both parties was intact and there was no expectation of the presence of blood. In his opinion, there was also an absence of written guidelines to address this issue until 1996. He agreed that the absence of written protocols does not mean there were no commonly recognized standards. Universal precautions to prevent the spread of known and unknown pathogens were an accepted standard in the early to mid 1990s. All of the references in the document published by the College of Physicians and Surgeons of Ontario in March 1995 entitled "Infection Control in the Physician's Office" predated 1995. It was the opinion of Dr. Zoutman that the use of gloves in universal precautions is not always necessary. In his opinion, the use of gloves while performing needle electrode EEGs was discretionary depending on the technologist. This also was the case for the current practice for phlebotomists. However, it was Dr. Zoutman's opinion that cleaning obvious blood from the head of a patient without the use of gloves fell below the standard of practice. Needle electrodes, if allowed to dangle from a table or chair, pose a risk of contamination and this scenario would fall below the standard of practice. The practice of removing all the needle electrodes at once would pose the risk of needle stick injuries and potential blood spatter, thereby resulting in increased risk of infection. In his opinion, this too fell below the standard of practice.

Standards for the sterilization of medical instruments in an office setting were published in the College of Physicians and Surgeons document dated 1994. Dr. Zoutman agreed that these are minimum standards and that it is imperative to monitor the sterilization process and record the results each time equipment is sterilized. Failure to do so, or to monitor less often, in Dr. Zoutman's opinion, falls below the standard of practice. In the opinion of Dr. Zoutman, soaking equipment in glutaraldehyde for thirty minutes only also

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

falls below the standard of practice. Lack of written policies and procedures for the EEG clinics also falls below the standard of practice.

In Dr. Zoutman's opinion, using a blunt needle to scratch the head of a patient undergoing disc electrode EEG without cleaning the needle between patients demonstrated a failure in training of the EEG technologists.

It was Dr. Zoutman's initial opinion that Dr. Wilson's activities did not fall below the standard of practice. However on cross-examination he varied from this opinion in the areas detailed above.

The panel considered Dr. Zoutman's evidence to be helpful, particularly in relation to opinions expressed in cross-examination as set out above.

DR. BRYAN YOUNG

Dr. Young is Assistant Professor, Department of Clinical Neurological Sciences, University of Saskatchewan, Saskatoon; Director of EEG Laboratory, University Hospital, Saskatoon; and Consultant Neurologist, University, St. Paul's and City Hospitals, Saskatoon. The Panel accepted Dr. Young as an expert witness in the specialty of Neurology.

Dr. Young is the author of an article entitled "Minimal standards for electroencephalographic laboratories" published in the Canadian Medical Association Journal in 1991. The article states "Disc electrodes should be used instead of needle electrodes" and "The electrodes should be cleaned or sterilized between patients with the use of standard indicators or methods." In his testimony, Dr. Young stated that these were recommendations and not directives, as he had no authority to make such directives. A further document published by the Canadian Association of Electroneurophysiology Technologists entitled "Minimal Technical Standards EEG/EMG 1991 to 1993" also states "Surface or cup electrodes are recommended for routine clinical use." In the opinion of Dr. Young, the use of needle electrodes was first prohibited in a letter of

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

March 6, 1996 sent to all physicians by the College of Physicians and Surgeons of Ontario.

Dr. Young participated in a survey in 1994, which polled all physicians who were billing EEG OHIP codes. In this survey, seventeen percent of those physicians stated that they were using needle electrodes. This concerned Dr. Young because, even though needle electrodes have been used for many years, he did not think their use a good idea. He stated that there could be small amounts of bleeding associated with their use. He believed that the quality of the recording was practically sufficient for diagnosis. He also believed, prior to receiving the survey results, that no physician was using needle electrodes and that their use was an unacceptable practice. He stated that he would not have allowed their use in any clinic that he was responsible for. Most EEG clinics moved away from using needle EEG electrodes in the mid 80's with the advent of the awareness of AIDS.

In Dr. Young's opinion, the Medical Director of EEG clinics was responsible for ensuring that the technologist performing the procedure was qualified and knowledgeable with respect to infection control. The Medical Director is also responsible for setting of policies, which should be reviewed with the technologist. The technologist would be responsible for the day-to-day operations of the clinic. On reviewing Mr. K.'s resume, Dr. Young considered him to be qualified to function in an unsupervised way. He also considered, that in the situation where the physician and the technologist were in almost daily contact, that the need for written policies and procedures would be less.

In his response to questioning about the indications for EEG testing in the patient files available, Dr. Young expressed the view that it would not be unreasonable to perform three to four EEGs where the situation is unclear, as the diagnostic accuracy for a single EEG is only fifty percent. In two other cases, he did not see an indication for the order for an EEG and in two cases, considered that the EEGs were performed for the purpose of patient reassurance. He also indicated that, in all cases reviewed, Dr. Wilson diagnosed and managed the patients appropriately. Dr. Young was shown a copy of an OHIP billing

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

log from Dr. Wilson's clinic. It was apparent from this log that on some days Mr. K. had performed twenty-one or more EEGs on one site. Dr. Young stated that generally an EEG technologist would be able to perform three or possibly four EEGs in a day. If, as Medical Director, Dr. Young had seen such a log he would have taken steps to investigate the possibility that procedures were not being appropriately followed.

Dr. Young opined that the risk of transmitting blood borne pathogens with EEG needles was very low and would not normally be discussed with the patient. He expressed the view that gloves should be worn when performing this test. He also testified that bleeding was seen very occasionally and that the technologist's fingers were in close proximity to the needles during insertion. Patients are also not normally given choices as to the technique of the test. He did not consider it necessary for the scalp to be measured. An experienced technologist could place the electrodes in approximately the right place. The physician reading the EEG would not be able to tell from the tracing whether the scalp was measured or not.

Dr. Young stated with no reservations that, as Medical Director of the EEG clinics, Dr. Wilson was responsible for the controlled medical acts delegated to the technologist.

The Panel found Dr. Young's testimony helpful on certain of the issues identified above, particularly as clarified on cross examination. He was straightforward and the Panel considered Dr. Young to be a credible witness.

DR. KEITH MELOFF

Dr. Meloff is an Instructor in the Division of Neurology, University of Toronto, and Examiner, American Board of Psychiatry and Neurology. The Panel accepted Dr. Meloff as an expert witness in the area of community neurological practice. Dr. Meloff was also the Medical Director of an EEG lab in Etobicoke, which employed a single technologist until 2000.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

After review of their resumes, Dr. Meloff considered that Mr. K. was qualified to function as an independent EEG technologist and that Dr. Wilson was qualified to act as Medical Director of an EEG lab.

Dr. Meloff was aware of the results of the 1994 survey on EEG practices in Ontario and that seventeen percent of the participants were using needle electrodes. He testified that he personally would not routinely use needle electrodes and personally favoured and used disc electrodes. There was fairly solid consensus for this opinion in the years 1990 to 1996. Dr. Meloff agreed there was a small risk of bleeding with the use of needle electrodes and required his technologist to wear gloves routinely. In Dr. Meloff's opinion, failure to discontinue the use of needle electrodes during this period fell below the standard of practice.

Dr. Meloff's EEG clinic performed an average of four to six EEG's in a day to a maximum of eight if demand was heavy. When shown the OHIP billing logs from Dr. Wilson's office, Dr. Meloff appeared to be visibly uncomfortable. He stated that he would assume that a qualified technologist was following proper procedure and that he would want to make certain that this was being done.

The Panel found the testimony of Dr. Meloff not particularly helpful, although generally his opinions on identified issues in cross examination reflected those of the other expert witnesses.

THE EVIDENCE OF DR. RONALD HAROLD WILSON

Dr. Wilson is a 65-year-old qualified Neurologist licensed by the College of Physicians and Surgeons of Ontario and holding a fellowship from the Royal College of Physicians and Surgeons of Canada. At the time in question, he was practicing at the locations described in the Agreed Statement of Facts.

In 1970, Mr. K., who was then working as an EEG technologist at Centenary Hospital, approached Dr. Wilson to form a partnership to provide EEGs in a community setting, in

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

response to a perceived community need for such services. Dr. Wilson reviewed Mr. K.'s resume and references, noted that Mr. K. was CBRET trained according to CAET standards, and considered that he would be comfortable having Mr. K. as a technologist in such a clinic. Dr. Wilson stated that the clinic was set up using hospital standards of policy and procedure. Asked to assess Mr. K., Dr. Wilson replied that Mr. K. worked extremely hard in that he was the first to arrive in the morning and the last to leave. Dr. Wilson was not aware of the exact details of the working hours of Mr. K. and saw no need to review logbooks at the EEG clinics where Mr. K. was the technologist. Dr. Wilson described him as professional, efficient and meticulous, the last of which could sometimes lead to abrasive relations with other clinic staff. Dr. Wilson described Mr. K. as "not diplomatic".

Dr. Wilson acted as Medical Director for these clinics. He agreed that he was responsible for patient care and care of the equipment used. He was at all times responsible for staffing issues and the quality of care provided as well as administrative issues and policies and procedures. The use of, and type of, sterilization of the needle electrodes was his responsibility, as was the supervision of Mr. K.. Dr. Wilson believed that it was the role of Mr. K. to take a medical history from the patient and to explain the procedure, as well as to clean the needle insertion sites and measure the head. Having regard to this, he believed an average EEG would take twenty-five to thirty minutes.

Needle electrodes were used in these clinics because both Dr. Wilson and Mr. K. were trained in their use and were comfortable using them. When Mr. K. left Centenary Hospital in 1979, the hospital started to use surface electrodes exclusively. Dr. Wilson and Mr. K. continued to use needle electrodes because of the comfort of use issue and because the clinic had encountered no problem in such use. Keeping an inventory of such leads was the responsibility of Mr. K.. Dr. Wilson never saw such an inventory and saw no need to review any such inventory because of Mr. K.'s qualifications.

Dr. Wilson reviewed the OHIP billing log and testified that he was "not really" aware of the actual numbers of EEGs being performed. However on cross-examination he changed

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

that statement. He stated that the larger volume days might be accounted for if a backlog had occurred or because of community need. Dr. Wilson stated that he totally trusted Mr. K.'s expertise, based on his qualifications and previous job performance. Dr. Wilson was not concerned with the large numbers of tests being done, especially in the area of needle sterilization. Dr. Wilson was confident that "things were being done properly". He was aware that Mr. K. was working very long hours. Dr. Wilson's only concern was that Mr. K. might be working too hard. Dr. Wilson testified that he saw no reason to review the appointment books (and did not ever do so) and was not aware that appointments for EEGs were being booked at fifteen-minute intervals. Dr. Wilson never saw Mr. K. perform an entire EEG. Dr. Wilson never audited Mr. K.'s activities in the clinics or performed any performance appraisal.

Dr. Wilson stated that the clinics had no written protocols because Mr. K., who he regarded as very familiar with procedures, was the only person performing such EEGs and they spoke regularly. During the epidemiological review of the EEG clinics in 1995, the Public Health officials made it clear to Dr. Wilson that written protocols were expected. In response to this, Dr. Wilson instructed Mr. K. to write these protocols.

Dr. Wilson recalled the incident with patient X very clearly. He spoke with patient X's father and readily agreed with him that removing all the EEG leads at once was not appropriate. Subsequently, Dr. Wilson instructed Mr. K. to discontinue this practice. He believes Mr. K. complied. Dr. Wilson asked every patient on their return visit about the EEG test and no other patient reported such activity nor did any patient report any bleeding of the head after the test. Dr. Wilson denied that he ever saw a patient bleed or that any patient was ever upset after an EEG.

When the College of Physicians and Surgeons surveyed EEG clinics in 1995 and asked for volunteers for a task force to review all aspects of such clinic activity, Dr. Wilson sought advice about sterilization of equipment from Ms. M., Infection Control Officer at Centenary Hospital. Ms. M. suggested that Dr. Wilson not use needle electrodes and sent him a copy of Dr. Young's minimal standards article from the Canadian Medical

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

Association Journal. Because of this consultation, Dr. Wilson realized that he should be using steam sterilization and took steps to implement this. One other change in sterilization in the clinics was implemented in the 1980's with the advent of the awareness of AIDS, when the cleaning solution was changed from Dettol to Javex. Dr. Wilson was confident that Mr. K. was following standard infection control protocols because he was very qualified, interested in his own education and totally interested in his profession. They regularly spoke at the end of the working day.

Dr. Wilson was not aware of any requirement to keep sterilization logs at the time in question but in hindsight agreed that there should have existed some reference materials for physicians with these details. He was not aware that one of the sterilizers on his premises was broken until Public Health Officials brought it to his attention during the outbreak investigation. Dr. Wilson testified that he believes there was a vacuum in standards and information at the time in question. He did not know that biological monitors or chemical test strips were available until the publication of the College of Physicians and Surgeons guidelines in May 1995. The manufacturer's instruction for the sterilizers did not contain this information. Dr. Wilson instructed Mr. K. to check the temperature with an external thermometer once weekly. At the end of 1995, Dr. Wilson had lost confidence in dry heat sterilization and a steam sterilizer had been purchased and was operational. No indicators were used for this sterilizer. Dr. Wilson stated that he did not know where to purchase biological monitors. Dr. Wilson testified that it was not clear to him at the time whether logs should be kept for this machine's operations. Dr. Wilson stated that he telephoned Dr. D'Cunha, who was then Medical Officer of Health for Scarborough, and asked for advice on sterilization procedures. He testified that he was told to follow the manufacturer's instructions.

At the advent of the general awareness of the blood borne character of the AIDS virus, Dr. Wilson did have discussions with Mr. K. about the use of gloves while performing EEGs. Mr. K. said he was concerned that glove use would hamper his dexterity. Taking Mr. K.'s qualifications into account, Dr. Wilson did not press the point.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

Dr. Wilson was aware of the disease Hepatitis B during the period from 1990 to 1995 because of the potential for liver toxicity in the use of anti-convulsant medications and hepatic encephalopathy. In the late summer and early fall of 1995, when he became aware of three patients who had tested positive for Hepatitis B, he did not attach significance to this. It was his belief that the disease was common and that the patients had identifiable risk factors. He did not immediately suspect transmission of the virus by way of the EEG needle electrodes. When Dr. Wilson did recognize this possibility, he instructed Mr. K. to discontinue using them and the needle electrodes were taken to Centenary Hospital where they were incinerated. Dr. Wilson also started testing other patients for exposure to the Hepatitis B virus. He testified that he informed the patients of the reason for the testing.

During the course of the Public Health investigation, Dr. Wilson became aware that a potential twenty patients had been exposed to Hepatitis B via the needle electrodes, and he found that information shocking and disturbing. He cooperated fully with the investigation, releasing patient files and keeping the office phones open over the weekend to answer patient inquiries after the situation was made public.

Dr. Wilson was asked to review some of the patient files in evidence. In his view, one patient had potential focal seizure activity. He stated that a single EEG has only a fifty-percent diagnostic accuracy and that four EEGs are required to reach ninety five percent accuracy. The further six EEGs were indicated to monitor the need for anticonvulsant therapy.

Dr. Wilson testified that he made an effort to stay current with standards for the safety of patients. He believed that there were no guidelines recommending that needle electrodes not be used in 1985. He maintained standards based on textbooks and peer reviewed journal articles. He stated that he does not read the Canadian Medical Association Journal and was not aware of the minimal standards article by Dr. Bryan Young until he received a copy from Ms. Wartman in 1995. He was aware that Centenary Hospital started using

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

only surface electrodes in late 1970s and saw no need to change his private clinical practice, relying on a textbook chapter by a world-renowned authority published in 1988.

The Panel did not question Dr. Wilson's qualifications as a Neurologist. In testimony, he often contradicted other credible witnesses as well as himself and was evasive. Where his testimony was at variance with that of other witnesses, the Panel preferred the testimony of the other witnesses.

DR. COLIN D'CUNHA

Dr. D'Cunha is currently the Chief Medical Officer of Health for Ontario. From 1990 to 1995, he was in the position of Associate Medical Officer of Health for Scarborough and from 1995 to 1997 acted as the Medical Officer of Health for Scarborough.

Dr. D'Cunha was asked if he received a telephone call from Dr. Wilson in the fall of 1994 regarding reusable EEG needles and requesting assistance in infection control procedures for such equipment. Dr. Wilson testified earlier that he had telephoned Dr. D'Cunha for such advice. Dr. D'Cunha testified that he "clearly did not recall" providing such advice. He also stated that, had he provided such advice, the advice would have included the use of universal precautions and appropriate sterilization of the reusable needles following recommendations for the sterilizer being used. He stated that this sort of call from a physician's office was not routinely received by himself or his office and that this would have been the first such call he had ever received. He did agree that he could not be 100% certain that it did not occur.

The Panel considered Dr. D'Cunha to be a credible witness with a very professional manner.

FINDINGS AND DECISION

After careful consideration of all evidence and submissions, the Panel finds that Dr. Wilson failed to maintain the standard of practice of the profession that he engaged in

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

behaviour relevant to the practice of medicine that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

REASONS FOR FINDING

The Committee was aware throughout that the activities described by witnesses occurring in the EEG clinics were performed by Mr. K. and not directly by Dr. Wilson. Dr. Wilson was at all times the Medical Director of these EEG clinics and therefore bore full responsibility for these activities. The Committee accepts that normally the technologist in an EEG clinic would be responsible for the day-to-day activities of the clinic. However, the Committee considered the failure of Dr. Wilson to appropriately supervise directly or audit the behaviour of Mr. K. over a period exceeding twenty years egregious in the extreme. Dr. Wilson clearly continued to be unaware of the practice of removing the needle electrodes all at once even after he instructed Mr. K. to cease this activity. Dr. Wilson made no attempt to monitor compliance with his instruction. Dr. Wilson admitted that he had never observed an EEG being performed by Mr. K. in the years that they worked together. He was unaware that Mr. K. was rolling the needle electrodes in his bare fingers to test for sharpness.

Dr. Wilson was aware in the mid 1980s that gloves should be worn when there was patient contact. He discussed this with Mr. K. at that time but still allowed Mr. K. to continue to insert the EEG needle electrodes and to handle them after use without wearing gloves, even though contamination by blood was a real possibility.

Dr. Wilson continued to allow the use of needle electrodes in the performance of EEGs after published articles and guidelines recommended the use of surface electrodes, thus placing his patients and staff at an unnecessary risk for contracting disease from blood borne pathogens. He continued to allow the use of needle electrodes after he became aware that Centenary Hospital, where he was a member of the Medical Staff, had discontinued such use in 1980.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

Dr. Wilson failed to protect his patients by failing to ensure adequate sterilization of the needle electrodes used. The clinics had no written policies or protocols addressing sterilization techniques to be used until after the Public Health Department visit in 1996. In the absence of indicators used to monitor the sterilization process, Dr. Wilson had no way of ascertaining whether the electrodes were actually sterile while in use. In the absence of logbooks to monitor the operation of the sterilizers, Dr. Wilson had no way of knowing whether the sterilizers reached adequate temperatures for long enough to ensure that the electrodes were sterile, or if the sterilizers were in working order.

Dr. Wilson did not offer Hepatitis B vaccination to his staff or advise them to be tested for exposure to Hepatitis B. He did not make available written policies and procedures for the appropriate response to needle stick injuries. The clinics had no written or posted guidelines regarding standard infection control procedures for patient contact or the handling and cleaning of equipment. The Committee considered that, in circumstances where needle stick injuries are almost inevitable when using needle electrodes, Dr. Wilson's failure to ensure the health and safety of his staff and patients in this way showed disregard for practice standards and was, in fact, disgraceful.

The reuse of needle electrodes from patient to patient without sterilization or cleaning in any way, does not meet any standard of practice in place at the time and is of course reprehensible.

Dr. Wilson was aware of the number of EEGs being performed on any given day in his clinic. The Committee considers that this in itself should have triggered a review of the practice with respect to the quality of the testing. A prudent physician should have taken steps to ensure that appropriate infection control procedures were followed in the processing of the electrodes, as well as ensuring that the results of the test were adequate for clinical interpretation. This is particularly so given that a member of his staff, Mr. A., had alerted him about possible deficiencies.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

The Committee considered that all of the expert witnesses, to varying degrees, were professional and knowledgeable in their field of expertise and very helpful to the Committee's understanding of the issues involved, to the extent indicated previously. It is significant that all of them expressed concern about certain of the practices in the EEG clinics.

Having regard to all these facts the Committee is satisfied that Dr. Wilson failed to meet the standard of the profession and that he committed an act or was guilty of an omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee finds that Dr. Wilson failed to maintain the standard of practice of the profession by:

- Failing to ensure and /or implement appropriate infection control practices in the EEG laboratory from 1989 to 1996;
- Failing to ensure the use of gloves during the insertion of needle electrodes when exposure to blood and bodily fluids was probable;
- Failing to ensure the use of gloves during the cleaning and disinfection procedures used for the needle electrodes;
- Failing to ensure, prior to December 1996, that the processes in EEG laboratory were performed according to a protocol for cleaning, disinfection and sterilization procedures;
- Failing to implement a monitoring process to ensure the adequacy of sterilization procedures;
- Failing the ensure that personnel responsible for the cleaning and sterilization procedures were adequately educated and continuingly competent in the area of infection control generally, and specifically infection control of blood borne pathogens;
- Allowing needle electrodes to be used on successive patients without appropriate cleaning, disinfection or sterilization processes; and

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

- Continuing to use invasive needle electrodes in the 1980s when he knew, or should have known, that their use was considered unsafe by the hospital that he was affiliated with and by a majority of his colleagues.

The Committee further finds that Dr. Wilson committed an act or was guilty of an omission relevant to the practice of medicine that, having regard to all circumstances, would be regarded by members as being disgraceful, dishonourable or unprofessional for the reasons stated above and by:

- Failing to ensure the safety of his staff by not providing appropriate training in and ongoing supervision of infection control procedures;
- Failing to ensure the safety of his staff and patients by not offering Hepatitis B vaccine to his staff and by failing to advise them to be tested for exposure to Hepatitis B;
- Ordering and performing EEG testing on patients for whom the test was not medically necessary;
- Allowing large numbers of EEG tests to be performed daily in his laboratory without ensuring that appropriate procedures were being followed; and
- Failing to ensure that his instructions not to remove all the EEG needles at one time were being followed.

The Committee also finds that, for the previously stated reasons, Dr. Wilson displayed incompetence in that his professional care of patients displayed a lack of judgment and disregard for the welfare of his patients of a nature and to an extent that demonstrates that he is unfit to continue in practice or that his practice should be restricted.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

Indexed as: **Wilson (Re)**

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF **a Hearing directed by the Complaints Committee of The College of Physicians and Surgeons of Ontario, pursuant to Section 26(2) of the** *Health Professions Procedural Code*, **being Schedule 2 to the** *Regulated Health Professions Act*, 1991, **S.O. 1991, c.18, as amended**

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. RONALD HAROLD WILSON

PANEL MEMBERS:	DR. C. HILL (CHAIR) DR. D. BRADEN R. SANDERS J. FREDERICK
Hearing Dates:	January 21 – 25, 2002 February 4 – 6, 2002 March 4 – 7, 2002
Decision/Released Date:	August 21, 2002
Penalty Hearing Dates:	November 11 & 12, 2002
Penalty Decision/Released Date:	November 12, 2002

PUBLICATION BAN

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

REASONS FOR PENALTY DECISION

The Discipline Committee held a penalty hearing in the matter of Dr. Ronald Harold Wilson on November 11 and 12, 2002. The College asked for revocation of Dr. Wilson's certificate of registration and requested costs of $25,000.00, be ordered. Dr. Wilson, through his defense counsel, requested that the Committee consider a lesser penalty such as a period of suspension and restrictions on Dr. Wilson's certificate of registration. After deliberation at the conclusion of the hearing, the Committee delivered its decision in writing directing the Registrar to revoke Dr. Wilson's certificate of registration.

PUBLICATION BAN

The Discipline Committee ordered under section 45 (3) of the *Health Professions Procedural Code* that neither the names of the complainants nor any information by which they, or any patient of Dr. Wilson, may be identified, published or broadcast.

EVIDENCE ON PENALTY HEARING

The Committee heard from seven witnesses for the defense who were physicians and professional colleagues during the time in question. Some of them worked with Dr. Wilson directly at one hospital and referred patients to him from the Emergency Department. One was a family doctor who regularly referred neurological patients for consultation from her office. Two were specialists at another hospital who received referrals from Dr. Wilson. All of these witnesses stated that Dr. Wilson was an excellent neurologist who was available when necessary, saw consultations in a timely manner and investigated them appropriately. None of these witnesses recalled hearing any mutual patients complain about Dr. Wilson in any way. Although some of these physicians interacted socially with Dr. Wilson at medical and hospital functions on occasion none were close friends.

When asked what impact revocation would have on patient care in Dr. Wilson's practice area, they were agreed that there would be a deficiency of diagnostic and therapeutic neurological patient care that would adversely affect the community.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

None of these witnesses were aware of the finding of excessive use of EEGs until the day they testified. None of them had read the detailed reasons for the Committee's decision finding Dr. Wilson guilty of professional misconduct, for failure to maintain the standard of the profession, among various grounds, and as well finding him to be incompetent.

The Committee considered that all these witnesses were credible and testified to the facts in the areas of their knowledge of Dr. Wilson's practice in a professional and straightforward fashion. However the Committee took into account in weighing the usefulness of their testimony the fact that the findings and reasons for the findings were not based on Dr. Wilson's office or emergency neurological practice, with the exception of his ordering excessive EEG testing on some patients. The findings of the Committee were based on his activities, and omissions occurring in these activities, while he was functioning as Medical Director of his private EEG clinics.

Two of the witnesses for the defense were patients of Dr. Wilson. Both spoke very highly of his professional and personable manner while he was dealing with them. Both had spoken with other patients of Dr. Wilson who felt the same way. They stated that neither they nor the other patients felt that they had been rushed in Dr. Wilson's office. One agreed that he knew about the finding of excessive EEG testing but stated that he did not understand the issue. The other stated it was her opinion, based on an internet search that the EEG testing seemed appropriate. Both agreed with the previous physician witnesses that revocation of Dr. Wilson's certificate of registration and his subsequent inability to practice would adversely affect neurological care in the community.

These witnesses testified in a forthright manner but the Committee concluded that their views were outweighed by the need to protect members of the public from seriously deficient and incompetent practice as established by the evidence in this case.

Dr. Brian Young also testified. He stated that he had reviewed in detail the reasons for the findings given by the Discipline Committee. He stated that, in his opinion, Dr. Wilson

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

had regard for the welfare of his patients and overall delivered good care and treatment to his patients both in his role as a clinician and in his role of Medical Director of the EEG clinics. Dr. Young testified that the ordering of excessive EEGs does not place the public at risk, as it is quite a safe procedure. He stated that these roles were different and that, in his opinion, it would be reasonable to consider these roles as different components of Dr. Wilson's practice. He does not believe that Dr. Wilson showed deficiencies in his ordinary clinical practice. Dr. Young was asked whether it was necessary in his opinion to revoke Dr. Wilson's certificate of registration to protect the public and he stated that, in his opinion, "overall I would say no". Dr. Young did agree on further questioning that the appropriate penalty was a matter for the Committee to decide on the evidence before it. Dr. Young felt that, given that Dr. Wilson did not appear to have deficiencies in his clinical practice, the issue of ordering EEG testing could respond to remediation, if Dr. Wilson had insight into these matters.

The Committee found Dr. Young a generally credible witness with the exception of his viewpoint on EEG testing being a "quite" safe procedure. The members of the Committee felt that the evidence put before them in this hearing demonstrated quite the opposite and that patients could be seriously harmed by EEG testing done in an invasive manner with needle electrodes.

A large number of patient testimonial letters were also entered into evidence.

REASONS FOR PENALTY

The Committee ordered the Registrar to revoke Dr. Wilson' certificate of registration, effective immediately.

In reaching its decision the Committee took into account the opinions of all the physicians who testified that Dr. Wilson was a professional, approachable and available neurologist who appeared generally to order appropriate diagnostic testing and deliver appropriate therapeutic care. However the Committee felt strongly that Dr. Wilson, acting

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

in his role as Medical Director of his private EEG clinics, demonstrated a serious lack of knowledge of basic clinical standards, especially in the area of infection control. His failure to supervise Mr. K.'s clinical activities over a period exceeding twenty years demonstrates a significant lack of understanding of the proper role of a physician acting as a Medical Director. His failure to act, in any real way with regard for the concerns of patients and of a member of his staff, strongly indicates a singular lack of insight into the potential harm that could befall his patients who underwent invasive testing with needle electrode EEGs.

Mr. K. was not a rogue employee. Dr. Wilson was not caught up in a chain of unfortunate events. He was responsible for the Hepatitis B infections in his patients that led to one death, many seriously ill people, and many who will continue to be carriers of the disease. Dr. Wilson created the environment that allowed this tragedy to occur by lack of supervision of his employees, lack of protection of his employees and patients from infectious diseases, lack of any formal training of his employees in the area of infection control and lack of any monitoring of the sterility of the needles used to perform the EEGs. The Committee did not consider this the behaviour of a young naïve physician where an attempt at remediation would possibly be of value. This disregard for patient welfare took place over a period of many years. Dr. Wilson made no attempt in that period of time to change or improve his own knowledge or that of his employees. His concerns with the use of gloves while performing EEG procedures revolved primarily around the health of Mr. K. He knew that standards required that gloves be worn during invasive procedures but chose not to enforce their use. Dr. Wilson's patients came to him for healing but instead were exposed to avoidable risks. Whether Dr. Wilson was aware or not that Mr. K. was a Hepatitis B carrier was immaterial to the fact that he should have introduced and enforced the use of universal precautions in his clinics.

Dr. Wilson has not demonstrated to the Committee that he has remorse for, or even insight into, his part in the development of these unfortunate events. He consistently abdicated blame to Mr. K. When he became aware that some of his patients had developed Hepatitis B, he tested them for the disease without informing them why the

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

blood tests were necessary. His background, experience and qualifications make his actions and lack of action more troubling to the Committee, not less.

While the Committee heard abundant evidence that Dr. Wilson was, and is, practicing appropriately as a neurologist, the Committee felt that the circumstance of the events show remarkable lack of clinical judgment. He ordered and performed, through his clinics, EEGs that were not clinically necessary. He continued to approve the use of needle electrodes to perform EEGs long after he knew, or should have known, that this was not the recommended standard of practice. In considering whether the role of clinician and Medical Director could be isolated from one another the Committee judged that this was not just a matter of administrative incompetence. Taken as a whole Dr. Wilson's lack of judgment and insight applied to all areas of his practice.

The Committee considered the evidence presented on the impact of revocation and the loss of Dr. Wilson's clinical services to the community. Other consideration in the public interest outweighed this in the final analysis. The Committee believes that, given the nature of Dr. Wilson's involvement in the cause of this epidemic and his lack of remorse and insight, the welfare of the public and reputation of the profession are best served by denying Dr. Wilson the right to practice.

By judicial precedent, revocation is reserved only for those who have been found to repeat unprofessional behaviour or for the most serious cases of professional misconduct and incompetence. The Committee believes that the latter has been unequivocally demonstrated at this hearing. Dr. Wilson's behaviour over a prolonged period of time clearly shows disregard for his patients' welfare as well as for the welfare of the public generally. Many of his patients became ill, some seriously, to the extent where they could no longer work or engage in normal family and social activities. Patients suffered anxiety that they may have transmitted this disease to members of their family. The Committee believes that the publication of the Public Health Department report resulted in profound fear and mistrust of the profession. This outbreak has led to real, permanent physical and

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.

emotional damage to the public in its interaction with and perception of the medical profession.

The trust of the public in dealings with the medical profession has been seriously undermined. The extent of the risk to Dr. Wilson's patients, both past and future, and to the public in general, and the major damage that this outbreak caused to the reputation of the profession as a whole, is serious and deserving of a penalty no less than revocation.

The question of costs will be decided by the Committee upon receiving written submissions from the College and Dr. Wilson, such submissions to be delivered within fifteen days of the delivery of the Committee's penalty decision in writing.

On November 5, 2003, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Wilson [2003] O.J. No. 4236.