SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Cory Torgerson (CPSO #77996)
(the Respondent)

INTRODUCTION

The Complainant is the medical director of an out-of-hospital premises (OHP) (the "Clinic"). In June 2019, the Respondent made a request to rent the Clinic.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **did not give him the College's confirmation number in advance and brought his own equipment and circulating nurse into the Clinic**
- **made "disrespectful demeaning threatening" comments and said that the facility had "so many problems" that it should not have passed the College's OHP approval**
- **engaged in behaviours that "intentionally and directly" disrupted the care of a number of patients.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of June 3, 2022. The Committee required the Respondent complete a specified continuing remediation and education program (SCERP) consisting of self-directed learning (review and written summary of the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control document, with respect to reprocessing and medical equipment being brought into the receiving facility; the *OHPIP Program Standards*, with respect to sterilization of instruments and a medical director's responsibility to approve all staff working at an OHP; and the College's policy, *Physician Behaviour in the Professional Environment*).

COMMITTEE'S ANALYSIS

When it considered this matter in April 2022, the Committee had concerns about the Respondent's conduct and decided to direct staff to negotiate a remedial agreement with the Respondent. The Respondent elected not to sign the remedial agreement.

Upon reconsidering the matter in June 2022, the Committee remained concerned about the Respondent's conduct in this matter and noted the following:

- As the medical director of his own OHP, the Respondent knew or ought to have known that PIDAC required that the instruments he intended to use at the Clinic be delivered in advance to be sterilized at the facility. This would have been in accordance with the Clinic's policies and procedures. By arriving at the Clinic on June 25, 2019, and proceeding to use in a surgical procedure equipment and instruments that he had not provided in advance to the Clinic for reprocessing at the Clinic, the Respondent was in breach of the requirements of the PIDAC document and the *OHPIP Program Standards*.

- The Respondent indicated to the College that his decision to bring his own employee to the Clinic because there was no properly credentialed sterilization/reprocessing technologist present for surgery day solved a major problem in a time-sensitive situation; however, it was not within the Respondent's role to create a "work around" for any issues he identified, except in exigent circumstances. By making the decision to bring his own reprocessing technologist with him to the Clinic on June 25, 2019, the Respondent was usurping the authority of the medical director of the Clinic.

- Based upon the information provided by the Respondent and the Complainant, it was established that there was conflict and misunderstanding on June 25, 2019, that disrupted patient care. This led the Committee to conclude that there were aspects of the communication between the Respondent and the Complainant prior to surgery day that should have been clearer. The Respondent had the ultimate responsibility to ensure a seamless day by communicating clearly and effectively about the sterility of instruments and the availability of trained staff, as these were his patients being drawn into a disorganized, last-minute situation.

Given that the Respondent declined to sign the remedial agreement, the Committee therefore required that he complete the SCERP outlined above to address the educational needs identified in this case.