Indexed as: Gale (Re)

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

IN THE MATTER OF a Hearing directed
by the Executive Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 36(1) of the ***Health Professional Procedural Code,***
being Schedule 2 of the ***Regulated Health Professions Act, 1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. GEORGE DOUGLAS GALE

PANEL MEMBERS: DR. M. GABEL (CHAIR)
J. DHAWAN
DR. O. KOFMAN
P. BEECHAM
DR. M. DAVIE

Hearing Date: May 10, 2004

Decision/ Release Date: May 10, 2004

DECISION AND REASONS FOR DECISION

This matter came on for penalty hearing before the Discipline Committee on Monday, May 10, 2004, at the College of Physicians and Surgeons of Ontario in Toronto. At the conclusion of the hearing, the Committee made its order and delivered it in writing, with reasons to follow.

MATTER REMITTED BY THE DIVISIONAL COURT

The panel was charged with the responsibility of determining an appropriate penalty for the findings of professional misconduct made by a previous panel of the Discipline Committee, which were upheld on appeal to the Divisional Court. The College did not proceed with other allegations, the findings in relation to which were not upheld in the Divisional Court.

The allegation in the Notice of Hearing on which the prior panel of the Discipline Committee made findings of professional misconduct, stated as follows:

1. It is alleged that Dr. George Douglas Gale has committed an act of professional misconduct under ss. 1(1)(2) of Ontario Regulation 856/93 made under the Medicine Act, 1991, in that he failed to maintain the standard of practice of the profession.

THE FACTS

The Discipline Committee admitted in evidence a statement of agreed facts, which had appended to it the Reasons of the Divisional Court released on October 10, 2003. The facts underlying the findings of professional misconduct are set out in the statement of agreed facts and in the reasons of the Court. The Committee accepted the statement of agreed facts, which provided:

1. At all material times Dr. George Douglas Gale ("Dr. Gale") was an anaesthetist with a certificate of registration in Ontario, practicing at a Pain Management Clinic (the Clinic).

2. Dr. Gale's licence to practice medicine was restricted as of 12:01 a.m. on May 10, 2001 pursuant to a S.37 order. The restriction remained in effect until his licence was revoked. The restriction was as follows:

   The Executive Committee of the College of Physicians and Surgeons of Ontario directs

the Registrar to impose on the certificate of registration of Dr. George Douglas Gale under section 37 of the Health Professions Procedural Code the terms and limitations that Dr. Gale be prohibited from performing general anaesthesia, conscious sedation or nerve blocks.

3. The restrictions were such that Dr. Gale could assess chronic pain patients, give medical opinions, give medication and do medical/legal reports but could not do nerve blocks or give anaesthesia at the Clinic.

4. On February 5, 2002, the Discipline Committee found Dr. Gale had committed acts of professional misconduct for failing to maintain the standard of practice, prescribing drugs for an improper purpose and engaging in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional. In addition, Dr. Gale was also found incompetent. On March 15, 2002, Dr. Gale's certificate of registration was revoked further to an order of the Discipline Committee.

5. Dr. Gale appealed the February 5, 2002 and March 15, 2002 decisions of the Discipline Committee to the Divisional Court. On October 10, 2003, the Divisional Court released its decision. The Divisional Court upheld two findings of failing to maintain the standard of practice (with respect to Dr. Gale's resuscitation of a patient, #1, and his use of heavy sedation or light general anaesthesia), set aside two findings of failing to maintain a standard of practice (with respect to Dr. Gale's prescription of oral opioids and his administration of high doses of Marcaine to one patient) and set aside the finding of incompetence as it was based on the totality of the findings. [Excerpts from the Divisional Court Reasons are set out in subsequent paragraphs]

6. The Divisional Court also set aside the penalty of revocation. In doing so, the Court noted that, even if the court had upheld all of the findings of professional misconduct and incompetence, the penalty of revocation was excessive to the point of being unduly harsh.

7. The Divisional Court remitted the matter to the College before a differently constituted panel to determine the appropriate penalty.

8. The College is not proceeding on the matters that were overturned by the Divisional Court. It is now up to this panel to determine the appropriate penalty for the two findings that have already been made and were upheld by the Divisional Court.

9. Dr. Gale's licence, as previously stated, was restricted as of May 10, 2001 and was revoked as a result of the Discipline Committee's decision, effective March 15, 2002. The Divisional Court set aside the revocation and Dr. Gale's licence was reinstated on October 10, 2003 at 11:59 p.m. Dr. Gale was effectively deprived of his licence (with the exception of doing some consultations, some medical management and some medical/legal work in the ten months during which his licence was restricted) for a period of two years and five months.

Reasons for Judgment of the Divisional Court

Counsel for the parties submitted that the relevant paragraphs in the Divisional Court reasons relating to the findings of professional misconduct upheld by the Court, are as follows:

Re: Patient #1

[33] The Committee found that there had been an unreasonable delay in the commencement of cardiac massage and that, in the circumstances, Dr. Gale should have taken steps to commence that procedure or to advise Dr. A to do so earlier than he did. The Committee found a professional obligation on Dr. Gale as a qualified member of the resuscitation team to intervene where the team leader was failing to take adequate steps and the patient was deteriorating.

[34] It based those findings on evidence which it accepted from Dr. B, Dr. C, Dr. A and Dr. D, plus evidence on cross-examination of several defence witnesses. It made four important findings that it found established by the evidence:

> (i) There was a significant delay in commencing cardiac massage in circumstances where there were sufficient indicators to make it clear that cardiac massage should have been commenced;
> (ii) There was substantial agreement among the experts that in circumstances where patient #1 had a weak pulse and a barely detectable

> blood pressure, a ‘near cardiac arrest’ situation existed and cardiac massage should have been started immediately;
>
> (iii) A significant number of the expert witnesses testified that a team member should take over a resuscitation from the team leader where the resuscitation was failing as in the circumstances of this case. Some of the experts had themselves taken over during a failing resuscitation.
>
> (iv) Dr. Gale was a senior anaesthetist and was knowledgeable and capable of questioning or advising Dr. A on the difficulties which arose during the resuscitation. He failed to do so.

[35] The appellant submitted that there were serious errors in the Committee’s approach. It failed to advert to much evidence in its reasons that was seen by counsel as helpful to Dr. Gale and made a number of manifest errors.

[36] An important example given by counsel is the time of Dr. Gale’s arrival at the emergency. There was conflict in the evidence as to when Dr. Gale actually arrived at the scene. Counsel submitted that the Committee should not have found that Dr. Gale was not credible when he said that he did not arrive until 12:35 pm. He had been attending another patient, along with Dr. A. When the emergency call came, Dr. A left at once and Dr. Gale tended to the patient until she reached the recovery room and he was satisfied as to her condition. The recovery room nurse noted that the other patient arrived at 12:25. Therefore Dr. Gale could not have arrived at the emergency until a few minutes after 12:25, not at 12:17 as a late (after the event) entry on the chart by Nurse Z indicated.

[37] Counsel for the College noted that there was other evidence, some from Dr. Gale himself, that he arrived much earlier. He himself said in a report the same day that he arrived at patient #1 at 12:20 pm and was present when Dr. A started the Ringer’s lactate and administered atropine. In other statements he repeated the 12:20 arrival. He resiled from it only shortly before the hearing, explaining that he had copied the times from the nurses’ notes and only recently realized they could not be right. The nurses’ notes show that Ringer’s was started at 12:25 and the atrophine (sic) was also given then. The evidence was that Dr. Gale ‘bagged’ the patient and this was recorded as ongoing in the nurses’ notes at 12:35, implying an earlier arrival. The Nurse Supervisor made notes an hour after the event and placed her arrival at approx. 12:20 and found Dr. Gale already there bagging the patient. She then

assisted Dr. A by starting the Ringer's lactate. There was a difficulty with the contemporaneous notes because Nurse Z became so stressed that she had to be replaced, but the Nurse Supervisor gave a competent explanation of them.

[38] In summary, as to the arrival time point, counsel for the College submitted that there was evidence upon which the Committee could rationally arrive at its conclusion. The evidence might well have supported a different finding, but that was not the task of this court.

[39] There is a significant gap in the Committee's reasons in this area. It actually never made any finding as to when Dr. Gale arrived. It said that it accepted the evidence of a number of doctors, but there is no unanimity among them. Dr. B stated in reply evidence on this point that whether Dr. Gale arrived at 12:20 or at 12:35 made no difference to her analysis because there was still at least 15 minutes before the cardiac massage was begun, an unreasonable delay in the circumstances. This appears to be the basis upon which the Committee proceeded. It said that Dr. B "credibly called into question Dr. Gale's suggestion that he had to remain" with his other patient. But it made no finding that he did not in fact remain with that patient. If he did, he did not arrive until 12:35. It was open to the Committee on this evidence to find, as it did, that he was present during an unreasonable delay in commencing cardiac massage, so this omission in the findings does not affect that conclusion. However, we will refer to this point again in dealing with the penalty phase of the hearing.

[40] A second example put forward by the appellant was the Committee finding, at paragraph 79 of its reasons, that there had been an unreasonable delay in the commencement of cardiac massage. At paragraph 36 of the reasons, the Committee stated that the allegation of falling below the standard of practice attached primarily to the failure to begin cardiac massage in a timely manner.

[41] It must not be forgotten that the initial call came because the recovery room nurse discovered patient #1 without a pulse and without a pressure. The patient was obviously in distress from the outset.

[42] Dr. B testified that even if Dr. Gale had not arrived until 12:35, there was still an unreasonable delay in the initiation of massage at 12:51, sixteen minutes later. She also testified that the indications for massage existed when there was no response to the repeat doses of cardiac stimulants in the first 10

minutes of the resuscitation effort. This referred to doses of atropine (2) and of ephedrine at 12:25, adrenaline 1 mg at 12:30 and then adrenaline 1 mg at 12:35. Counsel took issue with this testimony because the chart showed a response, the ECG returned to a healthier rhythm after the large dose of adrenalin was given at 12:35.

[43] The entire note at 12:35 and that at 12:36 are instructive:

> 12:35 Adrenaline I mgm IV 1/1000 given by Dr. A
> Patient bagged IV NIL [Ringer's lactate] infusing
> ECG returned after adrenalin given - slowed down
> 12:36 Atropine 0.6 mgm IV given Patient intubated.

[44] The chart makes it clear that the response to the 12:35 adrenaline was exceedingly short-lived; the ECG rallied but then slowed down and within a minute atropine, another cardiac stimulant, was given. For the adrenaline to act at all there must have been some circulation to deliver the drug to the heart, but the evidence of Dr. B was that the dose of one milligram was so large that anyone with any pulse would have reacted much more vigorously.' In her cross-examination on this point, Dr. B insisted that there could not be a situation where there was a pulse but no measurable pressure. There was also no reading on the oximeter on the patient's finger indicating no oxygen present.

[45] The key point in Dr. Gale's case is that he heard Dr. A say repeatedly that he felt a pulse. Dr. A agreed in his evidence that he did report a pulse as described by Dr. Gale. It was Dr. Gale's position that he was entitled to accept that a pulse existed and therefore there was no cardiac arrest and no need for cardiac massage. Dr. B testified that Dr. A's report of an initial pressure was a very unlikely possibility, but that once he could not obtain a pressure any more, the patient was in near cardiac arrest. That situation did not last for 30 minutes, the patient was soon in full cardiac arrest. Dr. A's ongoing reports of the pulse were not reasonably believable in the light of the absence of a pressure, the absence of evidence of oxygen saturation or digital perfusion, and no response to drugs. The report of the pulse had to be wrong. The patient was in cardiac arrest.

[46] The Nurse Supervisor testified that Nurse Y advised the team of the patient's vital signs at least every five minutes and perhaps more frequently. Consistently she reported that she could obtain no

pressure and no pulse. Dr. Gale himself could obtain no pulse in the patient's neck or temple. Dr. D listened for heart sounds and found none, which she reported to the team.

[47] The Committee also had available, and accepted, the evidence of Drs. C and D. Their evidence generally supported the view that there had been unreasonable delay. Dr. C was a senior anaesthetist with 30 years experience. He agreed that there had been unreasonable delay in commencing cardiac massage. He testified that if patient #1 had a weak pulse and barely detectable pressure, it was a near cardiac arrest and massage was indicated. He was cross-examined to suggest that his opinion that Dr. Gale should have intervened depended on there being a report of a "weak" pulse, whereas no one testified that Dr. A had reported a "weak" pulse, only a pulse. Dr. C pointed out that cardiac arrest occurs when the heart fails to beat or beats too weakly to circulate blood effectively; that and not total absence of heart activity is the prompt for instituting massage. One must look to the effectiveness of that pulse, is it actually generating sufficient circulation. The reported pulse was not indicative of a functioning heart given the other evidence.

[48] Dr. D was the physician who administered the nerve block to patient #1. He was essentially an observer of the resuscitation, standing near the head of the patient. He arrived after the patient had been hooked to the ECG, which had been at 12:20, and Dr. Gale arrived some four or five minutes later, approximately 12:25. He said that he had no opportunity to brief Dr. Gale on the kind of nerve block or the nature of the sedation which had been given to patient #1. He observed the rhythm of the patient's heartbeat on the monitor and described it as idiosyncratic. He recalled that Dr. A and Dr. Gale commented on it, but could not recall what they said. He could not be sure that the monitor revealed an improvement when the medications were given; it changed, but returned to its former state in less than three or four minutes.

[49] Dr. F was called for the defence. In chief he said that he would not start cardiac massage in the presence of a pulse. If the patient has a pulse, she should also have a pressure; if there was no pressure, there should be no pulse. It would be possible to have a pulse and not be able to get a pressure reading if the cuff was in error or the pulse was so weak it did not create enough pressure on the vessel walls to be read. The oximeter reading showing the absence of oxygen in the blood in the finger revealed that cardiac output was diminished and the patient did not ventilate. It was unlikely that the patient could have a pulse and not show oxygen saturation.

[50] In cross-examination, counsel put to Dr. F as a hypothetical, the fact situation derived from the chart, omitting the statements of Dr. A that he felt a pulse. Dr. F said that the patient was in cardiac arrest. Counsel then added the statements of Dr. A that he felt a weak radial pulse at 40 beats/minute. Dr. F agreed that the patient was either in near cardiac arrest or in cardiac arrest. When asked if he would start cardiac massage in that situation, Dr. F said that if you followed the guidelines you probably would not but if nothing else was helping, he would do so. At the least, he would have tried to assess the pulse himself and if he found none, there would be a "full-blown code, cardiac massage etc."

[51] Dr. G was called for the defence. In cross-examination counsel put to him the initial summoning of the doctors because of no pressure and no pulse; no oxygen saturation on the oximeter, to assume that at 12:16 there was a weak pulse of 40 beats/minute and possibly BP of 60/30; no effective reaction to the medications; no response to painful stimuli; and monitoring of the vitals disclosed no pressure and no pulse. On these facts, Dr. G said that cardiac massage should have started at 12:15.

[52] Dr. G disagreed with the view of Dr. C that Dr. Gale fell below the standard of practice by failing to recognize the need for immediate cardiac massage and failing to intervene to get it started. He disagreed because he felt that Dr. Gale was getting information from Dr. A that there was a pulse and was entitled to rely on his colleague. He agreed that if there was a pulse, there should be a pressure and the nurse's report of no pressure raised an inconsistency; that the oximeter reading indicated either a weak pulse or no pulse; that the patient was not breathing on her own; and that she was not responding appropriately to the medication. These factors would have raised the question of whether Dr. A was wrong. As a reasonable anaesthetist, he would have said something, such as asking: 'Are you sure?' He would have checked the pulse himself, although that may be difficult since bagging the patient required both hands. As time went on with no improvement, he would have pushed the issue with further questions. Finally, he agreed that with no blood pressure, whether there was a weak pulse or no pulse, the prudent thing would have been to start cardiac massage. He also agreed that in assessing whether a physician met the standard of care, it is not a question only of what they believed, but also of what they ought to have believed or known as a competent physician.

[53] It is clear that the evidence that cardiac massage was called for in the circumstances did not come

only from Dr. B, whose impartiality was attacked before us, but from other doctors as well. There is no need to multiply examples, what has already been referred to illustrates that there was evidence upon which the Committee could reasonably have reached the conclusion that there was no meaningful response to the administration of very large doses of cardiac stimulants and that the circumstances dictated immediate commencement of cardiac massage. It would also not be unreasonable if the Committee accepted that cardiac massage was indicated before 12:35 on the basis of the circumstances that existed from the outset.

[54] There was also evidence, from Dr. B, Dr. C, Dr. G to the extent noted, and others upon which the Committee could reasonably conclude that Dr. Gale fell below the standard of care to be expected from a competent physician in failing to recognize the situation and failing to intervene appropriately. As before, there was also evidence upon which the Committee might have reached a different conclusion, but re-trying the finding of the facts is not the function of an appellate court.

[55] For these reasons, the appeal against the findings of the Committee that Dr. Gale did not meet the standards of the medical profession in his conduct at the resuscitation must fail. Whether Dr. Gale was responsible for the death of patient #1, as appears to have been assumed by the Committee in the penalty phase of the hearing, is an entirely different question, which will be dealt with later in these reasons. [The Divisional Court stated that it seems quite improbable that a reasonably timely intervention on Dr. Gale's part could have affected the outcome, but that does not excuse his failure to act when he should have realized that Dr. A was in error as to the pulse.]

Re: H.S./G.A.

[56] Dr. Gale was accused of failing to maintain the standard of practice of the profession in providing HS/GA to six specific patients to whom he administered one or more of three blocks; the stellate ganglion block, the epidural/caudal block and the paravertebral block.

[57] The clinic employing Dr. Gale and its methods of treatment appear to have been well-known in chronic pain circles. It's patients came from referrals by physicians both in Ontario and abroad. It has a long waiting list. Perceived difficulties with the administration of HS/GA arose after the clinic came to the notice of the College of Physicians and Surgeons as a result of a referral from the Coroner's

office following the death of the patient #1.

[58] Before dealing with the substantive evidence, it should be noted that counsel for the College in his opening submitted that Dr. B would testify that Dr. Gale used some nerve blocks to treat pain when that type of block was not called for. In the end, that allegation was dropped. Counsel further pointed out that the evidence would show that Dr. Gale used nerve blocks with great frequency; that Dr. B did not agree with this practice; but that there was no consensus in the profession on the matter, so Dr. B could not say that Dr. Gale was in breach of the standards of the profession in the frequency with which he used blocks. The frequency with which Dr. Gale used nerve blocks on particular patients was therefore not an issue.

[59] The concession that Dr. B could not testify that the frequency of use of the blocks was below the professional standard is of some importance for another reason. There is evidence that Dr. B has been vocal about her disdain for the "block docs" and their approach to pain management focusing on nerve block, the antithesis of everything she had been taught. She also presently works with Dr. H, a physician who had engaged in a difference of opinion, indeed a defamation lawsuit, with Dr. I, the owner of the clinic, over whether the clinic's use of repeated nerve blocks was ineffective and dangerous. This matter was cross-examined upon, but is not mentioned in the Committee's reasons. Nevertheless, the Committee would have been aware of the baggage that Dr. B brought with her to the hearing.

[60] Dr. B's evidence was that the most probable reason for the death of patient #1 was high spinal shock. In injecting the local anaesthetic to block the pain, the needle had come too close to, or into, a nerve root sleeve, and the solution, intended to be outside the sleeve, traveled into the nerve sleeve, then into the cerebrospinal fluid and basically anaesthetized the brain stem. This led to depression of the centres controlling respiratory and cardiac function leading to depression of the patient's breathing and heart rate, and ultimately to respiratory and cardiac arrest. High spinal shock is a well-recognized, but very rare, complication of paravertebral blocks, which can happen in the best of hands. In other words, patient #1 died from a known complication of the procedure she was undergoing.

[61] Dr. B testified that the use of the three nerve blocks listed above is accepted by most of the practitioners in the field of chronic pain management. The complaint was not the administration of

these blocks but the use of HS/GA prior to administering the block. This was allegedly done to prevent pain and/or anxiety during the administration of the nerve blocks. In Dr. B's opinion little or no sedation should have been used with these patients. Certainly HS/GA should not be used to eliminate pain; the purpose should be to make the pain manageable. Either very light or no sedation was necessary for the blocks in question, and it was preferable to do these blocks without HS/GA so that the patient would be awake and able to communicate with the physician and give early warning if anything went wrong. The concern was that inability to communicate as a result of the HS/GA might lead to difficulties as had probably occurred in the case of the patient #1.

[62] Dr. Gale's response was that these patients were invariably difficult cases who had been referred to his clinic by other physicians as a last resort. He argued that by the time that these chronic cases came to him they were often traumatized. He would not recommend HS/GA purely as a preference, but would assess the risks versus the benefits. He takes a humanitarian approach and offers patients pain management, provided after full discussion with the patient and only when it is clear that the patient will benefit from the blocks but will not tolerate the pain associated with administration of the blocks without sedation.

[63] Counsel for Dr. Gale submitted that the Committee erred in ignoring a substantial body of medical opinion which supported Dr. Gale's practices. He also referred to the Committee downgrading the evidence of certain defence witnesses by mistakenly finding them to be friends of or acquainted with Dr. Gale. Nothing in the literature proscribed the use of HS/GA with these particular blocks.

[64] While these criticisms were to some extent borne out, the Committee could, nevertheless, reasonably conclude that the weight of evidence was that the use of HS/GA was not appropriate in the six cases before it. There was evidence in the cross-examination of Dr. Gale that four of the six patients under review before the Committee received sedation without any reason being charted. One received HS/GA on the first set of nerve blocks, and two on the second set. In none of these cases did the chart reveal any reason for this.

[65] A review of the literature in evidence leads to the conclusion that there is powerful support for the Committee's view that it was preferable to do the three blocks without HS/GA so that the patient could tell the physician of any early signs of complications. The leading text in the area does not rule out the

use of HS/GA:

> The common goal, however, is to either retain the patient's consciousness (albeit depressed) or have it restored very soon after the procedure has been completed

but warns repeatedly against having the patient unconscious:

> Excessive sedation incurs the risks of airway obstruction or circulation collapse and will also mask the early warnings of complications of the block, such as an unintentional high spinal or epidural block or intravascular injection.
> There should be no local pain during the injection of solution. Pain indicates misplacement of the needle and the injection should stop.
> ***Maintaining verbal communication with the patient is the simplest, and in some ways the most reliable, method of detecting adverse side effects.
> A cautious anaesthesiologist and a conscious patient usually can detect the prodrome of CNS toxicity before frank seizures occur.

[66] Other exhibits contain similar statements:

> In adult patients, administration of conscious sedation levels of anxiolysis and injection of 1 per cent lidocains should allow most procedures to be performed with the patient both awake and comfortable. Although it may be customary in some settings to perform regional anaesthesia in the anaesthetized patient, the anaesthesiologist should carefully consider whether the benefits of this approach are greater than the risk of a rare catastrophic, but potentially preventable, outcome.

[67] The discipline committee found that Dr. Gale had made extensive use of HS/GA for the three types of nerve blocks in question; that this had been done very early in the patient's treatment; and that in the cases of the patients mentioned, his notes contained insufficient clinical indications supporting

the need for this degree of sedation. It did not accept that there was a need in these particular cases for the use of HS/GA. As has been set out above, great deference must be extended to professional tribunals when they are determining standards to be met by the members of their profession. There was evidence upon which the Committee could come to its conclusion that it was preferable not to use HS/GA in such circumstances, that in the cases of the patients specified, the clinical notes did not contain information which would justify the use of HS/GA, and that in the circumstances Dr. Gale failed to maintain the standard of practice of the profession.

[68] It follows that the appeal against the Committee's finding that Dr. Gale did not meet the standards of the profession in the use of HS/GA in the six cases before the Committee must fail.

JOINT SUBMISSION AS TO PENALTY

The statement of facts and consent disposition filed as exhibit 2 contained a joint submission as to penalty, as follows:

> 10. The College and Dr. Gale agree that the appropriate disposition of the outstanding findings is as follows:
>
> (a) Dr. Gale undertake at his own expense no earlier than 6 months and no later than 12 months after he resumes practice, an assessment of competence through a Specialty Assessment Program by the Quality Assurance Committee (QAC) of the College;
>
> (b) the QAC will be provided with:
>
> i. the reasons of the Divisional Court in their decision rendered October 10, 2003; and
>
> ii. all relevant clinical information and evidence arising out of Dr. Gale's disciplinary proceeding to assist the QAC in designing an appropriate assessment methodology,
>
> and the assessment should consider and address the concerns identified in the Divisional Court decision and focus on Dr. Gale's practice (including, but not limited to, pain management);

(c) Dr. Gale shall comply forthwith with the QAC's recommendations;

(d) Dr. Gale shall comply with any terms, limitations and conditions which the QAC may direct the Registrar to impose on his certificate of registration; and

(e) in the event Dr. Gale does not comply with paragraphs (a), (c) or (d), the Registrar shall suspend Dr. Gale's certificate of registration until evidence of compliance has been provided to the satisfaction of the Registrar.

PENALTY ORDER AND REASONS

The Committee accepted the joint submission and made the order requested by the parties.

The Committee considered that Dr. Gale had already served a two and one half year suspension: a long suspension followed by restrictions on his license, which is a severe penalty. The Committee accepts that the public will be protected by the QA assessment and follow-up. The penalty proposed also sends a message to the profession that physicians must be diligent in patient care. The Committee accepts that the applicable principles in determining an appropriate penalty, including protection of the public, rehabilitation of the member, general deterrence to the profession and specific deterrence to the member, have been met with the proposed joint submission as to penalty.

Accordingly, the Committee made and delivered the following order as to penalty:

1. that Dr. Gale undertake at his own expense no earlier than 6 months and no later than 12 months after he resumes practice, an assessment of competence through a Specialty Assessment Program (SAP) by the Quality Assurance Committee (QAC) of the College.

2. that the QAC will be provided with:
   (a) the reasons of the Divisional Court in their decision rendered October 10, 2003; and
   (b) all relevant clinical information and evidence arising out of Dr. Gale's disciplinary proceeding to assist the QAC in designing an appropriate assessment methodology;

   and the assessment should consider and address the concerns identified in the Divisional Court decision and focus on Dr. Gale's practice (including, but not limited to, pain management).

3. that Dr. Gale shall comply forthwith with the QAC's recommendations.

4. that Dr. Gale shall comply with any terms, limitations and conditions which the QAC may direct the Registrar to impose on his certificate of registration.

5. that, in the event Dr. Gale does not comply with paragraphs 1, 3, or 4, the Registrar shall suspend Dr. Gale's certificate of registration until evidence of compliance has been provided to the satisfaction of the Registrar.