NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Sukdev Singh Kooner this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of patients or any information which may identify them under subsection 45(3) the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under section 45 or 47 is guilty of an offence and on conviction is liable to a fine of not more than $10,000 for a first offence and not more than $20,000 for a subsequent offence.

Indexed as: Kooner (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 Professions 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. SUKDEV SINGH KOONER

PANEL MEMBERS:

DR. M. GABEL (CHAIR)
DR. J. SCHILLINGER
D. EATON-KENT
DR. J. DOHERTY
J. DHAWAN

Hearing Dates:	January 15-19, 29-31, 2007 August 20, 2007 October 9 & 12, 2007
Decision/ Release Date:	August 1, 2008
Release of Written Reasons:	August 1, 2008

PUBLICATION BAN

DECISION AND REASONS FOR DECISION:

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") heard this matter at Toronto on January 15, 16, 17, 18, 19, and on January 29, 30, 31, and on August 20, and October 9 and 12, all in 2007. At the conclusion of the hearing, the Committee reserved its decision.

PUBLICATION BAN

On January 15, 2007, the Committee ordered that no person shall publish or broadcast the identity of or information that could disclose the identity of patients, pursuant to subsection 45(3) of the Code.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Sukhdev Singh Kooner committed acts of professional misconduct:

1. by failing to maintain the standard of practice of the profession, as defined by paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), and

2. by an act or 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, as defined by paragraph 1(1)33 of O. Reg. 856/93.

It is further alleged that Dr. Kooner is incompetent as defined by subsection 52(1) of the Code, in that his care of a patient displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

RESPONSE TO THE ALLEGATIONS

Dr. Kooner denied the allegations as set out in the Notice of Hearing.

EVIDENCE

Agreed Facts

1. Dr. Kooner previously underwent a disciplinary hearing in respect of the allegations in the Notice of Hearing.

2. This hearing proceeded in October of 2000. The sentencing hearing proceeded on November 14, 2001.

3. Dr. Kooner has not practised alternative allergy since November 16, 2001.

4. By decision dated December 9, 2002, the Divisional Court ordered a rehearing of the allegations contained in the Notice of Hearing.

Agreed Documents

The College and Dr. Kooner filed as Exhibit 1 a five-volume book of documents consisting of:

- patient chart of patient A;
- hospital chart of patient A;
- 25 patient charts submitted by the College from Dr. Kooner's practice;
- interview notes of the College investigator dated May 22, 1998 with Dr. Kooner;
- practice guidelines from the American Academy of Allergy, Asthma and Immunology, 2006; the American Academy of Allergy, Asthma and Immunology, 1995; the American Academy of Allergy, Asthma and Immunology 2003;
- Canadian Society of Allergy and Clinical Immunology position statement;
- Canadian Society of Allergy and Clinical Immunology consensus guidelines;
- curriculum vitae of Dr. Z;
- edited report dated November 20, 2006 (Dr. Z) with guidelines of the Pan American Allergy Society, American Academy Otolaryngic Allergy, and American Academy of Environmental Medicine;
- paper by King et al, "Provocation -- Neutralization: a two-part study";

- Report of the Ad Hoc Committee on Complementary Medicine (the “Walker report”), dated September 22, 1997; and
- College of Physicians and Surgeons of Ontario policy regarding "Complementary Medicine."

Additional Evidence

Both parties introduced other documents into evidence, either through their own witnesses or through cross-examination of witnesses. These included:

- report of the Ad Hoc Committee on Environmental Hypersensitivity Disorders, August 1985 (the "Thompson Report") (Exhibit 2);
- Book of Documents (Exhibit 3) containing four reports: the American Academy of Allergy, Position Statements - Controversial Techniques; the American Academy of Allergy and Immunology, Position Statements - Clinical Ecology; the American College of Physicians, Position Paper, Clinical Ecology, 1989; and the Canadian Society of Allergy and Clinical Immunology, 1995, Guidelines for the Use of Allergen Immunotherapy;
- paper by Dr. Dennis Ownby in the Journal of Allergy and Clinical Immunology, 1994 (Exhibit 6);
- paper by Nelson et al, in the Journal Allergy and Clinical Immunology, 1992 (Exhibit 7);
- “The New Health Care Consent Act: Guidelines for Physicians” published in Dialogue, May 1996 (Exhibit 20);
- letter from the College investigator to Dr. X, dated January 15, 1998 (Exhibit 4);
- letter from the College investigator to Dr. X and attached interview notes, dated June 4, 1998 (Exhibit 5);
- book chapter entitled "Otolaryngology" (Exhibit 9);
- newsletter entitled "Intracutaneous Provocative Neutralization Food Allergy Test" dated July 11, 1989 (Exhibit 10);
- pamphlet entitled "A Guide for the Food Allergic Patient" (Exhibit 11);
- information sheet entitled "How to Avoid Allergens" (Exhibit 13, formerly Exhibit A);
- information sheet entitled "Precautions for Sensitive Skin" (Exhibit 14);

- information sheet on beta-blockers (Exhibit 15, formerly Exhibit B);
- Pan American Allergy Society, Practice Guidelines, revised 1994 (Exhibit 16);
- instruction sheet entitled “Serial Dilution Titration Dilutions” from the Pan American Allergy Society (Exhibit 17);
- article on serial end point titration (S.E.T.) reprinted from J.A.M.A. (Exhibit 18); and
- copy from the Compendium of Pharmaceuticals and Specialties on the drug, "Tenormin" (Exhibit 19).

The College led evidence from Ms. B, as well as from its expert witnesses Dr. Y, Dr. X and Dr. W.

The defence led evidence from Dr. Kooner, as well as from its expert witness Dr. Z.

The panel heard oral testimony from Ms. B with regard to Dr. Kooner’s care of her daughter, patient A. Her evidence, as well as the relevant evidence of the expert witnesses and of Dr. Kooner in connection with Dr. Kooner’s care of patient A, is incorporated under the heading “Evidence Relevant to Patient A.” The testimony of each of the experts with regard to 25 charts of Dr. Kooner that the College selected for review is combined below under the areas of concern stemming from their chart reviews and oral testimony. In addition, the individual expert testimony with regard to the general aspects of allergy is presented separately, as is Dr. Kooner’s testimony as to his manner of practice.

OVERVIEW OF THE ISSUES

In making a decision concerning the allegations, we considered the specific evidence concerning the patient A, and the evidence relating to the randomly selected patient charts, with emphasis on the areas noted below. A more complete analysis of certain specific areas was undertaken. The standard of proof utilized by the Committee was the *Bernstein* standard of balance of probabilities based on clear, cogent and convincing evidence. We considered that it was imperative to analyze the evidence in light of the standard of practice in each of these areas at the time that the patients in question were under Dr. Kooner’s care.

The following issues are examined in detail:

1. Failing to maintain standard of the profession
    a. Charting
        i. History and physical examination
        ii. Communication with referring physicians
        iii. Takeover notes
        iv. Testing and medications ordered without diagnosis

    b. Issues specific to allergy
        i. History and physical examination sufficient to make a conventional diagnosis
            A. Inhalant allergy
            B. Food allergy
            C. Interpretability of charts
        ii. Testing by intracutaneous methodology versus skin prick methodology
        iii. Testing methods for immediate food allergy
        iv. IPFT tests for “delayed” food allergy
        v. Testing for allergy to petrochemicals and non-protein/peptide substances
        vi. Testing for venom allergy

    c. Treatment
        i. Immunotherapy performed on patients of allegedly inappropriate age
        ii. Immunotherapy for patients with asthma and/or on beta-blockers
        iii. Avoidance therapy
        iv. Medication therapy
        v. Informed consent
        vi. Epipen prescription
        vii. Immunotherapy for delayed food allergy

    d. Issues specific to patient A
        i. Misrepresentation of form of allergy testing and treatment

ii. Peanut allergy testing
    A. Type of testing
    B. Specific consent
    C. Initial testing
    D. Dosage
    E. Second testing
iii. Peanut allergy desensitization
iv. Epipen prescription

2. Disgraceful, dishonourable or unprofessional behaviour
    a. Informed consent
    b. Letterhead of practice stationary

3. Incompetence
    a. Treatment of patient A
    b. Other Patients
    c. Present status

The College alleged that Dr. Kooner failed to maintain the standard of practice of the profession in respect of other clinical areas. The panel's analysis of Dr. Kooner's conduct in these areas is subsumed within its analysis of the areas noted above.

The panel looked at the evidence as it applied to Dr. Kooner's practice, examining how he performed in relation to the standards that are reasonably expected of the ordinary, competent medical practitioner in his field of practice. Counsel for the College said that the College was not asking the panel to rule on the merits of clinical ecology, environmental medicine or alternative allergy and we have not done so.

At the conclusion of the hearing, the panel reserved its decision. The panel determined that the allegations in the Notice of Hearing were proved to the requisite standard.

INTRODUCTION

Dr. Kooner, having trained in internal medicine at the University of Saskatchewan from 1981 to 1985 and having done a fellowship in respiratory medicine at the University of Saskatchewan from 1985 to 1987, obtained his certification in internal medicine from the Royal College of Physicians and Surgeons of Canada in 1987. In 1987, he began in private practice with Dr. V, who, for the previous 15 years as a family physician, had confined his practice exclusively to allergy. During the relevant time, from 1987 to 1997, Dr. Kooner divided his practice into two parts. The first part was hospital-based in internal medicine and respiratory medicine including work in the ICU. The second part was office-based in the afternoons and confined to alternative allergy. Dr. Kooner and Dr. V did not practise mainstream allergy medicine, but rather an alternative form of allergy medicine based on the theory of Dr. Rinkel, with standards as set out by the Pan American Allergy Society that falls within the heading of "environmental medicine." (In these reasons, the panel refers to this alternative form of allergy medicine as "alternative allergy".)

In September, 1996, patient A, a patient born in June 1989 whom Dr. Kooner had been treating for allergy since 1993, suffered anaphylaxis following testing that Dr. Kooner ordered in his office for peanut allergy. She was successfully resuscitated in his office, and observed in the hospital emergency department for a short period of time. Patient A's mother, Ms. B, returned the following week, to discuss the incident with Dr. Kooner and again returned with patient A for retesting for peanut allergy later in September, 1996, in order to establish a proper dosage schedule for desensitization of peanut allergy. There was no untoward reaction at the retesting. Subsequent to this retesting and prior to beginning desensitization therapy, having spoken to another parent, Ms. B contacted the Allergy and Asthma Association, who suggested that she speak with a Dr. U. Following that conversation, she decided against peanut desensitization and she contacted the College.

The College then instituted an investigation. The medical inspector, Dr. X, reviewed 25 charts of patients treated for allergy selected at random from Dr. Kooner's practice as well as the chart of patient A, interviewed Dr. Kooner regarding these charts and his practice of allergy, and submitted a report. An additional report was obtained from Dr. Y based on his review of the

same charts. Both Drs. X and Y have allergy practices, are certified in internal medicine, with additional certification in allergy and clinical immunology, and hold university teaching appointments. Both were accepted by the panel as experts in allergy and clinical immunology.

In April of 2000, at the request of Dr. Kooner's previous counsel, Dr. Kooner underwent a two-week traineeship with Dr. W. Dr. W practises allergy medicine, is certified in allergy and clinical immunology, and holds a university teaching appointment. This traineeship was designed to assess if Dr. Kooner could practise allergy based on his previous training in allergy, including whether or not he could prescribe allergy immunotherapy. For the purpose of this hearing, Dr. W was accepted by the panel as an expert in allergy and clinical immunology. However, counsel agreed that he would not be asked to comment on the 26 cases reviewed by the other experts.

The defence tendered Dr. Z as an expert in the treatment and diagnosis of allergy. The panel accepted Dr. Z as an expert in allergy, while reserving the weight it would give to his evidence. Dr. Z was trained and certified in the United States as an ENT surgeon and gradually progressed into practising alternative allergy. He has gained extensive experience in the practice and training in that field in the United States. He has held office in the Pan American Allergy Society and worked on the development of standards for that Society. He is a member of the American Academy of Otolaryngic Allergy (a subgroup of the American Academy of Otolaryngology) and chaired the committee that developed its practice guidelines. Also, he is a member of the American Academy of Environmental Medicine. He has given courses on the evaluation and treatment of allergy for both organizations. He submitted two reports for the defence based upon a review of the reports of Drs. Y and X and an interview with Dr. Kooner.

RELEVANT BACKGROUND EVIDENCE ON THE PRACTICE OF ALLERGY MEDICINE

The following is based on the testimony of the College’s expert witnesses Drs. Y, X and W.

Training, Education and Guidelines

Allergists in Canada, following certification in internal medicine, have undergone two years of additional training in a recognized institution and obtain certification by examination by the Royal College of Physicians and Surgeons of Canada. Many physicians who are not allergy specialists, however, such as dermatologists, pediatricians or general practitioners, practise allergy medicine without such training. The College expert Dr. Y testified that any internal medicine specialist who chooses to practise allergy and clinical immunology would be held to the same standard of practice as an allergy specialist. Certification examinations for the Royal College are conducted through the Canadian Society of Allergy and Clinical Immunology. That organization and the American Academy of Allergy, Asthma and Immunology are the generally accepted authorities for care standards by mainstream allergists in Canada.

The College provided expert opinion on the practice of allergy medicine in Canada through the expert witnesses referred to above. None of these witnesses purported to know the theory or practice of the alternative form of allergy practiced by Dr. Kooner or of the standards promulgated by the Pan American Allergy Society or the American Academy of Otolaryngic Allergy. Dr. X stated that he did not pay attention to the Guidelines of the Pan American Allergy Society because it was not evidence-based medicine.

Record-keeping

Dr. Y opined that consultant allergist notes should document the chief complaint, history of presenting illness, past illness, family history, environmental history, medication history, social history which might reflect factors affecting compliance with treatment, and a full functional inquiry. Dr. X also emphasized the importance of the consulting note documenting a full functional inquiry. A detailed physical examination should be documented both to the specific system involved and to those systems which may be affected by the illness or which may be affected by tests or treatment. A diagnosis should be clearly stated, along with reasons for investigations and the results of those investigations, as well as a treatment plan. A notation of a discussion of treatment options and risks/benefits should appear in the chart. The results of skin tests should be such that they are clearly understandable by other physicians. The reasoning of the consultant should be clearly apparent from his or her notes. Discussion of the diagnosis and treatment plan with the patient should be documented in the chart. Follow-up progress notes

should be made reflecting any significant change in the patient or the therapy. Dr. Y's opinion was that this is a universal standard that applies to all physicians in Ontario.

Food Allergy and its Symptoms

Dr. X testified that allergy is an altered immune response to a protein or peptide. Thus, hydrocarbons or petrochemicals do not cause allergic reactions. Mainstream allergists consider that the only allergic reaction to food is IgE (immunoglobulin E)-mediated. Dr. X testified that there is no scientific evidence that food allergies cause ongoing allergic rhinitis or persistent asthma. He agreed that patients with IgE-mediated reactions to food may experience respiratory symptoms, including rhino conjunctivitis and asthma along with cutaneous symptomatology, although normally there would be other symptoms such as itching and hives. That is, it is always a symptom complex, and anaphylaxis is such a symptom complex. Part of this complex should include gastrointestinal symptoms, even if only a "tingling" of the tongue (although Dr. W stated an exception may exist in exercise-induced anaphylaxis following a food exposure and subsequent exercise). There must also be a temporal relationship between this symptom complex and a specific food ingestion and this requires taking a careful food history. Dr. X also agreed that there is a correlation between atopy (a state of clinical hypersensitivity or predisposition to develop allergy) in the family and food allergy.

Dr. Y testified that chronic rhinitis is rarely caused by food allergies where the food is ingested. He added that rhinitis could be caused by food allergy on rare occasions, in occupational settings where the food particles can become airborne and are inhaled, landing in the nose and causing allergic symptoms. Patients who are having an anaphylactic or systemic allergic reaction to a food may get rhinitis symptoms as part of the reaction. If a patient reports symptoms of rhino conjunctivitis accompanying other symptoms like hives, itchy skin or gastrointestinal symptoms such as nausea and vomiting, he agreed that that could be suggestive of a food allergy, as long as they are occurring within a temporal sequence. This sequence is usually over minutes or several hours following the ingestion of that food, as part of an acute allergic reaction. He agreed that the presence of atopy implies an increased risk of food allergy. He also agreed that there is a correlation between atopy in the family and food allergy. This does not, however, support

screening a patient for food allergy in the absence of a history of the patient having an adverse reaction to the food.

Although the prevalence of food allergy is purported to be 25% of the population at some time in their lives, Dr. Y suggests that this includes food reactions as opposed to true allergy.

Testing

Prick Skin Test for Allergy

Both Dr. X and Dr. Y testified that, in Canada, mainstream allergists consider the standard test for allergy to be the prick skin test. This is an epidermal test. Dr. X testified that, if a prick skin test for inhalant allergy is negative, it may be followed by selective intra-dermal testing. However, intra-dermal skin testing for food allergy is not carried out by any conventional allergist. Dr. Y testified that selective intra-dermal testing can be done occasionally for inhalant allergies and, also, for venom and drug allergy testing. He also said that the standard of practice for food allergy testing is the prick skin test. Intra-cutaneous or intra-dermal testing of foods is not appropriate. He noted that intra-cutaneous tests have a problem of false positives caused by irritant reactions, and are felt to be more prone to IgE-mediated anaphylaxis because of the larger allergen load delivered to a more vascular area. He testified that the Canadian Society of Allergy and Clinical Immunology and the American Academy of Allergy, Asthma and Immunology supported this position.

Dr. Y, in asserting the safety of prick skin tests, said he was unaware of any deaths related to this test. He was asked about a study that showed 46 reported deaths between 1946 and 1987 from skin testing. He said that his understanding of the study was that it related to deaths from skin testing, not skin prick testing, and that he had heard reports of deaths from intradermal testing. Dr. X did not challenge the assertion that there had been a study showing that there had been 46 reported deaths between 1946 and 1984 (*sic*) from conventional allergists' testing methods. He acknowledged that it was theoretically possible that a patient could have an anaphylactic reaction as a result of a dosing error in a skin prick test, but said that he had never seen one and suggested that such an error could not happen in his office.

View of Intra-cutaneous Provocation-Neutralization Testing

Dr. X expressed the strong opinion that intra-cutaneous provocation-neutralization testing (IPFT) as done by Dr. Kooner, not being mainstream testing and not based on scientific evidence, is deemed to be experimental and should only be done with a formal signed consent. He contrasted this with mainstream allergy testing, which he said was scientifically valid, not experimental, and did not require a signed consent form. When it was suggested to Dr. X that Dr. Kooner's testing methods were not experimental and were validated by thirteen double-blind studies, he stated that he did not believe the studies were good science, and that his personal opinion was that Dr. Kooner's methods were not evidence-based and were not scientifically valid. When Dr. X was taken to a double-blind study published in the journal Otolaryngology: Head and Neck Surgery, he said that he did not place much weight on it because it was not published in a well-respected, highly-rated journal. He indicated that, if he saw a study published in a highly-rated, peer-reviewed scientific journal such as the New England Journal of Medicine, he would say that it is a very serious article that he must read and try to understand.

Treatment – Avoidance, Medication, Immunotherapy

Dr. Y testified that the standard of practice in the field of allergy and clinical immunology is to first discuss with the patient avoidance of allergens. The second step is medications in the form of various antihistamines and decongestants, or oral or inhaled steroids. The third step is to add immunotherapy where medications have not been enough, or have intolerable side effects and cannot be complied with, or where the patient refuses to take medications. Dr. X's evidence about the standard of practice in dealing with environmental allergy is that the first line of treatment for inhalant allergies is over-the-counter antihistamines and decongestants, the second is nasal steroids, and only in the most serious cases where the patient does not respond to, or cannot afford, the medications would he select a patient for immunotherapy. While he agreed that written material was an acceptable way of communicating avoidance to a patient, it was not sufficient, and that time must be spent discussing with the patient how to achieve this.

Immunotherapy and Food Allergy

Dr. X gave evidence that the position of the Canadian Society of Allergy and Clinical Immunology is that immunotherapy should not be carried out for food allergy patients. He said that food allergy cannot be desensitized and that no one should try it in a practice setting. Dr. X was asked about an article from 1992 (Exhibit 7) by Oppenheimer, Nelson et al. about a trial of immunotherapy for peanut allergy under highly controlled conditions in a hospital. He said that the research showed that, theoretically, one may be able to desensitize for food allergy, but that it was not recommended until it could be proved that it could be safely carried out. Dr. Y testified that the standard of practice is that there is no justification for giving food allergy injections to patients with a suspected anaphylactic allergy to food, and that those types of injections are highly experimental. He referred to the 1992 article as concluding that it may be possible to desensitize patients with peanut allergy but only under highly controlled conditions. He also noted that the trial referred to in the article was discontinued because of a patient death due to an error in the labelling of one of the treatment extracts.

Immunotherapy and Age of Patient (Children)

Dr. X testified that most conventional allergists would not treat children under the age of five years and would refer them to pediatricians or pediatric allergists who have special training, although he acknowledged that there was nothing preventing an allergist from seeing children under five. He also agreed that it was possible that an allergist could perform a skin test even on a one-year-old child, although he added that the reactivity of skin testing was “extremely limited” when you are dealing with an infant. Dr. Y testified that the common view of Canadian, European and American Allergy Societies was that immunotherapy should not be given to patients under the age of five years because they are at higher risk of systemic allergic reactions to immunotherapy, cannot communicate well, are harder to resuscitate in the event of an adverse reaction, and may be psychologically adversely affected. It should only be given where the children have severe allergy symptoms and an exhaustive trial of avoidance and medication has been documented to be ineffective in treatment. Dr. Y further testified that in the case of children under the age of one year (infants), he had never heard of any of his colleagues in Canada prescribing immunotherapy, and that it was never appropriate to do it. Indeed allergies in infants are unlikely as their short lives have not been long enough to expose, and then re-expose, them to seasonal allergens.

Dr. Z disagreed. While acknowledging that he would not usually see children until they got older because they would be under the care of a pediatrician, his opinion was that there is no contraindication to treating a one-year old. With respect to possible psychological stress to children under five from needles, his opinion was that if the symptoms were bad enough, then the children should be treated. He disagreed with Dr. Y's assertion that a one-year-old could not be exposed to allergens, suggesting that infants are exposed to a wide variety of allergens.

Immunotherapy and Age of Patient (Over 60)

Dr. Y expressed the opinion that immunotherapy should be used with "extreme caution" in a patient over 60. It is relatively contraindicated, as these patients often have non-apparent co-morbid conditions such as cardiac disease, which would render adverse reactions to immunotherapy dangerous. The exception is venom immunotherapy, which is not contraindicated. He also expressed the opinion that it would be unusual for someone to be diagnosed with an allergy at that age, although he allowed that it was possible. He said that, in a significant number of patients over fifty who present with symptoms of rhinitis and asthma, even with positive testing, their symptomatology is not caused by allergy.

Dr. Z's response to Dr. Y's opinion on this subject was that the immune system knows no age boundaries. It does not turn off at age 60. He testified that he has patients who do not even begin to have IgE-mediated allergy until they are over 60. He also disagreed with Dr. Y's opinion that people over 60 will generally only have non-allergic rhinitis as opposed to allergic rhinitis. He disagreed that immunotherapy was relatively contraindicated for patients over 60 although he allowed that it would not be given to patients with co-morbid conditions who would not have a chance to benefit from it. He also disagreed that one would not treat a patient because of the possibility of the patient having undisclosed co-morbid conditions.

Dr. Y gave evidence that, generally, if a patient has a co-morbid condition in which the effects of an anaphylactic reaction could be catastrophic, immunotherapy would be contra-indicated. However, there is one exception: a patient who has venom allergy, where it is a life-threatening condition. The desensitization takes place in a controlled environment.

Immunotherapy and Asthma

With regard to asthma, Dr. Y stated that patients with asthma are at a higher risk of having an anaphylactic reaction from an allergy injection. He said that poorly-controlled asthma is a contraindication to immunotherapy although, if well controlled, it may not be**.**

Dr. Z testified that immunotherapy has been shown to decrease the development of asthma in those with allergic rhino conjunctivitis, the progression of asthma in those already affected, and the development of new allergies to inhalant allergens. The guidelines for the Canadian Society of Allergy and Clinical Immunology give some support to Dr. Z' opinion. Dr. Z agreed that an asthmatic with an anaphylactic reaction would be more difficult to treat but disagreed that anaphylaxis was more likely in asthmatics who are given an allergy injection. He suggested that asthmatics may benefit the most from immunotherapy by slowing the progression of the asthma.

Immunotherapy and Beta-blockers

Dr. Y gave evidence that beta-blockers should be avoided in patients on immunotherapy, again, subject to the exception of the patient undergoing venom immunotherapy for a potentially life-threatening condition. Beta-blockers can render the treatment of anaphylaxis more difficult and, thus, constitute a relative contraindication to immunotherapy. Dr. Y acknowledged that there are conventional allergists in the United States who do not consider beta-blockers to be a concern and who do not think they are a contraindication to immunotherapy. However, he said that the position of both the American Academy of Allergy and the Canadian Society of Allergy and Clinical Immunology is that beta-blockers should be avoided.

Dr. X testified that beta-blockers are contraindicated in patients who are on immunotherapy. He also testified that they are contraindicated in patients who have asthma. Beta-blockers can exacerbate asthma. Cessation of beta-blockers should be considered in asthmatics, if possible. Dr. Y opined that the first thing to do where a patient has symptoms of asthma and is on beta-blockers is to suggest to the family doctor to discontinue the beta-blocker and use another drug instead, since beta-blockers can precipitate or aggravate asthma. The beta-blocker would be tapered off over a few days under the supervision of the prescribing physician.

RELEVANT BACKGROUND EVIDENCE ON ALTERNATIVE ALLERGY

The following is based on the testimony of Dr. Z.

Training, Education and Guidelines

There are approximately 3,000 members of the American Academy of Otolaryngic Allergy (a subgroup of the American Academy of Otolaryngology and Head and Neck Surgery), which publishes "Practice Guidelines for Respiratory Allergy," and 350 members of the American Academy of Environmental Medicine which publishes "Practice Guidelines." These, and the Pan-American Allergy Society, are the base organizations of "alternative allergy." Based on a theory expounded by Dr. Rinkel, the form of allergy practice that he and Dr. Kooner perform, alternative allergy, differs from conventional or mainstream allergy practice in both testing and therapy.

Hands-on courses and teaching materials are provided by the organizations mentioned above, and range from a half-day to several days in duration. Neither the American Academy of Otolaryngic Allergy nor the American Academy of Environmental Medicine is a member board of the American Board of Medical Specialties, the organization that sets the standards for medical specialties in the United States. However, CME credits in the U.S. may be obtained by attendance at their training sessions. Dr. Z acknowledged that both organizations are self-designated boards whose standards are set by themselves only, and that the American Academy of Environmental Medicine does not require any type of residency in environmental medicine.

Dr. Z stated that the teaching of allergy to ENT residents is often done by practitioners of alternative allergy. Dr. Z has a chapter on allergy in a standard ENT text book.

Testing

Testing involves the intra-cutaneous injection of serial dilutions of commercially available reagents in a set volume of solution and measurement of the resulting wheal at a set time. A positive reaction is read as an increased wheal size (over two directions) of >2 mm compared to the previous injection and this is validated by injecting one strength past this first reaction.

Serial Endpoint Titration for Inhalant Allergens

For inhalant allergens, the test is called serial endpoint titration (S.E.T.) and is done by working progressively from weak to stronger solutions. The reaction is caused by immunoglobulin E (IgE) in the skin. The solution strength causing the reaction is deemed the endpoint and forms the basis for calculating the neutralizing dose used for treatment. The treatment is aimed at provoking the production of immunoglobulin G (IgG) to block the IgE. Many patients, after two to five years, can get their allergy shots with reducing frequency, and up to 50 per cent of patients can stop them and be cured, according to alternative allergists. S.E.T. testing has been used safely for over 30 years and has been deemed an acceptable practice in an article published in the Journal of the American Medical Association.

Food Allergy – Immediate and Delayed

Alternative allergists divide food allergy into two different basic types. The immediate (or fixed) type, accounting for approximately 5% of food allergies, is IgE-mediated with a direct anaphylactic cause and effect characteristic and recognized by mainstream allergists. The second and commonest group, according to alternative allergists, is termed delayed, hidden or cyclic food hypersensitivity, is not IgE-mediated, and is not recognized by mainstream allergists. Its manifestations involve multiple systems and organs, and its symptoms are more dependent on frequency and volume of food allergen exposure. Its causation is multi-mechanistic and its common allergens are often those foods eaten almost daily, such as milk, wheat, corn, yeast, soy, and egg. Perversely, improvement in symptomatology is often caused by the ingestion of some of the allergenic food in a phenomenon called masking or blocking.

Intra-cutaneous Provocation-Neutralization Testing for Delayed Food Allergy

Delayed food allergy is treated by using a rotary, diversified, or elimination diet, pharmacologically with antihistamines, and by the administration of a neutralizing or blocking dose of allergen. Should an elimination diet (getting the particular food out of the diet), or a rotating diet (where the suspect food is eaten only every four or five days), not be effective, one can proceed to "neutralization" therapy, which Dr. Z testified is a form of immunotherapy. This therapy will effectively mask the symptoms but, unlike immunotherapy for inhalant allergens, it will not cure the problem.

The neutralizing or blocking dose of allergen is determined through intra-cutaneous provocation-neutralization testing (IPFT). IPFT is performed using serial dilutions of allergen injected intra-cutaneously every 30 to 40 minutes looking for a significant change in a wheal and/or symptoms judged against a control injection. Significantly, one works from a strong dilution with a positive result, to progressively weaker dilutions looking for a negative reaction, which indicates the neutralizing (or blocking) dose. The efficacy of this testing method was purported to have been proven in a double-blind study that Dr. Z participated in, published in the journal Otolaryngology Head and Neck Surgery. On cross-examination, Dr. Z was asked about a study published by Dr. Jewett, published in the New England Journal of Medicine, that arrived at a different conclusion. Dr. Z stated that the conclusions in the latter article were wrong. He based this on his opinion that the study used the wrong patient cohort, the wrong technique, and did not do the IPFT test properly. Accordingly, he found that the study was worthless. Dr. Z stated that this test has been done safely in his office 80,000 times (although in one of his written reports he said that it was 60,000 times).

Dr. Z testified that dietary history is necessary to provide an indication to do the IPFT, as one should only test for foods that are in the diet and one must eliminate those foods for three or four days before doing the testing. IPFT is only used to detect hidden or delayed food allergy. IPFT is not used to diagnose immediate, IgE-mediated food allergy. The immediate food allergy is usually obvious through the dietary history. IPFT is not to be done for a food to which you know that the patient has had a severe reaction. If a patient has severely reacted to a food, there is no need to test for it because you already know how the patient reacts to it, and it could be

dangerous. The danger of anaphylaxis with immediate food allergy testing, particularly for peanut allergy, was underscored by Dr. Z' assertion that he did not keep peanut extract in his office for that reason. On cross-examination, however, Dr. Z testified that it was acceptable to test for potentially strong allergens such as peanuts using IPFT, but starting with a weaker dilution than with other foods because of the potential for problems.

Safety Rules for Testing Procedures

Safety rules must be strictly observed to prevent adverse reactions from the testing procedures. These are contained in an office handout of Dr. Z, dated July 11, 1989 (Exhibit 10), and form part of the teaching of the Pan American Allergy Society. Dr. Kooner testified that these were prominently displayed in his office where these tests were carried out. They read as follows:

> "1. Never test a patient for a food that historically produces a severe reaction. If the patient is sure of a specific sensitivity, there is no need for testing it and in addition such reactions have a high probability of being IgE-mediated with the risk of a potential anaphylaxis from performing the test.
>
> 2. Only test for foods that are in the diet. This test is designed to diagnose hidden food allergies. Infrequently eaten foods can be easily and inexpensively tested by properly performed challenge feeding tests.
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> 3. This technique is not to be used in patients who are exquisitely sensitive or who are on high doses of steroids such as a brittle asthmatic. Testing in these patients should be initiated using weak dilutions and progressing to more concentrated test substances."

EVIDENCE OF DR. KOONER ON HIS PRACTICE OF ALLERGY

Dr. Kooner testified that he practised alternative allergy. He did not have formal training in allergy, other than performing some prick skin tests informally when he was training in respiratory medicine. He began his private practice in allergy in 1987 with Dr. V, a family physician who, for the prior 15 years, was exclusively doing allergy. Dr. V's allergy practice followed the Guidelines of the Pan American Allergy Society. Dr. Kooner received hands-on

training from Dr. V, and he also took several courses and seminars with the Pan American Allergy Society, which he joined in 1988. He has not practised allergy since November, 2001. From 1987 to 1997, his referral base was mainly family doctors, dermatologists, ear nose and throat surgeons, internists and pediatricians. In that he practised the same form of allergy as Dr. V (who retired in 1991), he asserted that his physician base was aware that what he did was different from conventional allergy. He testified that he has never received comments from patients or referring physicians that they thought he practised conventional allergy. His letterhead says "Allergy, Respirology and Internal Medicine." He stated that his use of "Allergy" on the letterhead was consistent with what his predecessors in the practice had done. His patients were drawn from all walks of life and any age, from children to the elderly. His allergy practice was confined to his office in the afternoons from 12:00 or 1:00 p.m. to 5:00 p.m., five days per week.

The office, situated on the main floor, consisted of a waiting room and reception area, his office, and two examining rooms. There was another room for S.E.T. testing, another room for IPFT testing, and a last room for injections.

The office staff consists of five nurses and two secretaries. The nurses were all acquired from Dr. V, and had been trained by the Pan American Allergy Society. The nurses would perform the testing, take histories, and explain procedures to patients. They would also give them a food allergy questionnaire to fill out.

Patient History and Consent

Dr. Kooner testified that, in general, when he first saw a patient, it would be in his office or an examining room. He would obtain a history of present illness, past illness, family history, history of medicines, and a functional inquiry, and then do a physical examination of the ear, nose and throat, the respiratory and cardiovascular systems, the abdomen, musculoskeletal and central nervous system. The history-taking would take 15 to 25 minutes. He would then explain the different procedures such as S.E.T. testing and IPFT, and that these were intra-dermal injections. He would explain the possibility of complications, both systemic and local, and that his office was equipped to treat any of these reactions, including anaphylaxis. Dr. Kooner

testified that he explained the different procedures, and that they were different from those done by conventional allergists. Following the incident with patient A, he began to obtain a formal written consent, adapting a form from the standard consent form in the hospital where he worked. The form contained a category, “alternative treatment”. Dr. Kooner testified that he informed patients that his methods are not the ones used by conventional allergists, that they use a prick test whereas he uses an intradermal test. The patients were then sent off for testing by the nurses. Should he have to leave the office, testing would stop during the period that he was gone, although the nurses may continue to read the tests. When the testing was finished, the patients were sent back to Dr. Kooner, and he would discuss the results of the tests with them. He would then discuss the treatment modalities, such as avoidance, give them information sheets on these modalities, and explain the sheets to them. In the case of food allergy, a sheet was given to the patients explaining how to rotate foods, as opposed to avoiding them.

Testing

Dr. Kooner testified that the nurses performed the testing using allergens that he ordered according to the history. Dilutions of commercially available extract were prepared according to the method set out in material provided by the Pan American Allergy Society (Exhibit 17). This stipulated twelve vials labelled 1 to 12, each containing 4 cc’s of diluent. Each vial would be placed in a correspondingly labelled pit in a tray called a "pit bowl". The number on the vial or pit corresponded to the mathematical exponent of the dilution. One cc of allergen extract would be placed in vial 1 along with the four cc’s of diluent. One cc of that solution would then be drawn up and placed in vial 2 along with four cc’s of diluent, and so on, through to vial 12, so that each vial would be successively diluted. The preparation of the serial dilutions of allergen was the same for S.E.T. and IPFT. However, in doing the actual testing, for S.E.T. (inhalant allergy) one works from weak to strong dilutions. For IPFT (food allergy), one works from strong to weak, looking for that strength of solution for which there is no reaction, thus finding the "neutralizing" dose. For food allergy, the tester considered both the size of the wheal, and the presence of symptoms. The neutralizing dose, however, is dependent upon the wheal alone. He also noted that, for patients who are asthmatic or exquisitely sensitive, one works from weak dilutions to more concentrated test substances, as one would do with S.E.T. He did not begin

using glycerin control injections until around 1995 or 1996. He testified that this was on his own volition, although it was suggested by the Pan American Allergy Society at a meeting.

Dr. Kooner testified that the safety rules for IPFT, as set out in Dr. Z's newsletter and taught at the seminars of the Pan American Allergy Society, were displayed on the desk of the nurses in the injecting room and were reviewed with the nurses regularly.

Treatment

With regard to treatment, Dr. Kooner testified he always discussed avoidance with a patient as an adjunct to immunotherapy, and gave them informational handouts on that. He noted that most patients were referred to him by doctors, who had already tried their patients on avoidance and who had also tried patients on medication.

With regard to food allergy, Dr. Kooner said that, although the best way to test is to challenge with the given food, the commonest food allergens are in the everyday diet and difficult to avoid. In that it takes four or five days to clear the body of these food allergens before the food challenge, it is usually logistically impractical to carry out such a food challenge. Therefore, one must resort to the more practical IPFT.

Immunotherapy and Age of Patient

Dr. Kooner did not feel that age was a contraindication to immunotherapy. He acknowledged that elderly people are more likely to have underlying co-morbid conditions. If acute, uncontrolled conditions are found on history and physical examination, one cannot give immunotherapy. However, if co-morbid conditions are not evident from the history or on physical examination, immunotherapy is not a contraindication in elderly people. He testified that immunotherapy for children under age five is recommended to prevent the development of asthma or progressive damage from same. With respect to infants under one year of age, he said that they are exposed to both indoor and outdoor allergens. If they have a history that is suggestive of allergies and physical examination speaks to that, they can be tested and put on treatment in order to prevent chronic changes.

Immunotherapy and Beta-blockers

Dr. Kooner testified that, when he first started his allergy practice, he understood that beta-blockers were a relative contraindication to immunotherapy or testing. The Pan American Allergy Society recommended that members should warn the patient and the physician that, if they were on immunotherapy, they should avoid the use of beta-blockers, and he did so. However, he ceased providing these warnings around 1994 or 1995 when he heard that there was a group of physicians in the United States that did not believe that beta-blockers were a particular concern with regard to immunotherapy or testing, and when the Pan American Allergy Society started to say that it was not as dangerous as had previously been considered. Another reason that he stopped sending those warnings around that time was that new cardio-selective beta-blockers became available.

On cross-examination, he asserted that the position statement of the Canadian Society of Allergy and Clinical Immunology with regard to avoidance of beta-blockers while on immunotherapy constituted a relative contraindication, not an absolute one. He added that there were different schools of thought, and that the Pan American Allergy Society had made a statement that beta-blockers are not a contraindication to immunotherapy. He also stated, although accepting the Compendium of Pharmaceuticals and Specialties (CPS) as an authoritative publication, that its warnings with regard to beta-blockers and immunotherapy did not constitute an absolute contraindication and that there were no control studies supporting that it was an absolute contraindication.

EVIDENCE RELEVANT TO PATIENT A

A) Testimony of Ms. B (Mother of patient A)

Ms. B testified that patient A was born in June, 1989. At the suggestion of a friend, she first took patient A to see Dr. Kooner in April 1993 because of mood swings, itchy nose, dry skin and eczema. After skin testing for inhalant allergens found that patient A had hay fever and allergies to feathers and pets, she was started on desensitization therapy (allergy shots). Ms. B was not sure if she had or had not been given written material at that time about what things around the house might aggravate her daughter's allergies. From 1993 to 1995, she was given a vial of

serum, which she would take to a local clinic for injection every two weeks or so. Patient A was retested at intervals of less than a year by Dr. Kooner to have the dose adjusted.

Peanut Allergy Testing

Between 4:00 and 5:00 p.m. in September, 1996, Ms. B took patient A for retesting and dose adjustment. Towards the end of the retesting, Ms. B asked the nurse to test for a peanut allergy. Ms. B was concerned that patient A was allergic to peanuts because she refused peanuts in the past and also had to lie down for two hours after ingesting peanuts distributed at a parade. She had not discussed this with Dr. Kooner, and Dr. Kooner was not present at the time. She testified that the nurse did the test. She said that, generally, there would be two nurses present but she could not recall if there was one or two on this occasion. She said that she did not recall whether the nurse(s) left the room to speak to Dr. Kooner before proceeding with the test and she did not know whether he was consulted. Neither Dr. Kooner nor the nurse(s) spoke with her regarding what might happen during the peanut testing or any possible risks from the treatment, nor had she ever had any discussion with Dr. Kooner about this prior to September, 1996. She did not recall him giving her a consent form to review prior to the testing.

Following the injections, she took patient A downstairs to the washroom and upon returning up the stairs, patient A turned blue and had difficulty breathing. Ms. B stated that she became somewhat hysterical at that time. Dr. Kooner came immediately, put patient A in a room and gave her several injections including Benadryl. She quickly responded, although she was mildly incoherent. She was taken to the hospital by ambulance arranged by Dr. Kooner at the mother's insistence, although Dr. Kooner thought it not necessary. At the hospital, an IV was started. Patient A was monitored and discharged home after three or four hours. Ms. B does not remember if patient A went to school the next day. The following Wednesday, she returned to thank Dr. Kooner for saving her daughter's life and to discuss the incident. They talked about further testing at that time for mixed nuts and retesting for peanuts in order to place her on desensitization therapy to prevent anaphylactic reactions in the future (but not to cure her). No risks were discussed at that time. She said that it was Dr. Kooner who suggested the retesting for peanuts.

Peanut Allergy Retesting

Ms. B returned with patient A in September and the retesting for peanuts and mixed nuts was done over a two-hour period. At that time, Ms. B insisted that Dr. Kooner be in the building and, when told he would be absent for 30 to 40 minutes, she insisted the test be suspended, which it was. She noted that another infant was being tested at that same time, but does not remember actually seeing injections while Dr. Kooner was absent. Following the retesting (which went without incident), she and Dr. Kooner discussed that he would put peanut into patient A's serum, which was to be taken as usual to the clinic where she was already receiving bimonthly injections. Ms. B stated that she trusted Dr. Kooner.

At the suggestion of another parent, Ms. B contacted the Allergy and Asthma Association of Mississauga, who put her in contact with Dr. U. From that discussion, she decided against desensitization therapy.

Consent

Ms. B testified that at no time during her contact with Dr. Kooner were risks of testing or treatment discussed, and that she never signed a consent form. She was never told that Dr. Kooner was not an allergist or that he practiced Clinical Ecology, and that his methods and treatments were not conventional. The options of other forms of testing or treatment were not discussed. She testified that they only talked about environmental testing and never food testing.

B) Testimony of Dr. Kooner Regarding patient A

Dr. Kooner testified he first saw patient A, with her mother, in April 1993 at the request of their family doctor. He said that he explained to the mother how his practice differed from conventional allergists, about the testing, the possible complications both systemic and local, and the treatment of those complications. This was his routine with every patient. His diagnosis of patient A when he first saw her was allergic rhino conjunctivitis; she was sent for inhalant testing and placed on immunotherapy. His chart showed a second diagnosis of "?Asthma". He testified that he did not enter the diagnosis of asthma in her chart in April 1993, but in March, 1994. He used an accrual method of adding diagnoses to a chart but did not date this entry. His note of patient A's March, 1994 visit states "had asthma attack last week". Dr. Kooner did not feel that patient A had asthma in 1993. She had one attack in 1994 and, although perhaps some difficulty

in the summer of 1994 after immunotherapy injections, she was having infrequent episodes and was quite stable. Dr. V saw patient A in April, 1995. The note of that visit and the note of the June, 1995 visit with Dr. Kooner did not suggest a food problem or asthma. In September, 1995, there was a breathing problem, for which he held off desensitization injection for two weeks, but there was no suggestion of a food issue or asthma at that time. On cross-examination, Dr. Kooner acknowledged that, possibly at this stage, he was starting to think that she probably had asthma, but he had not confirmed it yet. Dr. Kooner acknowledged, however, that the note of October, 1995 was suggestive of asthma, although the lungs were clear.

In September, 1996, patient A came for retesting for inhalant allergens. He wrote: "On Saravent inhaler. Has had asthma episodes few times and received a short course of prednisone [by family doctor]. On examination, E.N.T. normal, lungs clear. Also on Becloforte inhaler. Continue with same medications." Dr. Kooner asserted that patient A had mild asthma, which was stable and well controlled as she had not missed school, did not get up at night to use the inhaler and did not have greater than four attacks per week. Were she unstable, she would have been seen in the emergency department and had some findings on physical examination. He did not understand why she was on three inhalants and prednisone when she had only a couple of episodes per year but, at the time, he did not see fit to question the prescribing physician because he had no doubt that patient A had mild, controlled asthma.

Peanut Allergy Testing

Patient A was then sent for her retesting for inhalant allergens while Dr. Kooner saw other patients. Dr. Kooner's evidence about what happened next was that he learned that patient A's mother wanted her to be tested for peanut allergy because she had had reactions to peanuts in the past. His evidence as to how this information was conveyed to him was inconsistent. In chief, he testified, "note comes back to me with the chart of the patient." He was then asked "What does [*sic*] she say?" and he responded, "She tells me that…," thus seeming to suggest that the information was conveyed to him orally by the nurse, Ms. C, rather than in the note to which he had just referred. He was then prompted by his counsel, "So the nurse brought the chart back in to you?" and he responded that the nurse told him that patient A's mother wanted her to be tested for peanuts. On cross-examination, he denied that the information was conveyed to him by note,

stating that the nurse came in with the chart and discussed this with him. He suggested that the reference to a note in the transcript of his examination in chief was a misprint.

Dr. Kooner then wrote on patient A's chart "mother wants testing for peanuts, which will be done today." He acknowledged that he did not record in the chart his conversation with Ms. C about patient A's prior reactions to peanuts. Dr. Kooner testified that his response to the nurse was that she should do the peanut testing according to safety rule number three, which was that testing for patients who are exquisitely sensitive should be initiated using weak dilutions. He directed the nurse to begin with dilution number 15 to 20. He said that he felt it was acceptable to test patient A for peanuts because they were in her diet, but because peanuts were known to cause strong reactions one always uses special precautions, so he directed the use of dilute solutions to start.

On cross-examination, he was taken to his testimony at the first hearing in November 2000. He testified then that Ms. B wanted testing because there was a family history of peanut reaction and she was afraid that patient A might eat peanuts accidentally. He also testified then that Ms. B had said that she had not given patient A peanuts in the past. Ms. B did not testify at the first hearing and it was suggested that he changed his testimony to say that he had been notified of a past peanut reaction after hearing Ms. B's recent testimony. He denied this, saying that he knew all along that patient A had had reactions but did not feel they represented true allergic reactions.

In addition, Dr. Kooner was cross-examined about why he directed that the testing proceed according to rule three. He said that it was not just because of his concerns about the potential dangers of testing for peanuts but also because of patient A's asthma, even though it was not severe, and her history of having symptoms after eating peanuts. It was pointed out to him that, for another patient with asthma, he did not proceed from weak to strong (Exhibit 1, page 117) in testing for peanut allergy. His response was that it depends on the individual case. When he was reminded that his own expert, Dr. Z, said that one should always test for strong allergens such as peanuts or shellfish by starting with weak dilutions and moving to strong ones, Dr. Kooner disagreed with Dr. Z. It was also pointed out to Dr. Kooner that for another patient with asthma, the nurse proceeded to test for shellfish (a food that is more likely than others to cause an

anaphylactic reaction) from strong to weak (even with no history of exposure). Although Dr. Kooner initially mused that she might have proceeded without his approval, he subsequently agreed that he must have authorised the test as done and without any notation of history of exposure.

Dr. Kooner testified that after he had spoken with the nurse, Ms. C, the nurse then went back to perform the test, while Dr. Kooner continued seeing other patients. He was then called to say that patient A was having a reaction and patient A was then brought to the treatment room. The nurse told him that she gave patient A a relieving dose of a dilute solution to relieve the symptoms. Dr. Kooner came in and gave epinephrine, Benadryl, and Solucortef. Although she was initially cyanotic, patient A came around with the treatment and, although groggy, she was much better. An ambulance was then called and she was taken to the hospital. Dr. Kooner testified that the mother asked that patient A be taken to the hospital and that he replied that, although patient A was fine, it was his policy that patients should be sent to the hospital for observation after a reaction.

Dr. Kooner was asked to explain the recording of patient A's peanut test on the IPFT sheet, which the nurse filled out. He explained it as follows. There are tick marks in two different boxes: number 10 and number 1. The number 1 refers to the test dose, and the symptoms provoked, which were "tongue swelling and abdominal pain" and a nine mm. wheal. The number 10 refers to the relieving dose. Attention was drawn to the nurse's note, which reads, "Within minutes patient started to complain of tongue swelling and abdominal pain. Relieving dose given immediately. Emergency action taken doctor notified." Dr. Kooner was also asked why patient A had an anaphylactic reaction. He said that he looked at the vials after the testing and saw that the #1 vial, which should have been in the #1 pit, was in the #15 pit, and the #15 vial, which should have been in the #15 pit, was in the #1 pit, so that the vials were reversed. Although there was no direct evidence as to what happened, he testified on cross-examination that, according to his understanding, the nurse thought that she was giving a #15 (a dilute dose), when in fact she was giving a #1 (the most concentrated dose); she thought she was doing the right thing but the vials were misplaced. When it was put to him that, if this were so, it made no

sense for the nurse to have ticked off the #1 box on the IPFT sheet, he agreed that it made no sense.

Later, Dr. Kooner called the emergency department physician and understood patient A was doing well. Besides observation, patient A was given Beclovent and prednisone and, after 1 ¾ hours, was discharged home. A follow-up note by the nurse, Ms. C, dated September, says, "Patient's condition much improved- in school today, Ms. C."

In September, 1996, patient A's mother returned alone to discuss the incident with Dr. Kooner. He testified that he explained to her that there had been a mistake in the dilution for testing and this caused a reaction and that retesting was not likely to cause a repeat reaction. Dr. Kooner testified that Ms. B said that she was still worried that, if patient A accidentally ate peanuts or other nuts, she may have a serious life-threatening reaction. Dr. Kooner testified that he told her that patient A had been on peanuts already without a serious reaction, and that this was likely an overdose due to a mistake. He testified further that they came to the conclusion after the discussion that patient A should be retested. He also felt that, although mixed nuts were in a different family, she might be allergic to those as well, and he discussed this with Ms. B. The note in September, 1996 states "retest for peanuts and mixed nuts. Testing revealed allergy to peanuts and mixed nuts. The testing was done again on the request of mother, in spite of the fact that patient A had severe reaction during testing in early September." Dr. Kooner testified that Ms. B wanted to do the retesting, and that he did not suggest retesting for peanuts, but that he was in agreement with Ms. B's suggestion that they re-test.

Dr. X expressed the opinion that Dr. Kooner's decision to test for mixed nuts was not indicated; there was no history related to mixed nuts and peanuts and mixed nuts are not in the same family.

Peanut Allergy Retesting

In mid September, 1996, the patient returned for retesting for peanuts and mixed nuts. The peanut testing began with a number 20 dilution and showed a positive reaction at a number 12 dilution. The mixed nuts began with a number 20 dilution, and showed a positive reaction at a

number 8 dilution. Based on this test, it was decided that desensitization should be attempted. The testing was suspended according to his policy when he had to leave the office to see a patient in hospital, and only restarted when he returned.

C) Testimony of Experts Regarding patient A

All three experts who studied this case agreed that the reaction was that of potentially fatal anaphylaxis induced by peanut allergy. They were not critical of the immediate resuscitation.

All three experts agreed that the patient had some degree of asthma. Dr. X expressed concern that peanut allergy testing was carried out in the office setting without proper documentation of asthma, and without objective measurement using lung function test or spirometric studies to assess the severity of the asthma. He said that there was not sufficient information for him to be able to conclude whether patient A had uncontrolled asthma. Dr. Y initially described her asthma as "moderately severe", but conceded on cross-examination that this was an assumption based on the medications that had been prescribed to her. Dr. Z stated that she seemed to have significant asthma, although he was not able to say if it was moderate or severe.

Dr. Y was critical of Dr. Kooner for using immunotherapy as the initial treatment of patient A's inhalant allergies. He said that Dr. Kooner should first have recommended avoidance measures to Ms. B of the identified allergens, and a trial of medications.

Dr. X expressed the opinion that invasive diagnostic testing of patient A for peanut allergy should not have taken place without properly documenting whether patient A had asthma or not. He also testified that where a patient asked to be tested for peanut allergy, he would only perform the test where the patient had a questionable reaction to peanuts in the past and, if the patient was asthmatic, if the asthma was stable and the lung function was normal. If the asthma was unstable, he would not test for peanuts, due to safety reasons. If a parent came in and asked to have a child tested where the child had had throat swelling or a clinical situation that sounds like an anaphylactic reaction, he would be even more cautious than normal in conducting the testing. Dr. Y testified that, assuming patient A's mother did not tell Dr. Kooner whether patient A had been exposed to peanuts before, he would not have done skin prick testing without having further

discussions with the mother. Assuming, on the other hand, that patient A's mother did give some information to Dr. Kooner about patient A's food reactions, he would have tested if he thought that the symptoms were related to the food, but only using the prick method**.**

Dr. Z testified in chief that, assuming patient A's mother did not tell Dr. Kooner about patient A having had prior reactions to peanuts, but that she was concerned about her exposure to peanuts, it would have been reasonable to test her for peanuts. He testified further that if the testing had started with a number 15 dose, that would have been very diluted and would have been a safe dose to start. He also expressed the opinion that patient A's asthma was not a contraindication to the testing given the dilute solutions that were planned.

On cross-examination, Dr. Z acknowledged that patient A seemed to have "significant asthma." He admitted that safety rule number 3 is that injection testing for food should not be used on patients who are exquisitely sensitive, which includes those who are severely asthmatic. He was taken to testimony he gave in another proceeding in 1997, in which he said the practitioner should be warned that, if the patient has severe asthma or was on "monstrous" amounts of drugs, the patient would be better dealt with by not injecting anything. He said that he had since learned that, even in severe asthmatics, the test is safe. However, he admitted that, in 1997, he would have given this warning to practitioners, and that the standard of practice for members of the Pan American Allergy Society in 1997 was that IPFT should not be done on patients who were severe asthmatics. Despite this, he saw no reason why patient A's asthma should have prevented Dr. Kooner from testing her in 1996 since she was not on large doses of medication for the asthma. On re-examination, he stated that, based on the history that Ms. B gave to the nurses about patient A's prior reactions to peanuts, he did not think that she showed "exquisite sensitivity" to peanuts.

Dr. Z acknowledged on cross-examination that the testing technique, which Dr. Kooner used on patient A, was IPFT, and that there was no evidence in the chart that patient A's mother had been asked for or given a food diary before the testing was done. He admitted that, if peanuts had not been in patient A's diet, Dr. Kooner was breaching one of the basic rules of IPFT in testing her for it, but he added that, at the weak dilution, which (he assumed) Dr. Kooner had ordered, it

would not have caused her any problems. Later, he said that Dr. Kooner "really didn't break the rules" because there was no evidence that the food was in or out of patient A's diet, and she did not give a past history of being seriously allergic to peanuts. He said that Dr. Kooner had used IPFT principles, but he understood that, because peanuts can cause "big problems," one should start with a weaker dose, and that was "perfectly appropriate." Dr. Z also testified that he did not personally test for peanuts and did not even keep peanut extract in his office because of the danger of reaction.

On re-examination, Dr. Z testified that, had Ms. B told Dr. Kooner that patient A had the past reactions to peanuts as indicated in her evidence, he would not have done the standard test for peanuts, but it would have been reasonable for Dr. Kooner to have told the nurse to go ahead and test starting with a number 15 dilution. Later, he was asked whether it would have been unreasonable to test for peanuts had the nurses told Dr. Kooner that patient A had previously consumed peanuts. His response was that he would not do it, but that the standard of care among general and pediatric allergists is that they would test for anaphylactic foods using the prick method.

Dr. X testified that he saw no evidence from the chart that there was any discussion with patient A's mother of either alternatives to, or risks of, the test. Dr. X also testified that, where a nurse was conducting food allergy testing, he would be physically present.

Both Drs. X and Y stated they would do only prick testing because of the danger of allergen load and vascularity with intra-cutaneous testing. Dr. X expressed the opinion that IPFT techniques should never be used to test food allergies, although he acknowledged he was not an expert on the technique. Dr. Y stated that provocative food testing was not a valid process. He expressed the opinion that doing intracutaneous testing on patient A was not in keeping with standards and raised concerns about Dr. Kooner's knowledge, skill and judgment due to the significant risk of anaphylaxis.

Dr. Z did not agree with the College's experts. He testified that, whether a patient is tested intra-dermally, or by a prick test, is not pertinent; what is pertinent is the patient's sensitivity and the

dilution that is used. He opined that patient A's anaphylactic reaction was caused by an error in dosage, although it was pointed out in cross-examination that in neither of his written reports did he say that. He stated that he had just been made aware of this since writing his last report.

Retesting

With respect to the retesting that was done ten days later for peanuts, Dr. X stated that it was "appalling" and "unacceptable" and said that he could not think of any justification whatsoever for it. He said that it put the patient at risk of another life-threatening anaphylactic reaction. Dr. Y called it a "gross error in judgment" to test a patient after she had had an anaphylactic reaction, and that there was "absolutely no rationale" for it. He said that Dr. Kooner had put patient A in a repeat circumstance of what he called "unacceptable risk." While acknowledging that there was no repeat anaphylaxis, he explained that there is often a refractory period following an anaphylactic reaction, but this cannot be counted on.

Dr. Z conceded that testing for peanut allergy after a demonstrated anaphylactic reaction to peanuts broke the first safety rule, that a patient should never be tested for a food that historically produces a severe reaction. He agreed that a patient who has reacted with anaphylaxis to a food should never be re-diagnosed by any kind of skin test, and that any competent physician practising in accordance with the guidelines of the Pan American Allergy Society should not retest in those circumstances.

EpiPen Prescription

Dr. X testified that the standard of practice in allergy medicine, where the patient is known to have had an anaphylactic reaction, is to advise the patient, as well as her parents, family members and her family doctor or pediatrician, that the patient has peanut anaphylaxis. The patient should be advised to avoid peanuts and its related products at all times, and the patient should be advised to carry an EpiPen (a pre-loaded adrenaline injection). The allergy physician should teach the patient and her parents how to use the EpiPen. Dr. X saw no evidence from the chart that Dr. Kooner had done any of this. He acknowledged that notes of a meeting that he attended with Dr. Kooner and a College investigator in 1998 show Dr. Kooner had said in

response to the question, “What other advice do you give to a patient who has an anaphylactic reaction?”, that he would give them an adrenaline kit and patient A already had an adrenaline kit.

Dr. Z agreed that a patient who had had a severe reaction that forced her to go to hospital should be given an EpiPen.

Dr. Kooner maintained on cross-examination that he had given patient A an adrenaline kit prior to September 5, 1996, stating that her mother had requested this because of her inhalant allergies. The panel notes that there is no notation in the chart of this.

Peanut Allergy Desensitization

On the issue of the desensitization treatment that Dr. Kooner recommended for patient A, Dr. X stated that there was no documented evidence that peanuts could be safely desensitized. He testified that the standard of practice at the relevant time was that food allergy cannot be desensitized and that it should not be tried in a practice setting. He referred to a highly controlled study in the United States with regard to the safety of desensitization therapy for peanut allergy. He said that it was an experimental procedure and that normally patients would have to sign a consent form. Dr. X was asked about an article from 1992 (Exhibit 7) by Oppenheimer, Nelson et al. about the study. He said that the research showed that theoretically one may be able to desensitize for food allergy, but that it was not recommended until it could be proved that it could safely be carried out.

Dr. Y testified that he was “flabbergasted” by Dr. Kooner’s decision to recommend immunotherapy, and that there is not currently any type of immunotherapy that is safe for peanut allergy. He said that the standard of practice is that there is no justification for giving food-allergy injections to patients who have an anaphylactic or a suspected anaphylactic allergy to a food. He said that such injections were considered highly experimental. He also referred to the 1992 article about the study in the United States. He noted that the conclusion of the article was that it was possible to desensitize patients with peanut allergy in a structured intensive care unit. He also noted that the study was eventually stopped in 1997 when a patient died due to a dosing

error. He opined that Dr. Kooner's recommendation of desensitization therapy represented a significant lack of knowledge and judgment.

The defence expert, Dr. Z, countered that, at the time of this incident, some felt desensitization could be done, but he agreed that, in accordance with the Guidelines of the Pan American Allergy Society, Dr. Kooner should not have attempted desensitization. He referred to articles from the early 1990's that desensitizing anaphylactic foods like peanuts was too dangerous. He confirmed that he stood by the statement in his report of November 20, 2006, that "if a patient has reacted with anaphylaxis to food, it should not only never (*sic*) be treated, it should not even be diagnosed by any type of skin test." He agreed that to attempt to desensitize would be contrary to safe standards of practice and would show a lack of medical judgment. He agreed that the only treatment for patient A was complete avoidance of peanuts. Although he had stated in his report that Dr. Kooner did not try to desensitize for peanuts, he did agree that Dr. Kooner's note of September, 1996 stating, "please treat for peanuts and mixed nuts", and the note of the next day in September, 1996 stating, "P.I.T.", which he assumed meant "prescribe immunotherapy," did indicate that this was Dr. Kooner's plan.

Lastly, Dr. X reported that, during the 1998 interview that he attended with Dr. Kooner and the College investigator, Dr. Kooner said that he would handle a case such as patient A in the same manner. Dr. X said that he was very surprised by this statement**.**

EVIDENCE RELEVANT TO CASE REVIEWS

The College randomly selected 25 charts from Dr. Kooner's practice that he identified as relating to patients who he was actively treating for allergy. Two College experts, Drs. X and Y, reviewed these charts and submitted reports. One of the experts, Dr. X, having interviewed Dr. Kooner, had the opportunity to question Dr. Kooner with regard to these cases. The expert for the defence, Dr. Z, reviewed the reports of Drs. X and Y and submitted two reports in which he commented on them.

Immunotherapy

Both experts for the College were critical that almost all the patients whose charts were reviewed had positive findings of allergy, and almost all were treated initially with immunotherapy rather than avoidance and a trial of medication. However, neither expert knew the criteria for selection of the charts that were to be reviewed. Dr. Kooner testified that the way in which the charts at issue were selected was that the College investigator came to his office and asked him to show her the charts only for allergy patients that he was actively treating with immunotherapy. In fact, not all of the patients that he saw in his allergy practice were on immunotherapy. He estimates that it was approximately 80%. The remaining 20% either did not have symptoms that he thought were from an allergic disorder, or they could be managed with medications and were sent back to the referring physician.

Dr. Kooner also testified that, for each patient who tested positive for an allergen, he discussed avoidance with the patients when they returned from the testing and gave verbal instructions on avoidance along with printed literature, a sample of which was entered into evidence. The College experts acknowledged that this printed material was of good quality. However, on cross-examination, Dr. Kooner stated that avoidance does not cure anything and he referred to studies questioning the efficacy of this mode of treatment. He said that most of the patients who were referred to him had been tried on avoidance and/or medication by the referring physicians prior to the consultation. At that point, he would discuss with the patient that these modes of treatment had not helped the patient and it was time to go to the next mode of treatment. On cross-examination, it was put to Dr. Kooner that often patients were begun on immunotherapy on the same day as the testing. He said that he prescribed immunotherapy because: antihistamines and nasal steroids have side effects and only block the symptoms, whereas the intent of immunotherapy is to alter the immune system, which is the basic cause for the allergies; immunotherapy should be started early, particularly in children, in order to prevent chronic changes from developing in the airways; immunotherapy can prevent the development of asthma in patients who have allergic rhinoconjunctivitis; and, immunotherapy prevents new allergies.

On cross-examination, Dr. Kooner acknowledged that the percentage of patients that he would place on immunotherapy was 80% as opposed to 20% for conventional allergists. He maintained that the only effective way to cure the problem of inhalant allergies is with immunotherapy.

Record-keeping

Both experts for the College felt that Dr. Kooner's charting was poor and lacking an appropriate functional inquiry, an environmental history, and a diagnosis or differential diagnosis. Dr. Kooner explained that he included the functional inquiry in the charts under "history of present illness" or "past history," and that he only recorded positive results. If there were a negative history, he would not note it, unless it was relevant. The panel notes that Dr. X's criticism of the lack of environmental history was negated several times during his cross-examination when it was demonstrated that Dr. X had overlooked significant history of environmental exposure in the consultation note, which justified specific allergen testing. Dr. Kooner admitted on cross-examination that a chart should have a diagnosis or differential diagnosis and that this was the standard. Dr. Z agreed that, if a diagnosis was made, it should appear on the chart.

Both College experts felt that the documentation of Dr. Kooner's physical examination findings in the charts was inadequate with particular reference to those systems involved in allergy or affected by treatment of allergy. Dr. Y referred to the "repetitive nature" of the physical findings, and stated that the frequent notation "The rest of the physical examination was within the normal range" did not provide him with any useful information as to what else Dr. Kooner examined. Dr. Kooner's evidence was, again, that his charting for the physical examinations documented only positive findings. Otherwise, if he said, "rest of physical examination is normal," this was his short-form way of describing that he had examined the lungs, heart, gastrointestinal system, central nervous system, skin, head and neck, and that he made no negative findings. Dr. Y acknowledged that physicians might sometimes use shorthand in their charts to describe the types of examinations that they perform**.**

Both College experts felt that the charting of the tests was uninterpretable to anyone practising in the field of allergy. The panel noted that the expert for the defence clearly explained the charting for S.E.T. and IPFT. Similarly, Dr. Kooner explained the coding on the charts. Dr. X admitted he

did not take advantage of his opportunity to question Dr. Kooner about this testing during his interview of Dr. Kooner.

History Taking – Questionnaire

Both College experts expressed considerable concern regarding the adequacy of the "Questionnaire" about allergy history and symptoms obtained by Dr. Kooner's nurses and relied on by him, particularly in reference to food allergy. Dr. X testified that, before testing a patient for food allergy, the patient has to give a history of a temporal relationship between manifestations of food allergy and a particular food ingestion. He said that, without a history, you do not routinely test patients based on a questionnaire. He felt that many of the questions were vague or unrelated to any potential food allergy. Dr. Y testified that many of the questions in the questionnaire were non-specific. He said that the questionnaire was not helpful because it included many symptoms that he would not attribute to food allergy and that, if a physician diagnosed food allergy based on that kind of questionnaire, he would be doing so based on misleading information, although he acknowledged that the answers to some of the questions would be helpful.

Dr. Kooner justified food testing on the basis of this questionnaire, although he said that testing would not have been justified based solely on a patient answering "yes" to a single question. Dr. Kooner said this questionnaire was adapted from one of the allergy societies.

Dr. Z opined that it was reasonable to test patients for food allergy based on their responses to the questionnaire. He also stated that he had designed the questionnaire that Dr. Kooner used.

Testing by Intra-cutaneous Methodology versus Skin Prick Methodology

As noted above, Dr. Y was very critical of Dr. Kooner for performing skin testing intra-dermally rather than using a prick skin test. Dr. X opined that intra-dermal testing for food allergy of the sort done by Dr. Kooner was experimental and should only be done with a formal signed consent.

It is clear from the evidence of Dr. Kooner and Dr. Z that practitioners of alternative allergy do their testing intra-dermally. Dr. Kooner testified that he used five-fold dilutions of already dilute extracts, as opposed to skin prick testing, where 100% of the original extract is used for testing. He also said that he calculated precisely a safe dose, whereas there is no precise dose for immunotherapy in a skin prick test. He pointed to an article in the Journal of the American Medical Association that referred to S.E.T. testing as a reliable and valid diagnostic tool. On the issue of food testing with IPFT, he disagreed with the suggestion that IPFT poses more of a risk of anaphylactic reaction than does skin prick testing.

Dr. Z disagreed with Dr. X's evidence that IPFT was unproven and, therefore, experimental and pointed to eleven double-blind studies proving that neutralization therapy works. In response to the suggestion that it was dangerous, he said that his personal experience performing thousands of the tests without untoward reaction spoke for itself. He disagreed that IPFT is dangerous because one is injecting a significant amount of food antigen under the skin, noting that clinical experience does not prove that to be true.

On the issue of consent, Dr. Kooner gave evidence that prior to the incident involving patient A, he did not use written informed consent forms; he said that his predecessor had not used them and the Pan American Allergy Society did not recommend their use until later. He testified that before he tested his patients, he told them verbally that unlike conventional allergists, he did his testing intradermally, and he told them of the possibility of complications. He also testified that he explained to patients the risks and benefits of his type of testing and immunotherapy as opposed to the risks and benefits of conventional testing and immunotherapy. There was, however, no documentation in any of the charts that alternative prick testing was discussed with the patients. Subsequent to the incident with patient A, he adopted a standard consent form for allergy testing. He developed it from consent forms that were used in two hospitals where he worked. As stated on the form, he would explain the procedure to the patient and the likely outcome. He stated that the term "alternative treatment", which appears on the consent form, indicates this is not a method of conventional allergists. He would tell the patient that, unlike conventional allergists who use a prick test, he tests intra-dermally and there are possible complications from the test, including local, systemic or life threatening reactions.

Knowledge of Allergy

Dr. X testified that, based on his interview with Dr. Kooner, he concluded that Dr. Kooner lacked basic knowledge of allergy and clinical immunology. He noted that Dr. Kooner told him that foods and beverages that patients consume regularly cause allergies and that patients are more likely to be allergic to foods that they eat a lot. Dr. X stated that there was no support for these conclusions in published peer review journals. Dr. X stated that Dr. Kooner could not explain to him what dust mites were from an allergy point of view. When he asked Dr. Kooner if he could tell him about mould allergies, he replied that mould was mushrooms, which is not what Dr. X would have expected from someone practising in the community with a letterhead showing allergy as a specialty. Dr. X admitted on cross-examination, however, that he asked Dr. Kooner on several occasions to answer questions as though he were an 18-year-old person or a layperson, and to explain terms in lay terms that a patient would understand. Dr. X was also critical of the fact that all of the charts that were selected showed that Dr. Kooner tested patients for "T.O.E." but Dr. Kooner was unable to explain to him what that was. In his evidence, Dr. Kooner explained that T.O.E. was a combination of three moulds or fungi- the "T" stands for "trychophyton", "O" is "oidiomycine", and "E" is "epidermalphyton". He ascribed his inability to answer Dr. X's question as due to a mental block.

Use of and Testing for Certain Allergens

The College experts were also critical of some of the allergens used. Dr. X was critical of Dr. Kooner for testing patients in his practice for allergy to hydrocarbons and sugar, neither of which is a protein/peptide and, therefore, does not cause allergies based on the IgE-mediated mechanism. He also referred to petrochemicals being tested in Dr. Kooner's practice, but he acknowledged on cross-examination that the testing was not done by Dr. Kooner but by his predecessor, Dr. V. Dr. Kooner confirmed in his testimony that he did not test patients for petrochemicals. A number of the charts at issue (for example, patient D and patient E) showed that in 1995 and 1996, Dr. Kooner tested the patient for hydrocarbons. Dr. X stated that he found this "appalling" because "you can't test for something that doesn't exist."

Dr. Y also testified that hydrocarbons are not recognized agents for allergy testing.

Dr. Kooner maintained in his evidence that one could be allergic to hydrocarbons, but he also said that he stopped testing for hydrocarbon allergy within a few years of joining Dr. V's practice.

Dr. Z testified that one can be allergic to sugar, but that it is not an IgE-mediated reaction. On the issue of hydrocarbons, Dr. Z explained that, in 1996, skin testing was an accepted method among alternative allergists for trying to determine if a patient was sensitive to chemicals, but that it is no longer done.

The panel noted that, for alternative allergists, testing for sugar and hydrocarbon allergies appears to be similar to testing for food allergy of the delayed type, in that they are testing for something that is not IgE-mediated. The idea that one can have an allergy that is not IgE-mediated is not accepted by mainstream (conventional) allergists, and is a major difference between mainstream allergists and alternative allergists.

In his written report, Dr. X was particularly critical that, for several patients, testing was done for inhalant allergens to which the patient had no exposure. The defence was able to demonstrate through cross-examination of Dr. X that exposure was charted in most, if not all, of these patients.

Follow-up or Progress Notes

Both College experts expressed concern about the lack of follow-up or progress notes to the referring physicians. They felt it important for Dr. Kooner, as a consulting specialist, to inform the family doctor of such matters as changes in the patient's condition and/or treatment.

Dr. X expressed the opinion that, in relation to the charts he examined, Dr. Kooner failed to meet the standard of practice in respect of progress notes and keeping other practitioners informed of what he was doing.

Dr. Y identified specifically five charts that were missing formal consultation notes or where no communication was sent to the family doctor. He stated that, in his opinion, there was no

justification for such material to be missing from the chart. The only circumstance in which a consultation note would not be required was if Dr. Kooner was acting as a primary care physician for the patient. On cross-examination, he acknowledged that, on one of the charts that was missing a consultation note, he had failed to notice that Dr. Kooner was acting as primary care physician for the patient, so he withdrew his criticism with respect to that chart. He indicated that, even in the case of patients that had formerly been treated by Dr. V who were being transferred to Dr. Kooner, a consultation note back to Dr. V or a note on the chart would be required and, as well, there should be communication back to the family doctor.

Dr. Kooner's evidence was that he treated most of his patients as would a family physician, and that he followed these patients exclusively for allergy problems. However, he acknowledged that he should have sent more information to the family physicians and said that, in future, he would do so. He acknowledged that the chart for one patient (patient F), whom he treated as a consultant, did not contain a consultation note. He said that he thought the note was likely misfiled. For the other cases lacking a consultation note, he explained that it was either because they were "walk-ins" who were not referred, or because they were taken on in conjunction with his partner, Dr. V.

Dr. Y also noted that there were no signatures on any of Dr. Kooner's progress notes. He expressed the opinion that it is a standard of practice for specialists that progress notes should be initialled, if not signed. Dr. Z said that he had no opinion on this other than to say that he did not think it was a "mortal sin" and that there was "no law" that requires that one sign "every note." The panel notes that, although the progress notes were not signed or initialled, they were in Dr. Kooner's own handwriting, on his own office charts.

In one instance**,** Dr. Y expressed concern about a progress note that was incomplete. This was the case of a child (patient G) whom Dr. Kooner placed on the drug Pediapred (a steroid), but Dr. Kooner failed to refer to this in his note to the family doctor. Dr. Y noted that this medication could mask significant inflammation. He said that, if the child went to the family doctor for abdominal pain, the physician might miss serious problems such as a ruptured appendix because of not knowing that the child was on the medication. Dr. Y acknowledged that this was the only

example he had seen where Dr. Kooner missed including reference to the medication in the consultation note. Defence counsel suggested to Dr. Y that the alarming scenario that he had spoken of would not likely occur because the child's parents would know what medication he was on. Dr. Y responded that it was quite common for parents not to know what medications their child was on. Defence counsel also suggested that, even if parents forgot the medication that their child was on, this had little or anything to do with whether or not Dr. Kooner had included reference to the medication in the consultation note. Dr. Y did not accept this suggestion.

Dr. Kooner's evidence with respect to this patient was that he had not intended to keep the information from the family doctor and that he must have forgotten to include reference to the medication in the consultation note. Dr. Z opined that masking of appendicitis by this steroid was unlikely.

EpiPen Prescription

Aside from patient A, one chart (patient H) noted that a patient had episodes of facial swelling and "throat closing" and that she had been to the emergency room. In his report, Dr. X was critical that there was no notation in the chart that an EpiPen had been suggested. Dr. Z in his testimony agreed that this patient should have been given an EpiPen.

Immunotherapy and Patients with Asthma and on Beta-blockers

Both College experts were critical of Dr. Kooner for having prescribed immunotherapy to a patient (patient I) who had asthma and was on beta-blockers. Dr. X explained that beta-blockers are contra-indicated in patients who are on immunotherapy and in patients who have asthma.

Dr. Y testified that beta-blockers should be avoided in patients on immunotherapy with the sole exception being venom immunotherapy where the patient has a potentially life-threatening condition. He referenced a position statement of the Canadian Society of Allergy and Clinical Immunology in support of this. With reference to patient I, Dr. Y noted that she presented with symptoms of shortness of breath, wheezing, cough, and chest tightness, and that Dr. Kooner stated in her chart that this was precipitated by the beta-blocker she was on. Dr. Y expressed the

opinion that, since the beta-blocker could exacerbate the asthma and since there were other drugs available for hypertension, Dr. Kooner should have stopped the beta-blocker or asked the patient's family doctor or the physician who prescribed it to do so. He noted further that, even when the patient's asthma worsened, Dr. Kooner still did not take her off the beta-blocker. He was especially critical of the fact that Dr. Kooner then put the patient on immunotherapy, saying that this put her at double jeopardy of a life-threatening outcome. Dr. Y explained that if patients on immunotherapy who have asthma have an anaphylactic reaction, there is an increased risk of an adverse respiratory outcome. As well, beta-blockers make asthma worse. When one tries to treats such a patient who has an anaphylactic reaction with adrenaline, the adrenaline will not work because of the beta-blocker. He concluded by saying that, had this patient had a reaction, she could have died and that Dr. Kooner put her in a position of possible harm (although he acknowledged that no harm actually came to this patient).

Dr. Y acknowledged that there was some academic debate in the United States with a school of allergists being of the view that beta-blockers are not a contraindication to immunotherapy. However, he said that even that school of allergists would not prescribe immunotherapy to a patient on beta-blockers who also had asthma. Dr. Y also noted that the American Academy of Allergists agreed that beta-blockers should be avoided for patients on immunotherapy.

Dr. Z's evidence was that, although beta-blockers were a contraindication to immunotherapy in the early 1990's, based on clinical experience they were no longer, and that that was the official position of the Pan American Allergy Society. With respect to patient I, he thought Dr. Kooner had approached this patient cautiously, and he agreed that Dr. Kooner's recommendations were appropriate. He disagreed with Dr. Y's opinion that Dr. Kooner should have stopped the beta-blockers. He said there was no scientific evidence that beta-blockers made asthma worse. He acknowledged, however, that people were still concerned about beta-blockers in 1995 when patient I was treated, and that he guessed that Dr. Kooner might have called the family doctor to switch to something else, "That's what we all did back then." He said that there was no contraindication to the performance of immunotherapy on this patient. He concluded that patient I was not put in circumstances that could have exposed her to harm in any way.

Dr. Kooner's evidence was that, at the time he started his allergy practice in 1987, beta-blockers were a relative contraindication (as opposed to an absolute contraindication) to immunotherapy or testing. At that time, the Pan American Allergy Society recommended that its members warn physicians and patients that if they are on immunotherapy, they should avoid beta-blocker use, and he did make that recommendation regularly. From about 1994 or 1995, he stopped sending those warnings, when the Pan American Allergy Society changed its position and concluded that beta-blockers are not a contraindication to immunotherapy. His evidence about patient I was that his plan was to put the patient on medications (Ventalin and Prednisone) that would help with her asthma and, if that cleared it up, it would be unnecessary to stop the beta-blockers. In response to Dr. Y's opinion that he should have stopped the beta-blockers immediately, he testified that the Canadian guidelines for conventional allergists did not recommend that. They only said that it was a relative contraindication, and that a note should be sent to the family doctor that the patient is on beta-blockers.

The panel notes that what the guidelines in fact say is that use of beta-blockers can lead to a severe aggravation of asthma or anaphylactic reaction, and that physicians should be informed of the potential increased risk of the simultaneous use of beta-blockers in any form of immunotherapy and allergen skin testing in patients with or without asthma. The guidelines also say that a history or risk of anaphylaxis or current immunotherapy as relative contraindications to beta-blocker treatment should be added to the next edition of CPS.

Dr. Kooner noted as well that the beta-blocker that patient I was on was cardio-selective and did not affect the lungs and, therefore, there was no indication to stop it. He stated that one cannot stop beta-blockers right away. They need to be tapered off over time. When he saw the patient for a second time, she was better and, therefore, he saw he no need to take her off beta-blockers. Although her symptoms were worse on a subsequent visit, that was because she had had surgery, not because of beta-blockers. He testified as well that the patient did well on immunotherapy, with no reactions and that, when he started her on immunotherapy, her lungs were clear and her asthma was asymptomatic.

Asthma Assessment

Dr. X expressed the opinion when giving evidence regarding the care given to patient A that, before testing patients with asthma for allergy, there should be a firm assessment of the severity of their asthma; to test without that would not be considered safe. He suggested that there should be objective measurement using spirometry.

Dr. Kooner stated that, in his experience when he does spirometry or lung function tests, they come back normal because the patient's mild asthma is generally because of her allergies. Also, even when the test comes back positive, it does not change the management of the patient. It is only with a severe case of asthma that one must do pulmonary function testing. Responding to another concern expressed by Dr. X about his treatment of a four-year-old child, Dr. Kooner testified that spirometry was unlikely to be effective in children because they are unable to cooperate with the test. Dr. Z agreed with Dr. Kooner on this point.

Immunotherapy and Chronic Urticaria

Dr. Y was critical of Dr. Kooner for prescribing immunotherapy for chronic urticaria (hives), which is a specific, self-limited disease entity not related to allergy. He referred in particular to the case of patient H. Dr. Kooner suggested that this was not a case of chronic urticaria but, rather, repeat acute urticaria due to food allergy. Dr. Y had admitted that acute urticaria can be caused by food allergy, albeit as part of a symptom complex. Dr. Z disagreed with Dr. Y. He testified that chronic urticaria can be due to food, chemicals or inhalants, although it can be difficult to diagnose. He said that there should be basic skin testing to see if there are any significantly positive antigens; if so, a trial of immunotherapy is not contraindicated.

Testing Based on Rhinitis

Both College experts were critical of Dr. Kooner for testing patients for food allergy based on the patient presenting with the solitary symptom of acute rhinitis. Dr. X testified that there is no good evidence that food allergies cause chronic or ongoing allergic rhinitis. Dr. Y testified that the only circumstance in which rhinitis could be caused by food allergy was in the case of workers in food processing plants who inhale food particles. He said that, otherwise, ingestion of food causing rhinitis symptoms was "extremely rare" and that he had never seen it. Both College experts agreed that patients having a system complex (anaphylaxis) could get rhinitis symptoms

as part of the systemic reaction. They referred to the treatment parameters of the American Academy of Allergy and Clinical Immunology.

Dr. Z disagreed. He said that foods can "very definitely" affect the upper and lower respiratory tract. Dr. Kooner testified that in his opinion allergic rhinitis that persists throughout the year (not just seasonally) may be a symptom of hidden food allergy (not IgE-mediated allergy).

Documentation to Support Testing or Treatment

With respect to a few charts, Dr. Y was concerned that laboratory or x-ray testing were ordered without any documentation in the chart as to why. For one patient (patient J), Dr. Y acknowledged in his testimony that he may have misread the chart. In the case of patient F, Dr. Y testified that it was inappropriate for Dr. Kooner to order an upper GI series of tests without a diagnosis, a potential diagnosis or a differential diagnosis being written in the chart.

Dr. Kooner agreed that it was a standard of practice applicable to all physicians that, if you are ordering a test, the chart should note the reason for doing so. In the case of patient J, he stated that the reason for his ordering the test ("complains of sore throat with tender glands") was written in the chart. In the case of patient F, Dr. Kooner again said that he had documented in the chart the reason ("burning stomach") for ordering the test. He testified that he had been trying to rule out stomach problems such as peptic ulcers or reflux disease. In answer to the question of why he had not noted that in the chart, he said that was self-explanatory. Dr. Z expressed the opinion that there was sufficient information in patient J's chart to explain why the test was ordered, and that the reason why upper GI tests had been ordered for patient F was "obvious," to rule out disease as the cause of the patient's frequent complaints of gastrointestinal problems.

With respect to one chart (patient E), Dr. Y testified that Dr. Kooner prescribed an antibiotic treatment without a diagnosis being clearly written in the chart. In response to questions put to him on cross-examination, he said that it is not sufficient for a physician to simply record the symptoms; a medical record has to record the thought processes of the physician and why the physician did what he did.

Dr. Kooner testified that he prescribed the antibiotic in order to control the patient's upper respiratory tract infection. On cross-examination, he took issue with the suggestion that the diagnosis was not noted in the chart. He said that the diagnosis was allergic rhinitis, infections in the upper airway were a complication of that, and the symptomatology and physical findings as noted in the chart support the diagnosis. Since the infection was a complication of allergic rhinitis, which was the diagnosis that was written in the chart, he said that it was unnecessary to write it in the chart.

With respect to two other charts (patient F and patient G), Dr. Y noted that Dr. Kooner prescribed various medications without providing any reason in the chart for why he was doing so.

In the patient F case, Dr. Kooner testified that he had been prescribing the medications listed on the chart from the beginning of treatment. He said that, since he was giving continuing care and the patient was just reordering medications that he had been prescribing to the patient from the beginning of treatment, the standard of practice did not require him to state the reason for prescribing in the chart. He acknowledged that the chart showed that he prescribed a new medication for the patient (Halcion) without stating a reason. His evidence was that it was replacing another medication (Xanax) that had not worked. He acknowledged that the fact that Xanax had not worked was not noted in the chart, but explained this by the fact that the patient had phoned him to say that the old medication was not working, although he admitted that there was no notation of the phone call in the chart either. Both Dr. Kooner and Dr. Z concurred that the reason for prescribing a medication should appear on the chart.

Dr. Y was critical of Dr. Kooner for prescribing immunotherapy to patients who very likely had no significant allergies. In one of these patients, a 69-year-old woman (patient K), Dr. Kooner diagnosed allergy in the presence of recurrent sore throat and enlarged tender lymph nodes in the neck. In Dr. Y's opinion, allergies do not cause these symptoms as a patient who presents with such symptoms is usually suspected of having pharyngitis. In his testimony, Dr. Kooner

defended his diagnosis and said that no age is immune from allergy. Dr. Z' evidence was that he agreed with Dr. Kooner's assessment of this patient as having allergic rhinitis and asthma.

In the case of another patient (patient J), Dr. Y was critical of Dr. Kooner for having ordered a "monospot" test (test for infectious mononucleosis) in the absence of an enlarged liver and spleen. Dr. Kooner explained that the patient was complaining of sore throat with tender glands, he thought infectious mononucleosis was a possibility, and the test was done to rule it out. Dr. Z agreed that a patient who came in with a bad sore throat and enlarged glands could have mononucleosis, and he felt that Dr. Kooner's care of this patient was appropriate.

Immunotherapy and Age of Patient (Over 60 and Children)

Based on the chart review, Dr. Y was critical in several instances of testing and immunotherapy performed on patients under five years of age or over 60 years of age. Dr. Y's rationale for this criticism is set out above, as is Dr. Z's opinion to the contrary.

With respect to children, Dr. Kooner testified that it had been demonstrated that immunotherapy should be started early, before irreversible changes happen in the airway that are difficult to treat. With respect to those over age 60, Dr. Kooner testified that, as long as any underlying conditions are controlled, age is not a contraindication to immunotherapy. He disagreed with Dr. Y's assertion that a patient over 60 years old would be unlikely to be developing allergies for the first time; he said that no age is immune to allergic disorder.

Both College experts expressed particular concern about a one-year old infant (patient L), who was tested for allergy with multiple injections and placed on immunotherapy. The child had been born two months premature, and had numerous health problems. Dr. X said that he found it "appalling" that Dr. Kooner would be seeing a one-year-old. He said that to assess anyone under five years old, let alone a one-year-old, requires special training. He said that Dr. Kooner should have referred the patient to someone who was qualified to deal with a one-year-old. He did admit that general practitioners are competent to treat and commonly see patients under age five.

In Dr. Y's opinion, Dr. Kooner's diagnosis that patient L was allergic to house dust, fungi, moulds, and pollens was not credible. He testified that it would not have been physically possible for a one-year-old child to be exposed to these items on a recurrent basis; it takes at least two years to become clinically sensitized to pollen and the like. Dr. Y felt that the treatment of immunotherapy for this patient was inappropriate. He said that first, Dr. Kooner should have worked vigorously on environmental controls and then, if the child was really symptomatic, the occasional antihistamine. On cross-examination, it was suggested to him that the child had recurrent otitis media, which can benefit from immunotherapy that can reduce the likelihood of the child getting asthma. Dr. Y responded that there is no evidence that immunotherapy helps recurrent otitis media, and that he was not aware of any pediatric allergists having used immunotherapy for recurrent otitis media in a one-year-old child.

Dr. Kooner's evidence was that children under one year of age do have allergies, although not as frequently as do adults. He said that inhalant allergies can develop at any age, from birth onwards. With respect to patient L, he testified that he recommended avoidance of allergens and, specifically, that there be no smoke in the house and that the child be kept away from animals. He also recommended immunotherapy. His reasons were that the child had had sneezing and coughing and a family history of asthma, so that he had a high likelihood of developing future respiratory problems. He felt that immunotherapy would control the symptoms, ensure that his asthma would not deteriorate, and ensure that he did not develop chronic changes in his airways. It would also prevent the development of new sensitivities and might also cure him, which Dr. Kooner said can happen in 50 percent of patients. When it was suggested to him on cross-examination that he should have tried avoidance before trying immunotherapy, he said that, with children, the thrust is to cure the problem; you do not "waste time" on avoiding allergens. He expressed no concern about the number of needles that were given to this one-year-old child during allergy testing, and noted that the guidelines for conventional allergists in both Canada and the United States say that up to 70 or 80 needles can be given to a patient.

Dr. Z' opinion was that patient L had gone through one pollen season and, therefore, could be allergic to pollen. He had no concern about a one-year-old child receiving 42 injections at a single testing session, since he had been referred by the family doctor for the very purpose of

doing an allergy evaluation. He was not concerned about a one-year-old child being on weekly needles; he said that if you think it is definitely going to be a benefit, then you do it. He felt that Dr. Kooner's diagnosis was reasonable. He was aware of research studies that immunotherapy can be beneficial to treating serious otitis media. He referred to studies that children under five who receive immunotherapy for allergic rhinitis may well reduce the possibility of asthma.

Dr. X was also critical of Dr. Kooner for failing to deal with the possibility that patient L had an immunodeficiency. Dr. Kooner's response was that this patient was referred specifically for allergy testing, not for an immunodeficiency work-up. He pointed to a note in the chart from the patient's neonatologist with regard to an immunodeficiency workup already being performed by the neonatologist.

Venom Allergy Testing

Dr. X was critical of Dr. Kooner for testing a patient (patient I) for venom allergy when there was no documentation of a stinging insect allergy in her history that would justify such testing. The chart for this patient showed that she was sensitive to mosquito bites. Dr. Y noted in his evidence that you do not use immunotherapy for mosquito bites. Mosquito bites are not like venom stings. Venom immunotherapy is used for allergy to stinging insects (honey bees, wasps, yellow jackets, yellow hornets and white-faced hornets) whose stings can cause systemic life-threatening reactions. It is not used for local reactions to mosquito bites, which tend to fade away as one builds up resistance.

SPECIALTY DESIGNATION ON LETTERHEAD

The College alleges that Dr. Kooner's use of "Allergy" on his letterhead along with respirology and internal medicine was a deliberate misrepresentation to patients and physicians in the community that he was equally qualified in all three areas when in fact he was only qualified in internal medicine, and that this constituted an act or 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.

Dr. Kooner's consultation notes all had "Allergy" on the letterhead beside "Respirology and Internal Medicine." Dr. X expressed the opinion that this was misleading, as Dr. Kooner was not trained or certified in allergy and clinical immunology. He said that it sent out a signal to the medical community and the public that he was practising conventional allergy and immunology. However, he acknowledged that he did not ask Dr. Kooner if the physicians who referred patients to him knew the nature of his practice. Dr. Kooner testified that he used "Allergy" on his letterhead because that was the designation that had been used by the people working in the clinic for forty years. He testified that the physicians who referred patients to him and, before him, to Dr. V, knew that their testing methods differed from those of conventional allergists. Dr. Kooner also testified that the normal procedure in his office, when an allergy patient was referred to him, included explaining to the patient that they used different procedures than those used by conventional allergists and how they differ. He never received any information from any patient to suggest that they thought he was a conventional allergist.

On cross-examination, Dr. Kooner admitted that there was no differentiation on his letterhead between "Internal Medicine," for which he is certified, and either "Allergy" or "Respirology," for which he is not certified. He admitted that in using the word "Allergy," he was indicating to other doctors and to patients that he practised allergy medicine. He did not put "Alternative Allergy" on his letterhead because members of the Pan American Allergy Society do not do so, since they do not consider their practice to be alternative. He said that when he put "Allergy" on his letterhead, he meant that he was a doctor who did allergy testing. When it was put to him that by having a letterhead that says "Allergy," "Respirology," and "Internal Medicine," he was leaving the impression that, just as he was a specialist in internal medicine, he was also a specialist in allergy, he said that he could not deny it, but that he had not set out to deliberately mislead anyone.

Dr. Kooner admitted ignorance that the regulations under the *Medicine Act* prohibited his use of "Allergy," but said that as soon as the College told him that, he changed his letterhead to say "Alternative Allergy."

EVIDENCE OF DR. W

Dr. W was tendered by the College and accepted by the panel as an expert in the field of allergy and clinical immunology. He was not, by agreement of both counsel, to comment on the case of patient A or on the patients in the chart review. He holds a university teaching position, with experience in the training and assessment of allergists. For two weeks in April of 2000, he co-supervised a traineeship of Dr. Kooner at Dr. Kooner's request and expense, specifically to assess Dr. Kooner's knowledge and ability in the field of allergy. In conducting this traineeship, Dr. Kooner, among other things, would be assigned patients to assess and make up treatment plans. His supervisors would then go over these assessments with Dr. Kooner.

Dr. W's assessment of Dr. Kooner was that, although he interacted well with patients, his knowledge of allergy was superficial and rudimentary for one practising in the field. For example, he felt that Dr. Kooner did not know what questions to ask with regard to IgE-mediated food allergy or the spectrum of medications available for the treatment of rhinitis. Dr. Kooner had difficulty working out doses for immunotherapy for desensitization. He was surprised to learn that Dr. Kooner did not know how to do skin prick testing, although he noted that, by the end of the traineeship, Dr. Kooner had become fairly proficient in doing it and just needed to continue practising. Dr. W was also concerned that Dr. Kooner was giving venom immunotherapy, which normally is initiated in hospital because of the risk of anaphylaxis. He noted that Dr. Kooner said that he was assessing people who had a history of anaphylaxis to insect stings, but he did not know what dose he was prescribing in order to desensitize them.

Overall, Dr. W’s opinion at the end of the traineeship was that Dr. Kooner should not act as an allergy consultant. He should not be assessing people with food allergy, urticaria, insect venom allergy, or atopic dermatitis, without further training, as he was not familiar with them, nor should he be prescribing immunotherapy, as he did not know how to do it. He felt that, based on Dr. Kooner’s previous training in internal medicine and respirology, he could do skin prick testing for inhalants, although he needed more training so that he would master and know how to do it. If Dr. Kooner felt that the patients needed immunotherapy, or he saw people with a history of venom anaphylaxis, then he should be referring them to an allergist. He was troubled with regard to Dr. Kooner's level of knowledge of venom allergy and of the IgE response to food.

On cross-examination, Dr. W acknowledged that Dr. X telephoned him to express his annoyance that he was giving a traineeship to Dr. Kooner. Dr. X felt that Dr. W could not train someone to practise allergy medicine in two weeks, and that to take someone for two weeks was setting a bad precedent.

FINDINGS AND REASONS

CREDIBILITY OF WITNESSES

1. Ms. B

This witness gave a straightforward description of the events involving her daughter and her interaction with Dr. Kooner. Her descriptions of the incident in September, 1996 and the subsequent appointments with Dr. Kooner were credible. She was candid in the areas where she was unsure of her recall, and her overall testimony matched the written record. She never expressed animus toward Dr. Kooner and was not vindictive but expressed satisfaction with his prior treatment of her daughter. Her testimony was internally and externally consistent. When in conflict with Dr. Kooner's version of events, the panel preferred her version.

2. Dr. Y

This witness was accepted as an expert in allergy and clinical immunology. He has extensive experience in training, teaching, and researching in that area and in teaching medical students in general. His testimony was clear and consistent. Inconsistencies between his report and patient records were freely admitted to and explained. His credibility with regard to the theory and present status of allergy and clinical immunology was high, and the panel put weight on his testimony in this area, as it did on his opinions regarding the standards of practice that apply to all physicians.

3. Dr. W

This witness, accepted as an expert in allergy and clinical immunology, has extensive experience in training, teaching, and researching in that area. He was also experienced in the training and assessment of non-certified allergists. He did not testify with regard to patient A or the other cases reviewed, but confined his testimony to the traineeship of Dr. Kooner. His testimony was clear and straightforward, and he was candid in his answers on cross-examination. He presented

without an obvious bias and was candid with regard to the phone conversation that he had with Dr. X. The panel found him to be credible and relied upon his assessment of Dr. Kooner's knowledge base and abilities in the year 2000 in relation to allergy and clinical immunology, particularly with reference to food.

4. Dr. X

This witness was accepted as an expert in the field of allergy and clinical immunology, and has extensive experience in training, teaching, and researching in that area. The panel was of the view that Dr. X has a wide knowledge of allergy, as well as of the basic standards that apply to all physicians and, therefore, it put weight on his testimony in these areas. The panel was, however, left with the impression that Dr. X was not very balanced in some of his comments about Dr. Kooner's practice. Cross-examination revealed a number of errors in Dr. X's reports, most of which were unfavourable to Dr. Kooner. For example, he was critical of Dr. Kooner for testing patients for inhalants to which they had no exposure when their charts made it clear that they did have such exposure. He also asserted that there were items missing in the histories of several patients when these were clearly present. The panel was concerned by the fact that Dr. X did not take the opportunity to clarify any uncertainty he had about the charts when he met with Dr. Kooner, before drawing conclusions in his report. In addition, the panel noted that when Dr. X was confronted on cross-examination with errors in his report, he explained that he (or his secretary in the case of the many typographical errors) was overworked, rather than acknowledging responsibility for his errors. Finally, the panel was disturbed by the fact that Dr. X would have telephoned Dr. W to complain that Dr. W was offering a traineeship to Dr. Kooner. Although Dr. X denied that he expressed anger to Dr. W, Dr. W was very clear that he did. The panel prefers Dr. W's evidence on the point. The panel was of the view that this telephone call was not what one would expect from an objective expert.

The panel was also left with the impression that Dr. X had an animus against alternative allergists. For example, he was dismissive of the standards of the Pan American Allergy Society, which he said he had not even read. When he was presented with the findings of a peer-reviewed study into the testing methods of alternative allergists, he was dismissive of the study, not because of its content but because of where it was published. However, the panel did not give

weight to Dr. X's opinions concerning the methods of alternative allergists in light of its finding (discussed below) that there was insufficient evidence to establish that the practices of alternative allergy are supported by a responsible and competent body of opinion.

5. Dr. Z

Dr. Z was accepted as an expert in allergy. The panel noted that his academic qualifications appeared to be inflated in his curriculum vitae with reference to his university teaching responsibilities, and that he had a paucity of research and publications. The organizations supporting his field of alternative allergy, with one exception, are generally unrecognized by the accrediting boards of American and Canadian organized medicine. The panel noted that Dr. Z gave expert testimony regarding Dr. Kooner's adherence to the standards of practice, yet he himself has been disciplined by his own regulatory body in the United States for not maintaining the standard of medical care. When Dr. Z was cross-examined about his disciplinary history, and the fact that he admitted the factual and legal allegations that had been made against him in the disciplinary proceeding, he stated that he had only made the admissions for reasons of financial expediency, rather than because they were true. This indicated to the panel that he placed a monetary value on the integrity of his word. As part of the settlement of those proceedings, Dr. Z was required to submit to a review of his charts at periodic intervals. He testified, in what appeared to the panel to be a boastful manner, that he was able to pick the reviewer, and he chose "one of [his] friends from a neighbouring town" to "go out once a quarter and look at charts." Thus, he appeared to the panel to be trumpeting his success in manipulating the monitoring process that was imposed upon him. In this, the panel detected a disdain for the monitoring process and for the need to maintain standards.

The panel was concerned about looseness in Dr. Z's use of data in some aspects of his written reports, such as the number of patients he had treated for allergy (80,000 in one as contrasted with 60,000 in the other).

In his written report of January 4, 2007, written less than four weeks before he testified, Dr. Z stated that patient A had suffered anaphylaxis, even though an extremely dilute solution had been used to test her, as the result of the patient's exquisite sensitivity to peanut. In his oral testimony,

however, he testified that the cause of the anaphylaxis in patient A was a mix-up in the testing procedures (starting the patient with the most concentrated dilution instead of the most dilute). He claimed that he had made a mistake in his report, but he was unable to offer any convincing explanation for how he could have made such a mistake after having interviewed Dr. Kooner, or why he did not correct his report when he found out that he had made a mistake. He suggested that it "made no difference" when he found out about the mistake, when it clearly did make a difference. While he claimed that he had only just discovered the error, and that he had "misinterpreted the chart," the panel was unconvinced. Overall, the panel was left with the impression that Dr. Z changed his opinion just prior to his testimony in order to fit with Dr. Kooner's theory of what happened, and that this affected his reliability and objectivity as an expert witness. In addition, Dr. Z's disparagement of conventional allergy was not supported by a body of peer-reviewed opinion.

Dr. Z's apparent lack of regard for standards in his own personal practice caused the panel to give little weight to his opinions concerning whether Dr. Kooner complied with the practice guidelines that he articulated.

Dr. Z gave evidence regarding the standards of a body of practitioners known as "alternative allergists", and he offered opinions regarding whether Dr. Kooner adhered to those standards. The defence argues that "alternative allergy" is a responsible and competent body of opinion that supports Dr. Kooner's conduct. The panel has concluded that Dr. Z's evidence lacks reliability and credibility, and therefore that there was insufficient evidence to establish that Dr. Kooner's conduct and judgment are consistent with a responsible and competent body of opinion.

6. Dr. S. S. Kooner

Dr. Kooner delivered his testimony in a quiet, reserved manner. Often his testimony about things that he said or did were not supported by corroborative evidence from the chart when such evidence should exist. For example, Dr. Kooner's evidence that he discussed the risks of his form of testing with patient A's mother in 1993, and obtained her consent, is unsupported by any reference in the charts, as is his evidence that he prescribed an Epipen to patient A for her inhalant allergies prior to September 5, 1996. Often his testimony was self-serving, such as that

regarding his letterhead. His assertion that patient A was tested for peanut allergy with solutions proceeding from weak to strong because of her history of asthma does not accord with the evidence of how he proceeded with food testing for others with asthma. His suggestion that the cause of patient A's anaphylaxis episode was a mix-up in the vials, when the chart clearly indicates a relieving dose was given after the first injection, lacks internal and external consistency. There was a discrepancy between the evidence that Dr. Kooner gave at this hearing concerning what he knew at the time of testing about prior peanut ingestion by patient A, and the evidence he gave at the earlier hearing. This change in Dr. Kooner's evidence came after Dr. Kooner heard Ms. B's testimony, and was entirely self-serving. In the view of the panel, the "growth" of Dr. Kooner's explanation of the event from his initial testimony to his cross-examination speaks to self-deception. Overall, the panel was unable to rely on Dr. Kooner's explanations of events when no corroborating evidence was presented.

REASONS FOR SPECIFIC FINDINGS

Preamble

The issues in this case are whether Dr. Kooner failed to maintain the standard of practice of the profession in his care of the 26 patients whose charts are in evidence, including patient A, whether he engaged in an act or omission that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and whether Dr. Kooner is incompetent. The panel proceeds on the premise that all physicians are responsible to adhere to the basic standards that are reasonably expected of the ordinary, competent medical practitioner in their field of practice, and to have a knowledge base and practice that protects their patients from harm no matter what the rationale for testing or treatment. Moreover, all physicians must conduct their practices in an honourable and professional manner.

In making its findings as described below, the panel took note of the fact that the College bears the onus of proof and that the standard of proof is on the balance of probabilities. Given the seriousness of the allegations, and the possible consequences from a finding, this requires that the proof must be clear and convincing and based on cogent evidence (*Bernstein v. College of Physicians and Surgeons* (1977)).

1. FAILURE TO MAINTAIN THE STANDARD OF THE PROFESSION

The first issue is whether Dr. Kooner failed to maintain the standard of practice of the profession in respect of his treatment of patient A and the other 25 patients whose charts are in evidence.

a. Charting

i. History and physical examination

The College alleged that the patient charts were deficient, with particular reference to the absence of a functional inquiry, which was necessary to show co-morbid conditions, and the lack of notation concerning environmental assessments. Similarly, the College alleged that the documentation of Dr. Kooner's physical examination findings in the charts was inadequate. The panel accepted Dr. Kooner's evidence that he included the functional inquiry in the charts under "history of present illness" or "past history," and that the absence of reference in the charts to findings on physical examination was because he only noted positive findings. Also, as noted above, there was evidence in the charts of Dr. Kooner having done environmental histories. The panel was of the view that the standard for charting as outlined by Dr. Y was excellent, but that a failure to meet that standard does not constitute a failure to maintain the standard of practice of the profession. The panel found that Dr. Kooner's records could be improved upon, but it was not satisfied that his record-keeping fell below the standard of practice. The panel therefore makes no findings with regard to charting, other than as noted below under issues specific to allergy.

ii. Communication with referring physicians

The panel finds that initial consultation notes to referring physicians were done in most cases. Where a consultation note was absent from the chart, the panel accepted Dr. Kooner's reasons for why it was absent. Nevertheless, the panel did note that ongoing communication from Dr. Kooner to his patients' family or referring physicians was almost universally absent from the charts. Dr. Kooner admitted that he should have sent more information to family physicians, and the panel finds that he should have. The College illustrated its contention about the dangers of not adequately communicating with the referring physician using the case of patient G, a child whom Dr. Kooner placed on steroids without informing his family physician. Without detracting

from the point that communication is important, the panel felt that the alleged dangers of non-communication in that case (that the family physician could miss a ruptured appendix because the symptoms would have been masked by the medication), were unlikely. In conclusion on this issue, the panel is concerned about the level of communication between Dr. Kooner and his patients' family physicians, but it finds that it was not so insufficient as to constitute a failure to meet the standard of practice of the profession.

iii. Takeover notes

Dr. Y was critical of Dr. Kooner for not placing takeover notes on the chart when he took over care of a patient from Dr. V. The presence of takeover notes on office charts when a physician takes on the care of a patient from an office partner would be commendable. However, the panel does not accept that the failure to do so constitutes a failure to meet the standard of practice of the profession.

iv. Tests and medications ordered without diagnosis

The panel accepts the evidence of the College's experts, with which Dr. Kooner agreed, that the standard of practice is that a chart should contain a diagnosis or a differential diagnosis. However, the panel also accepted Dr. Kooner's evidence that, in many of the incidents where he ordered tests or medications without the diagnosis being stated in the chart, the diagnosis was self-evident from the history, or it was not recorded because Dr. Kooner used the SOAP (Subjective Objective Assessment Plan) method of charting (in which he wrote the assessment in the chart rather than the diagnosis), or Dr. Kooner was re-ordering medication that he had been prescribing to the patient for some time. While in several incidents involving tranquilizers or antibiotics, there was a lack of useful information or documented reasoning in the chart, the panel was not persuaded that this amounted to a failure on Dr. Kooner's part to maintain the standard of practice of the profession.

b. Issues specific to allergy

i. History and physical examination sufficient to make a conventional diagnosis

A. Inhalant allergy: In the case of patient A, Dr. Y agreed that the history and examination justified Dr. Kooner's diagnosis of inhalant allergies for which she was referred and subsequently tested. Dr. Y was also of the opinion with respect to some of the patients, based on the information in the charts, that the diagnosis of inhalant allergy was wrong. The panel concluded that there was insufficient evidence to support the allegation that the history and physical examinations were insufficient in these cases to justify the diagnosis that Dr. Kooner made, or that this constituted a failure to maintain the standard of practice of the profession.

B. Food allergy: Without entering the debate with regard to whether there is such a thing as delayed food allergy, all of the experts in this case accepted that IgE-mediated food allergy is real and potentially dangerous. The panel finds that prior to testing for peanut allergy, the allergist must have a full understanding of the patient's prior exposure and reactions to peanuts. With regard to patient A, Dr. Kooner failed to obtain a proper history, prior to testing, of patient A's prior exposure and reactions to peanuts. This was a clear failure on his part to maintain the standard of practice of the profession. The panel notes as well that Dr. Kooner's failure to obtain a history to rule out that patient A had an anaphylactic food allergy, and a food questionnaire from patient A's mother, prior to testing, was even contrary to the guidelines of the Pan American Allergy Society to which Dr. Kooner professed adherence.

In addition, the panel concludes, following from the opinions expressed by the experts for the College as to the imprecision and/or vagueness of the food questionnaire, that the food questionnaire, on its own, is at best a screening tool. However, testing for food allergy based solely on the questionnaire cannot be justified. For the questionnaire to have any value as a screening tool, the physician must ask probing questions about the answers given in order to determine if there is a temporal link between the food and the symptoms. Dr. Kooner testified on cross-examination that he would ordinarily make a note in the chart indicating what, if any, discussions he had with a patient about their history of consumption of a particular food or a list of particular foods, and if they have ever reacted to such foods. In reviewing the charts in issue, the panel found that there was a lack of evidence of any such discussions, let alone any probing questions by Dr. Kooner. In some cases, the chart did not even show that a questionnaire or a food diary had been completed. In the case of patient K, Dr. Kooner acknowledged having

authorized her testing for shellfish without a notation in the chart that shellfish formed part of her diet. The panel concludes that Dr. Kooner failed to maintain the standard of practice of the profession in those cases where he tested for food allergy based solely on the answers on the questionnaire without obtaining a proper history from the patient (patients M, H, N and O), as well as in those cases where he tested for food allergy without even a questionnaire or a food history having been filled out (patients K, P and Q).

C. Interpretability of charts: The panel did not find that there was any difficulty with respect to the interpretability of the charts.

ii. Testing for inhalants by intra-cutaneous methodology vs. skin prick methodology

The College alleges that Dr. Kooner's use of intra-cutaneous skin testing for inhalant allergens, rather than epidermal prick tests, followed by selective intra-dermal testing, is in breach of the standard of practice. The Committee admitted into evidence, without objection from the College, a 1987 article from the Journal of the American Medical Association (Exhibit 18) stating that S.E.T. testing is a reliable and valid diagnostic test for inhalant allergens. No studies to the contrary were presented by the College's witnesses. The panel was therefore not satisfied on the evidence that Dr. Kooner's use of this technique for inhalant testing was a failure to maintain the standard of practice of the profession.

iii. Testing method for immediate food allergy

Both College experts said that testing for immediate food allergy should only be done by the prick method, and then only with caution. Dr. X said he would do a prick test using a minute dose of allergen when testing for highly reactive food allergens such as peanuts. Dr. X testified that IPFT skin testing is not carried out by any conventional allergist, and that Dr. Kooner failed to maintain the standard of practice in his food allergy testing (although he acknowledged that he did not know much about IPFT and that he was not an expert on it). Dr. X described IPFT as non-evidence based, not scientifically valid, invasive, and potentially dangerous. However, he implied that a practitioner could use IPFT, provided that he obtained informed consent from the patient. Dr. Y's opinion was that provocative food testing was not a valid process, and that the skin testing of patient A using that method was not in keeping with the standard of practice. On

another occasion, however, he stated that he was not going to comment on whether IPFT was right or wrong or the standard of practice, although in food testing one always had to be aware that it could precipitate an anaphylactic reaction. Dr. Y's evidence was that intradermal testing for food was dangerous. He testified that it introduced a larger dose of allergen into a more vascular area. He referred to a 2006 practice parameter of the American Academy of Allergy, Asthma and Immunology that said that intracutaneous (intradermal) skin tests for foods are potentially dangerous, overly sensitive and not recommended. They can give an unacceptably high false-positive rate, elicit systemic reactions, and should not be used. However, no objective studies were introduced into evidence to support this conclusion. Although Dr. Z testified that intra-cutaneous testing delivers a measurable and controlled amount of allergen as compared to the epidermal method, which is uncontrolled in its dosage, the potential danger of testing for highly allergenic substances such as peanuts was underscored by his testimony that he does not keep peanut allergen in his office.

Having regard to all of this evidence, the panel was not satisfied that Dr. Kooner fell below the standard of practice of the profession by reason only of the fact that he conducted testing for immediate food allergy using the intra-cutaneous method. However, Dr. Kooner had to obtain informed consent from his patients before subjecting them to this non-conventional testing method, which, as will be noted below, he did not do.

iv. IPFT for "delayed" food allergy

The College's experts testified that the only form of food allergy is IgE-mediated, and that the non-protein/peptide substances that according to Dr. Kooner cause delayed food allergies do not in fact cause allergic reactions. Dr. Kooner, on the other hand, maintains that IgE-mediated food allergies are not the only type of food allergy, and that non-protein/peptides can also cause allergy. The College submits that IPFT testing for delayed food allergy lacks scientific validity and that Dr. Kooner failed to maintain the standard of practice of the profession by employing it.

A study in the journal "Otolaryngology- Head and Neck Surgery" was entered into evidence (Exhibit 1, Tab 17), which concluded that IPFT testing was a practical and useful test for food hypersensitivity. Dr. Z was asked on cross-examination about a published study in the New

England Journal of Medicine that apparently reached an opposite conclusion, but that study was not entered into evidence. Therefore, and without getting into the debate about whether there is or is not such a thing as delayed food allergy, the panel was not satisfied on the evidence that Dr. Kooner's use of IPFT testing was a failure to maintain the standard of practice of the profession. Again, however, Dr. Kooner had to obtain informed consent from his patients before subjecting them to this testing method which, as will be discussed below, he failed to do.

v. Testing for allergy to petrochemicals and non-protein/peptide substances

The contention that Dr. Kooner tested patients for allergy to petrochemicals was shown not to be factual and therefore no finding was made. Although Dr. Kooner tested two of the patients, whose charts were reviewed, for hydrocarbons, that testing took place in 1995 and 1996, and his evidence was that he stopped testing for hydrocarbons within a few years of joining Dr. V's practice. The panel concluded that there was insufficient evidence to make a finding that Dr. Kooner failed to maintain the standard of practice of the profession by his previous testing of patients for hydrocarbon allergy.

vi. Testing for venom allergy

The panel finds that Dr. Kooner's testing of patient I for venom allergy, in the absence of any documentation of a stinging insect allergy in her history that would justify such testing, was a failure to maintain the standard of practice of the profession.

c. Treatment

i. Immunotherapy performed on patients of allegedly inappropriate age

The panel considered the evidence, including the opinions of the experts, regarding the testing and treatment of children under the age of five years and adults over the age of 60 years.

With respect to children, the panel noted that, although the College's expert, Dr. Y, testified that the common view of Canadian, European and American allergy societies was that children under the age of five years should not be given immunotherapy, the other College expert, Dr. X, acknowledged that he referred children of those ages to pediatricians or pediatric allergists. Dr. X also admitted that there is nothing to prevent allergists from seeing patients under age five, and

that it is possible that an allergist could perform a skin test even on a one-year-old child. Dr. Y admitted that skin prick tests are done on babies as young as one year old. He also admitted that there were studies that immunotherapy could be effective for patients under the age of five (although he said there were no studies in respect of infants, i.e., those one year and under). The panel noted that the practice parameters for allergy diagnostic testing indicated that there were "virtually no age limitations" for performance of skin tests, although skin test reactivity may be less in infants and the elderly. Dr. Y acknowledged that the consensus guidelines of the Canadian Society of Allergy and Clinical Immunology on the use of allergen immunotherapy contained no prohibition against infants receiving immunotherapy. A joint practice parameter of the American Academy of Allergy, Asthma and Immunology and the American College of Allergy, Asthma and Immunology noted that some studies had found that immunotherapy had been effective in children under age five, and that each case should be considered individually by weighing the benefits and the risks. The panel also noted that the article by Dr. Ownby, that was submitted into evidence and that Dr. Y testified about, indicated that immunotherapy in young children was relatively as opposed to absolutely contraindicated, and that there was no reason to presume that immunotherapy would not be effective for treatment of allergic rhinitis in young children. It did not say that immunotherapy was absolutely contraindicated in respect of infants.

Having regard to this evidence, the panel concluded that the evidence did not support the allegation that Dr. Kooner failed to maintain the standard of practice of the profession in testing and giving immunotherapy to children under age five.

The panel also concluded that the evidence did not support the allegation that Dr. Kooner failed to maintain the standard of practice of the profession by testing and treating patients over the age of 60 for inhalant allergens. There was conflicting evidence regarding whether new allergies can develop after the age of 60. Dr. Y acknowledged that someone could be diagnosed with allergies at that age, although he said it was uncommon. The panel was not persuaded from the charts in evidence involving patients over age 60 that Dr. Kooner had failed to maintain the standard of practice of the profession in respect of his care of those patients.

ii. Immunotherapy for patients with asthma and/or on beta-blockers

The College alleged that Dr. Kooner fell below the standard of practice of the profession in having prescribed immunotherapy to a patient (patient I) who had asthma and was on beta-blockers. Dr. Y asserted that this patient was placed at risk because immunotherapy was begun in the face of continued use of a beta-blocker, which itself may aggravate asthma. He expressed the opinion that the beta-blocker should have been discontinued to see if that ameliorated the asthma prior to contemplating immunotherapy.

The panel was not persuaded that Dr. Kooner failed to maintain the standard of practice of the profession in his treatment of this patient. The panel accepted as reasonable Dr. Kooner's evidence that the beta-blocker the patient was on was cardio-selective and did not affect the lungs and, therefore, that there was no indication to stop it. The panel also took note of the evidence that beta-blockers are a relative as opposed to an absolute contraindication to immunotherapy. As well, at the relevant time there was a school of conventional allergists in the United States that did not consider beta-blockers to be a contraindication to immunotherapy at all.

iii. Avoidance therapy

The College submitted that Dr. Kooner failed to maintain the standard of practice of the profession by not recommending avoidance as a first line of treatment before resorting to immunotherapy. The order of treatment is, in the opinion of Dr. Y, avoidance, medications, and then immunotherapy only if avoidance and medications do not have the desired effect. It was demonstrated that Dr. Kooner did use an acceptable information sheet in his office practice, which included advice on avoidance, and he testified that he discussed avoidance with his patients. However, he did so as an adjunct to immunotherapy rather than prior to resorting to immunotherapy. There are numerous examples in the chart review of immediate use of immunotherapy by Dr. Kooner without clear attempts at avoidance or food rotation.

However, while it may have appeared that Dr. Kooner was "rushing to treatment," in fact he testified that most of his patients were referred to him by doctors who had already tried avoidance and medication. The panel also accepted Dr. Kooner's evidence that he did not prescribe immunotherapy for all his patients, and that the reason that all the patients whose charts were reviewed were on immunotherapy was that the College investigator who selected the charts

for review had asked for the charts only of patients whom he was actively treating with immunotherapy. The panel therefore concludes that there was insufficient evidence to establish that Dr. Kooner failed to maintain the standard of practice of the profession by not counselling his patients on avoidance before putting them on immunotherapy.

iv. Medication therapy

Similar to its position regarding avoidance, the College also alleged that Dr. Kooner failed to maintain the standard of practice of the profession by not prescribing antihistamines and steroids to his patients prior to resorting to immunotherapy. There was a lack of precision in the testimony of the College's experts as to which medications should have been prescribed to which patients. The panel noted Dr. Kooner's explanation that he prescribed immunotherapy because antihistamines and nasal steroids have side effects, particularly for children, and only block the symptoms, whereas immunotherapy seeks to cure the allergies. Further, as noted above, Dr. Kooner testified that most of his patients were referred to him by doctors who had already tried avoidance and medication. The panel therefore concluded that there was insufficient evidence to establish that Dr. Kooner failed to maintain the standard of practice of the profession by putting patients on immunotherapy without first having tried a course of antihistamines or nasal steroids.

v. Informed Consent

The panel accepts that, as a basic tenet of the practice of medicine, informed consent must be obtained except in rare circumstances. Dr. X opined that a formal written consent was necessary for the IPFT testing that Dr. Kooner performed, on the basis that it is experimental. The panel was not satisfied on the evidence that IPFT testing was experimental or that a written consent was necessarily required. However, Dr. Kooner was obliged to ensure, in the cases under review, that his patients consented to the testing and treatment that he performed, and that their consent was informed. In keeping with the College policy on consent to treatment, this meant that he had to provide his patients with information about the nature of their treatment, its expected benefits, the material risks and side effects, alternative courses of action and the likely consequences of not having the treatment. In keeping with the College policy on complementary medicine, this meant that in assessing patients, he was obliged to advise them of the usual and conventional treatment options and their risks, benefits and efficacy as reflected by current knowledge, and to

document these discussions in accordance with the regulations. In treating patients, he was obliged to provide sufficient information to allow the patients to make informed choices.

If a physician is obtaining verbal consent from patients with respect to alternative testing and treatment methods such as those employed by Dr. Kooner, one would expect to see a notation in their charts as to what was discussed and what the patient agreed to. There are no such notations in the charts of patients from whom Dr. Kooner says that verbal consents were received. Aside from what Dr. Kooner said in his testimony, the only evidence of discussions that Dr. Kooner allegedly had with patients prior to testing and treatment is the evidence of Ms. B. She testified that at no time during her contact with Dr. Kooner did he discuss the risks of testing or treatment with her. He never told her he was not an allergist, or that his methods and treatments were not conventional. Further, he never discussed the options of other forms of testing or treatment with her. The panel accepts Ms. B's evidence. Based on this evidence, along with the absence of any notations in the other patient charts of any discussion between Dr. Kooner and the patient of the matters that Dr. Kooner says he discussed, the panel does not accept Dr. Kooner's evidence. The panel finds that Dr. Kooner did not obtain informed consents to the testing and treatment of those of his patients from whom he says that he obtained verbal consents. In particular, the panel finds that he failed to advise patients that he practised an alternative form of allergy; failed to inform patients of the usual and conventional treatment options, their risks, benefits and efficacy; failed to provide sufficient information to patients about the risks of the testing and treatment methods that he employed as opposed to the risks of conventional methods; and failed to document all of this. In failing to do so, he failed to maintain the standard of practice of the profession.

Dr. Kooner testified that after the incident involving patient A, he began using written consent forms, which recited that the decision maker and the physician had discussed the nature of the IPFT procedure, its likely outcome, "alternative treatment" and the consequences of not having the procedure performed. The forms also included a statement that the decision maker and the physician had discussed concerns about material risks and side effects of the procedure and "alternative treatment." The forms were signed by the patient or the parent, where the patient was a child. Dr. Kooner testified that under the category "alternative treatment," he would discuss with the patient that his methods were not the ones that were used by conventional

allergists. The panel was sceptical that that is what "alternative treatment" meant, but given these forms, and in the absence of any evidence to contradict Dr. Kooner's testimony, the panel felt that there was insufficient evidence to make a finding that after the incident involving patient A, Dr. Kooner continued to test and treat his patients without obtaining their informed consent.

vi. EpiPen prescription

The panel finds that in cases of severe, immediate food allergy such as patient A's, the allergy physician should advise the patient to carry an EpiPen and teach the patient (or the patient's parent) how to use it. Although Dr. Kooner testified that he had given patient A an EpiPen for her inhalant allergies prior to September, 1996, there was no notation of that fact in the chart, nor was there any notation of a discussion between Dr. Kooner and Ms. B about how to use the EpiPen. Ms. B was not asked about this issue during her testimony so the panel does not have her version of events. However, Dr. Kooner's failure to note either of these matters in the chart causes the panel to conclude that in fact he did not prescribe an EpiPen to patient A at any time. The panel is of the view that in any event, even had Dr. Kooner prescribed an EpiPen earlier, once he knew that patient A had a severe life threatening allergy to peanuts, he should have reiterated to Ms. B the importance of avoiding peanuts and of the need to carry the EpiPen at all times. He also should have ensured that the EpiPen he provided was up-to-date (had not expired) or prescribed a new one, and he should have ensured that Ms. B knew how to use the EpiPen. His failure to take any of these steps was a failure to maintain the standard of practice of the profession.

In the case of patient H, whose chart was one of those reviewed, there was no notation in the patient's chart that an EpiPen had been suggested. The absence of any notation in the chart that Dr. Kooner provided an EpiPen to this patient, leads the panel to find that he did not. The panel finds this to be a failure to maintain the standard of practice of the profession.

vii. Immunotherapy for delayed food allergy

The College experts alleged that Dr. Kooner failed to maintain the standard of practice of the profession in that he gave immunotherapy for an allergy that does not exist, i.e., delayed food allergy. The panel notes that the existence of delayed food allergy is a basic tenet of "alternative

allergy". The study in the journal "Otolaryngology- Head and Neck Surgery" referred to above that was entered into evidence provides some evidence that this type of immunotherapy is an effective form of treatment. No objective studies were entered into evidence to support the alleged lack of scientific validity of such immunotherapy, nor was there any evidence presented that it is dangerous. The panel therefore was not prepared to conclude that Dr. Kooner fell below the standard of the profession because he gave immunotherapy for delayed food allergy. However, as discussed above, he did fall below the standard of the profession in failing to properly advise patients that such treatment was unconventional and controversial and in failing to ensure that their consent to such treatment was fully informed.

d. Issues specific to patient A

i. Misrepresentation of form of allergy testing and treatment

The panel accepts the testimony of Ms. B that she was not informed that Dr. Kooner practised an alternative form of allergy medicine or that he used non-conventional testing and treatment methods. The panel finds that this is a failure to maintain the standard of practice of the profession (see above).

ii. Peanut allergy testing

A. Type of testing: For the reasons discussed above, the panel was not satisfied that Dr. Kooner fell below the standard of practice of the profession by reason *only* of the fact that he tested patient A for immediate food allergy using the intra-cutaneous method. However, as will be set out in detail below, he failed to maintain the standard of practice in respect of his testing of patient A in several important aspects.

B. Specific Consent: The panel accepts the evidence of Ms. B that at no time prior to the initial test for peanut allergy did Dr. Kooner or his nurses discuss with her what might happen during peanut testing or its potential risks, that he never told her his testing and treatment methods were not generally accepted or that they differed from those used by conventional allergists, and that he never told her that he did not practise conventional, mainstream allergy medicine. Dr. Kooner's testimony was that he discussed with Ms. B in 1993 that he was a non-conventional allergist, that he used different testing methods, and that he discussed the risks of

his testing method. However, there is no notation in the chart of any such discussion with Ms. B, and the panel finds that no such discussion took place. Even had such discussion taken place in 1993, that does not excuse Dr. Kooner's failure to obtain informed consent from Ms. B to testing for such a highly allergenic substance as peanuts. The panel finds that Dr. Kooner did not obtain informed consent from Ms. B prior to testing patient A for peanuts, and that this is a failure to maintain the standard of practice of the profession.

C. Initial testing: The panel finds that the standard of practice when deciding whether to do peanut allergy testing is that the patient must have had a questionable history of reaction to peanuts to provide a clinical indication to perform the test. The panel finds that there was no absolute contraindication to testing patient A for peanut allergy, provided that Dr. Kooner first obtained an adequate history to justify the test or to rule out any suggestion of prior immediate reaction to peanuts which might render this sensitive test dangerous. As noted above, the panel finds that Dr. Kooner did not obtain an adequate history. There is no evidence that he formulated a rationale for performing this test, as he testified that he added this food test to the inhalant tests in progress at the request of the nurse, without seeing the patient. His testimony as to what he was told by the nurses about patient A's prior exposure to peanuts was not convincing. He was evasive in his answers, his testimony was inconsistent with the testimony he had given in his prior hearing, and he made no notation in the chart of what he was allegedly told. In any event, regardless of whether or not he was told about patient A's prior exposure or reactions to peanuts, his failure to ensure that he obtained a complete history prior to testing patient A for such a highly allergenic substance as peanuts was a failure to maintain the standard of practice of the profession.

D. Dosage: The evidence is clear that patient A received a strong dose of peanut allergen when she was tested. The panel does not accept Dr. Kooner's evidence that he told the nurse to test patient A beginning with a weak dilution. The panel is of the view that this is an ex post facto explanation that was substantially weakened on cross-examination, is inconsistent with his prior testimony, and is not supported by anything in the chart. Dr. Kooner explained that he directed the use of weak dilutions to start because peanuts are known to cause strong reactions. However, this explanation was substantially undermined by his admission that another patient

(patient P) was tested for peanuts beginning with a strong dose, and that another patient (patient K) was tested for shellfish (a food that he admitted is more likely to cause a severe anaphylactic reaction than other foods) beginning with a strong dose, without his knowing whether she had ever consumed shellfish.

The panel does not accept Dr. Kooner's evidence that a mistake was made in the placement of the vials. Dr. Kooner was not in the room when the testing took place and he does not have any direct knowledge of what occurred. The chart makes it clear that the testing began with a concentrated dose (#1), to which the patient immediately reacted, and then was given a much more dilute dose (#10) as a neutralizing dose. There was nothing in the chart to suggest that a mistake was made in the placement of the vials. Had the nurse actually believed that she was giving a #15 dose rather than a #1 dose, it would have made no sense for her to place a tick mark in the box for a #1 dose on the testing form. Dr. Kooner admitted that this made no sense. Dr. Kooner is not relieved from the responsibility of maintaining the standard of practice by the fact that he delegated the testing to his nurse.

The panel also notes that Dr. Kooner's conduct with respect to patient A does not even conform to the guidelines of the Pan American Allergy Society, to which Dr. Kooner professed to adhere. The safety rules that form part of the teaching of that Society clearly state that testing in patients who are exquisitely sensitive, such as those who are severely asthmatic, must be initiated using weak dilutions. Dr. Z testified that one should always test for strong allergens such as peanuts or shellfish by starting with weak dilutions and moving to strong ones.

Dr. Kooner increased the risk that his patient A would suffer a potentially life-threatening anaphylactic reaction by failing to instruct his nurse to test patient A for peanuts beginning with a weak dilution. He thus failed to maintain the standard of practice of the profession.

E. Second testing: The panel accepts the opinion of the College experts that Dr. Kooner's performance of the second test for peanut allergy on patient A following anaphylaxis was clearly contraindicated. Even the defence expert agreed that this test should not have been done. The panel finds that this was a failure to maintain the standard of practice of the profession.

iii. Peanut allergy desensitization

The panel accepts, from the testimony of Ms. B and the chart of patient A, that Dr. Kooner fully planned to carry out a program of peanut desensitization despite a clear episode of anaphylaxis at testing. He admitted such and his evidence on cross-examination was that, at the time, he believed that patient A could be cured of her allergy to peanuts, or avoid a life-threatening reaction if she consumed peanuts accidentally, through desensitization.

The panel accepts the expert opinions that the standard of practice at the relevant time was that food allergy cannot be desensitized and that desensitization should not be tried in a practice setting. At the very least, such desensitization therapy was considered experimental and this ought to have been known by anyone practising in the field of allergy. There is no evidence that the experimental nature of desensitization therapy was discussed with patient A's mother, that she was asked to consent to it, or that she was given the information that would have been necessary for her consent to be informed. Again, even Dr. Z's evidence was that to attempt desensitizations would be contrary to safe standards of practice. The panel concludes that the evidence that Dr. Kooner planned to try to desensitize patient A to peanuts overwhelmingly indicates a failure to maintain the standard of practice of the profession.

d. EpiPen prescription

As noted above, the panel finds that Dr. Kooner did not provide an EpiPen to Ms. B for patient A's use after she had an anaphylactic reaction to peanuts and, as such, he failed to maintain the standard of practice of the profession.

SUMMARY - FAILURE TO MAINTAIN THE STANDARD OF THE PROFESSION

In summary, the panel concludes that in his care of patient A and the other 25 patients whose charts were reviewed, Dr. Kooner failed to maintain the standard of practice of the profession in the following respects:

1. He failed to obtain a proper history from patient A, prior to testing her for peanuts, to justify the test or to rule out a previous reaction to the peanut allergen.

2. He tested patients for food allergy without a questionnaire or food history having been filled out, and in some cases he tested for delayed food allergy based solely on the answers on the questionnaire without any further inquiry of the patient.

3. He tested patient I for venom allergy in the absence of any documentation of a stinging insect allergy in her history that would justify such testing.

4. He failed to obtain informed consents to the testing or treatment from those patients from whom he said that he obtained verbal consents.

5. He failed to provide an EpiPen to patient A when it was clearly indicated after she had an anaphylactic reaction to peanuts, and he failed to provide an EpiPen to patient H after she had episodes of facial swelling and a feeling of her "throat closing."

6. He failed to inform Ms. B that he practised an alternative form of allergy medicine or that he used non-conventional testing and treatment methods.

7. He failed to obtain an informed consent from Ms. B to conduct a potentially dangerous test for peanut allergy prior to testing patient A for peanut allergy.

8. He failed to instruct his nurse to test patient A for peanuts beginning with a weak dilution.

9. He exposed patient A to unnecessary risk by performing a second test for peanut allergy when the patient had already clearly demonstrated anaphylaxis to that same allergen.

10. He clearly intended to treat patient A with desensitization therapy which he knew, or ought to have known, was experimental and hazardous.

Each and all of these findings, based on clear, cogent and convincing evidence, support the allegation of failure to maintain the standard of practice of the profession. As such, the panel

finds that the allegation of professional misconduct as defined by paragraph 1(1)2 of O. Reg.856/93, has been proven to the *Bernstein* standard.

2. DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

a. Informed consent

The College policy on complementary medicine, of which alternative allergy is an example, is based on the "Walker Report" of 1996. The latter stated that patients may seek and doctors may practise alternative forms of medicine. The College policy adopted the recommendation of the Walker Committee that, in assessing patients, physicians should advise the patient of the usual and conventional treatment options, their risks, benefits and efficacy. In treating patients, physicians should provide patients with sufficient information to allow patients to make informed choices. As noted above, the panel has concluded that Dr. Kooner did not adhere to this policy in his interactions with the mother of patient A, nor did he do so in his interactions with his patients prior to the incident involving patient A. He also did not inform his patients that he practised an alternative form of allergy medicine. The panel finds that Dr. Kooner's conduct in this regard was relevant to the practice of medicine and, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional.

b. Letterhead

The panel notes that the words "Allergy" and "Respirology," in neither of which Dr. Kooner is certified by the Royal College of Physicians and Surgeons of Canada, were given the same emphasis on his letterhead as "Internal Medicine," in which he is certified. The College alleged that this was misleading to referring physicians and patients. Although no evidence was led that referring physicians or patients were actually misled by Dr. Kooner's letterhead, the language he used was clearly misleading. Dr. Kooner asserted that his use of the words "Allergy" and "Respirology" on his letterhead was consistent with how his predecessors had described their practices. Whether or not that is so, it does not alter his responsibility for his own letterhead. Subsection 9(2)(b) of O. Reg. 114/94 under the *Medicine Act, 1991,* provides that "[a] member shall not use a term, title or designation indicating or implying specialization, . . . in an area or branch of medicine in which he or she is not certified by the Royal College of Physicians and Surgeons of Canada." Dr. Kooner's use of "Allergy" and "Respirology" on his letterhead was in

breach of that subsection. The panel finds that Dr. Kooner's use of "Allergy" and "Respirology" on his letterhead, being potentially misleading to other physicians and to patients, and being in breach of relevant regulations, was conduct that was relevant to the practice of medicine and, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional.

The panel therefore finds that the allegation that Dr. Kooner has engaged in an act or 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, has been proven to the *Bernstein* standard.

3. INCOMPETENCE

Under subsection 52(1) of the Health Professions Procedural Code, a panel shall find a member to be incompetent if the member's professional care of a patient displayed a lack of knowledge, skill or judgment or a disregard for the welfare of the patient of a nature or to an extent that demonstrates that the member is unfit to continue to practise or the member's practice should be restricted. The onus is on the College to prove that Dr. Kooner is incompetent, to the *Bernstein* standard.

a. Patient A

The panel finds that Dr. Kooner's failure to obtain an adequate history from Ms. B to justify testing patient A for such a highly allergenic substance as peanuts, or to rule out any suggestion of prior immediate reaction to peanuts which might render such a sensitive test dangerous, displayed a lack of knowledge, judgment and a disregard for the welfare of his patient. The panel agreed with the two College experts that Dr. Kooner displayed a lack of knowledge and judgment, and a disregard for his patient's welfare in retesting this patient for peanut allergy after she demonstrated anaphylaxis to the same allergen. Dr. Kooner then planned to do desensitization therapy, demonstrating a lack of knowledge of the dangers of such therapy, even if done in a hospital setting, as well as a lack of judgment and a disregard for his patient's welfare. On this finding alone, incompetence is established. In addition, Dr. Kooner's failure to provide an EpiPen, which the panel finds was indicated in this case, displays a lack of knowledge

and judgment, and clearly put the patient at risk by failure to provide potentially lifesaving emergency treatment.

b. Other patients

The panel accepted the opinions of the College's experts that the food questionnaire, which Dr. Kooner relied upon in the area of food allergy, was vague. Without further probing questions, it would not show a temporal relationship between the ingestion of the food and any symptoms that could indicate a food allergy. The risk of harm to a patient as a result of inadequate history taking before testing for food allergy was demonstrated in the case of patient A. The panel finds that Dr. Kooner displayed a lack of knowledge and judgment, and a disregard for the welfare of those patients whom he tested for food allergy either without a questionnaire or food diary having been filled out or, where one was filled out, based solely on the answers on the questionnaire without obtaining an adequate history from the patients. The panel also finds that Dr. Kooner's care of the patient H displayed a lack of knowledge and judgment and a disregard for the welfare of this patient in failing to provide her with an EpiPen, which was clearly indicated, thus putting her at risk.

c. Present status

The panel considered whether Dr. Kooner has acquired any insight into his deficiencies or has changed his practice.

When Dr. X interviewed Dr. Kooner in 1998 about, among other things, his care of patient A, Dr. Kooner stated that if a child of similar age came to see him with peanut allergy, he would handle the patient in the same manner as he handled patient A. This indicated to the panel that Dr. Kooner continues to demonstrate a serious lack of knowledge and judgment.

The College called Dr. W to give evidence of the traineeship that Dr. Kooner undertook in 2000. Among other things, the traineeship involved Dr. Kooner assessing and outlining management plans for patients. Dr. W commented that Dr. Kooner's knowledge of allergy seemed superficial and was fairly rudimentary for someone practising allergy. Among Dr. W's comments were that Dr. Kooner missed certain things on his history taking and that, in dealing with food allergies,

Dr. Kooner did not know the questions to ask to determine if someone was reacting to a food. While Dr. W felt that Dr. Kooner improved over the two weeks, he still had certain problems including his ability to make an assessment based on a history, and being quick to jump to immunotherapy as opposed to first trying conservative medical management. Dr. W testified that, in his assessment following the traineeship, Dr. Kooner required more training with particular reference to food and venom allergy. He said that he did not feel that Dr. Kooner should be assessing people with food allergy, urticaria, insect venom allergy or atopic dermatitis based on his ability to ask the relevant history, his knowledge of how to assess the different factors in these conditions, and what the necessary management of these conditions should be. He felt that Dr. Kooner should not be prescribing immunotherapy. The panel concludes from this evidence that Dr. Kooner's lack of knowledge and judgment persisted more than three years after the incident involving patient A.

Dr. Kooner acknowledged that he continued to prescribe immunotherapy for food allergies in his patients after the traineeship, until he stopped practising in the field of allergy in November 2001. No evidence was led to suggest that Dr. Kooner's level of knowledge or judgment has improved since November 2001.

On cross-examination, Dr. Kooner demonstrated a lack of insight into his actions. For example, he disagreed with his own expert's opinion that if a patient reacts to a substance with an anaphylactic reaction, the patient should not be treated or even tested again with that substance. He continued to insist that it was appropriate to retest patient A for peanut allergy even after she had an anaphylactic reaction to peanuts.

The panel therefore concludes that Dr. Kooner's professional care of the patients referred to above displayed a lack of knowledge, skill and judgment and disregard for the welfare of his patients of a nature, and to an extent, that demonstrates that he is unfit to continue to practise or that his practice should be restricted. The panel finds that the evidence of this was clear, cogent and convincing, and thus the allegation that Dr. Kooner is incompetent has been proven to the *Bernstein* standard.

SUMMARY OF FINDINGS

The panel finds, on the basis of clear, cogent and convincing evidence, that the allegations below are proven to the *Bernstein* standard:

a. by failing to maintain the standard of practice of the profession as summarized above, Dr. Sukdev Singh Kooner has committed an act of professional misconduct as defined by paragraph 1(1) 2 of O. Reg. 856/93;

b. by an act or omission relevant to the practice of medicine as detailed above, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, Dr. Sukdev Singh Kooner has committed an act of professional misconduct as defined by paragraph 1(1) 33 of O. Reg. 856/93; and

c. Dr. Sukdev Singh Kooner's care of patients displayed a lack of knowledge, judgment and disregard for the welfare of the patients of a nature and to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted, and therefore he is incompetent as defined in subsection 52(1) of the Code.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made at the earliest possible date.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Sukhdev Singh Kooner, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of patients or any information which may identify them under subsection 45(3) the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the *Code*, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under section 45 or 47 is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence and not more than $50,000 for a subsequent offence.

Indexed as: Kooner (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(2) of the ***Health Professions Procedural Code***, being Schedule 2 to 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. SUKHDEV SINGH KOONER

PANEL MEMBERS: DR. M. GABEL (CHAIR)
DR. J. SCHILLINGER
D. EATON-KENT
DR. J. DOHERTY
J. DHAWAN

Penalty Hearing Date: October 28, 2008
Penalty Decision Date: November 28, 2008
Release of Written Reasons on Penalty Date: January 5, 2009

PUBLICATION BAN

DECISION AND REASONS FOR DECISION ON PENALTY

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") heard this matter at Toronto on January 15, 16, 17, 18, 19, and on January 29, 30, 31, and on August 20, and October 9 and 12, all in 2007. At the conclusion of the hearing, the Committee reserved its decision.

On August 1, 2008, the Committee delivered its written decision and made the following findings:

a. by failing to maintain the standard of practice of the profession, Dr. Sukhdev Singh Kooner ("Dr. Kooner") had committed an act of professional misconduct as defined by paragraph 1(1) 2 of O. Reg. 856/93;

b. by an act or 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, Dr. Kooner had committed an act of professional misconduct as defined by paragraph 1(1) 33 of O. Reg. 856/93; and

c. Dr. Kooner's care of patients displayed a lack of knowledge, judgment and disregard for the welfare of the patients of a nature and to an extent that demonstrated that he was unfit to continue to practise or that his practice should be restricted, and therefore he was incompetent as defined in subsection 52(1) of the Code.

On October 28, 2008, the Committee heard submissions on penalty from counsel for both parties, reviewed the brief of character reference letters filed on behalf of Dr. Kooner, and reserved its decision. Following the receipt and review of further comments from counsel for the parties on the wording of the proposed term, condition and limitation, the Committee released its Order on November 28, 2008, with written reasons to follow.

EVIDENCE AND SUBMISSIONS ON PENALTY

At the penalty hearing on October 28, 2008, counsel for the College submitted a draft order for consideration and submitted six cases as guidance as to an appropriate penalty. Dr. Kooner's counsel submitted a brief of six character reference letters, six cases, and a selection from a text by Richard Steinecke entitled *A Complete Guide to the Regulated Health Professions Act* (Aurora, Ont.: Canada Law Book, 2008) in support of his penalty submission.

DECISION AND REASONS ON PENALTY

In arriving at its decision as to the appropriate penalty, the Committee gave careful consideration to the findings, and the specific circumstances of this case, as well as to the overarching aim of the *Regulated Health Professions Act* to protect the general public. The Committee was mindful that in addition to protecting the public, the penalty must uphold the honour and integrity of the profession, deter Dr. Kooner from repeating these actions, and deter other members of the profession from engaging in similar acts or omissions.

The Committee considered the six character references provided by Dr. Kooner, five of which were from patients or former patients and one of which was from a member of Dr. Kooner's religious community. It was noted from the letters that Dr. Kooner has a devoted following of patients and is an active participant in his community. The Committee gave these letters little weight, however, as it was of the view that the comments in the letters did not mitigate the serious nature of Dr. Kooner's misconduct. The Committee considered it a mitigating factor that there were no previous discipline findings against Dr. Kooner.

Terms and Limitations

The College sought a term, condition and limitation on Dr. Kooner's certificate of registration prohibiting him from practising allergy medicine or alternative allergy medicine.

The College did not seek any limitations on Dr. Kooner's practice of internal or respiratory medicine. The Committee agreed that no such limitations were called for as the case did not touch upon Dr. Kooner's ability to safely continue his practice in those areas of medicine.

Dr. Kooner agreed that there should be a restriction on his practice. However his submission was that the term, condition and limitation should apply only to his practice of alternative allergy medicine. His counsel argued that the Committee's findings were all based on Dr. Kooner's practice of alternative allergy, that Dr. Kooner had not practised alternative allergy medicine since 2001, and that the condition he proposed protected the public. He argued further that a prohibition on Dr. Kooner practising allergy medicine might interfere with his ability to respond in an emergency situation, or to see patients in consultation in his internal medicine practice who had had allergic reactions. The College responded that Dr. Kooner had to be prohibited from practising allergy medicine, as otherwise the penalty would be inconsistent with the Committee's findings about his lack of knowledge, skill and judgment in allergy medicine. The College agreed that there should be an exception from the prohibition for emergency situations.

The Committee's finding that Dr. Kooner was incompetent related to his lack of knowledge, skill and judgment and disregard for his patients' welfare in his professional care of his patients in the area of allergy medicine in general, not just alternative allergy. The Committee was of the view that Dr. Kooner's submission that the Committee's findings related only to his practice of alternative allergy medicine, and not to allergy medicine in general, reflected a serious lack of insight into the nature of his professional misconduct and his incompetence as found by the Committee. The Committee concluded that a term, condition and limitation on Dr. Kooner's certificate of registration that would prohibit him from practising allergy medicine and alternative allergy medicine would protect the public by ensuring that he did not practise in the areas in which he had been found to be incompetent. However, the Committee recognized the need to allow Dr. Kooner to respond to emergencies, in the practice of internal medicine, which might have allergic components. Accordingly, the Committee decided that the term, condition and limitation prohibiting Dr. Kooner from practising allergy medicine and alternative allergy medicine should not be

construed as preventing Dr. Kooner from providing emergency care to a patient in an urgent situation. The Committee did not feel it appropriate to limit this exception, as suggested in the written submission from counsel for the College, to only "where there is no other physician available", as it could complicate the provision of emergency care.

Suspension

The College sought a suspension of three months commencing immediately or in short order. College counsel submitted that a suspension was appropriate to achieve general and specific deterrence. She submitted that the Committee's findings of multiple and serious failures to maintain the standard of the profession alone warranted a three-month suspension, as did the Committee's three findings that Dr. Kooner engaged in disgraceful, dishonourable or unprofessional conduct. Therefore, she submitted that the combination of all these findings warranted a three-month suspension.

Counsel for Dr. Kooner suggested that he had already effectively been suspended for six months, resulting from the revocation ordered in the previous hearing of this case, which was later stayed by an appellate court. That, combined with the significant inconvenience of the multiple appeals arising from that hearing (and noting that his appeals were successful), satisfied the need for specific and general deterrence. Counsel suggested that anything further would be harsh and punitive.

College counsel replied that the effective period between the revocation of Dr. Kooner's certificate in the prior case and the stay order had been only six weeks, and the requested three-month suspension took that period into account.

The Committee concluded that a suspension is appropriate to achieve the penalty principles of general and specific deterrence. The Committee finds that a suspension of three months is in keeping with the severity of its findings concerning Dr. Kooner's disgraceful, dishonourable and unprofessional conduct as well as his failure to maintain the standard of the profession. Furthermore, although the cases submitted by the College could all be

distinguished on the facts from the instant case, a suspension of three months was within the range of penalties imposed by the Discipline Committee in the cases submitted by the College whose facts were the most similar to this one. (*CPSO v. Dr. Alexander Franklin* [case of failure to maintain standards- suspension of four months, two of which would be suspended if certain conditions were met]; *CPSO v. Dr. William Arthur Tilly* [case of failure to maintain standards- suspension of six months, three of which would be suspended if certain conditions were met]). The Committee is of the opinion that the prior period during which Dr. Kooner was not permitted to practise, and the inconvenience experienced as a result of the previous hearing and ensuing appeals, should not further abate the period of suspension that it has imposed. But for these factors, the Committee might have imposed a longer suspension.

The Committee ordered that the suspension commence on January 5, 2009. The Committee was of the opinion that this start date would allow sufficient time to arrange coverage for his patients during the suspension period.

Costs

The College sought costs in the amount of $13,650. Counsel explained that she was seeking costs for only one-half of the eight days of the hearing in January 2007 and for only one of the two days of the hearing in October 2007. This was to take into account the fact that Dr. Kooner was successful in his defence to some of the specific allegations that the College made against him. Counsel further explained that the costs were calculated in accordance with the College hearing cost tariff which was in effect on the days in question. The College sought costs related to the hearing only, and not investigative or legal costs. College counsel made reference to the *Act* and to the Rules of the Discipline Committee which permitted such costs to be awarded, and to previous cases in which she argued that costs were awarded by the Committee under similar circumstances.

Counsel for Dr. Kooner submitted that an order that Dr. Kooner pay costs of $7,500 was more appropriate. He indicated that Dr. Kooner had been successful in defending 17 of the

allegations against him, which had taken up much of the hearing time. He also noted that time had been lost due to the College adjourning the hearing due to the schedules of two of its expert witnesses.

The Committee noted that both parties were in agreement that this was an appropriate case to award costs to the College. The Committee agreed with this. The Committee concluded that the quantum of costs should be reduced from the amount requested by the College as it did not adequately take account of the amount of hearing time that was spent on matters that ultimately did not lead to findings being made against Dr. Kooner. However, the Committee also concluded that the $7,500 offered by Dr. Kooner was not sufficient. The Committee was of the opinion that an order that Dr. Kooner pay costs of $10,500 would be appropriate.

ORDER

Therefore, the Discipline Committee ordered and directed that:

1. The Registrar suspend Dr. Kooner's certificate of registration for a period of three (3) months, commencing January 5, 2009.

2. The Registrar impose the following terms, conditions and limitations on Dr. Kooner's certificate of registration, as of the date of this Order:

    (a) Dr. Kooner shall be prohibited from practicing allergy medicine and alternative allergy medicine. This shall not be construed as preventing Dr. Kooner from providing emergency care to a patient in an urgent situation.

3. Dr. Kooner pay costs to the College in the amount of $10,500 within thirty (30) days of the date of this Order.

4. The results of this proceeding to be included in the register.