NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Straka, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the witnesses or any information that could disclose the identity of the witnesses under subsection 45(3) of 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.

> Every person who contravenes an order made under … section 45 … is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: **Ontario (College of Physicians and Surgeons of Ontario) v. Straka, 2016 ONCPSD 15**

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

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(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. PAVEL FRANTISEK STRAKA

PANEL MEMBERS:

DR. P. TADROS
DR. E. ATTIA (PhD)
DR. H. SCHIPPER
MS. D. DOHERTY
DR. P. CHART

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. M. KELLYTHORNE

COUNSEL FOR DR. STRAKA:

MR. P. GRIFFIN

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. G. FORREST

Hearing Date: **June 2, 2016**
Decision Date: **June 2, 2016**
Release of Written Reasons: **June 29, 2016**

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on June 2, 2016. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Straka committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991 ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

2. under paragraph 1(1)33 of O. Reg. 856/93, in that he 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.

The Notice of Hearing also alleged that Dr. Straka is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the Regulated Health Professions Act, 1991 ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. Straka admitted the first allegation in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession. Counsel for the College withdrew the second allegation in the Notice of Hearing as well as the allegation that Dr. Straka is incompetent.

THE FACTS

The following Agreed Statement of Facts and Admission was filed as an exhibit and presented to the Committee:

1. Dr. Pavel Frantisek Straka is an anesthesiologist who practises in Toronto, Ontario. He received his certificate of independent practice in 1982.

2. In February 2015, pursuant to an undertaking from Dr. Straka to the College, the College received an assessment of Dr. Straka's hospital-based anesthesia practice by Dr. Carol Loffelmann, which is attached at Schedule 1 to the Agreed Statement of Facts and Admission. Dr. Loffelmann's assessment was based on review of nine patient charts, her observation in August 2014 of Dr. Straka's provision of care to four patients, whose charts she also reviewed, and an interview with Dr. Straka. Dr. Loffelmann's assessment report outlined concerns regarding deficiencies in Dr. Straka's practice.

3. Dr. Straka provided an expert report to the College in April 2015 in support of his position. In addition, after the subsequent referral of allegations against Dr. Straka to the Discipline Committee, Dr. Straka provided the College with an expert report by Dr. Richard Doran on May 18, 2016, which is attached at Schedule 2 to the Agreed Statement of Facts and Admission. Dr. Doran reviewed the thirteen patient charts that Dr. Loffelmann reviewed and considered Dr. Loffelmann's report. Dr. Doran also observed Dr. Straka providing care to five patients in April 2016 and interviewed Dr. Straka. Dr. Doran disagreed with Dr. Loffelmann about some aspects of the care provided by Dr. Straka. However, Dr. Doran agreed that there were deficiencies in Dr. Straka's practice, including significant deficiencies in documentation and certain concerns regarding Dr. Straka's judgment and knowledge. Dr. Doran attributed some documentation issues to deficiencies in the anesthetic record used at Dr. Straka's hospital.

4. Dr. Straka failed to maintain the standard of practice of the profession of anesthesiology in a hospital setting. In particular:

a) Dr. Straka failed to document an appropriate pre-anesthetic assessment or to adequately document intraoperatively in his care of multiple patients.

b) Dr. Straka failed to document discussion of the risks and benefits of invasive procedures with multiple patients, and as observed by Dr. Loffelmann did not have any discussion with a patient regarding a transversus abdominis plane (TAPP) block which he later administered.

c) When administering general anesthesia, Dr. Straka inappropriately used 100% oxygen during the maintenance phase as a matter of routine in every case.

d) Dr. Straka failed to organize and prioritize medical issues in two complex patients undergoing emergency surgery.

e) Dr. Straka administered an inappropriately small dose of analgesic to a patient undergoing gynecological surgery, as indicated by the patient's respiratory rate and end tidal carbon dioxide.

f) Although Dr. Straka ultimately successfully intubated a patient after several attempts due to the patient's difficult airway, Dr. Loffelmann expressed concern regarding Dr. Straka's level of situational awareness. The patient experienced a marked hypertensive response as a result of an inadequate level of anesthesia for the multiple attempts at intubation, and Dr. Straka did not document the difficult airway, including the number of attempts.

5. Dr. Loffelmann made recommendations in her assessment report, including that Dr. Straka practise under high level supervision with respect to complicated/critically ill patients, that the supervisor be immediately available to Dr. Straka when conducting airway management, that Dr. Straka engage a clinical

preceptor with respect to other aspects of his hospital practice, and that Dr. Straka take educational courses.

6. Dr. Straka has practised under supervision pending this hearing as a result of an interim order in this proceeding. Among other things, since January 2016 the supervisor has reviewed and approved of all pre-operative assessments and treatment plans in advance of Dr. Straka providing general anesthesia, and has observed intubation in each case. The supervision reports made to the College by Dr. Straka's clinical supervisor have been positive.

7. In interviewing and observing Dr. Straka and in reviewing five patient charts in April 2016, Dr. Doran found that Dr. Straka's documentation had improved significantly, that his preoperative assessments were complete, and that there were no issues with Dr. Straka's performing of technical tasks under observation. When observed by Dr. Doran, Dr. Straka discussed the risks and benefits of blocks with patients. Dr. Doran identified that Dr. Straka appeared to have some gaps in his knowledge, that his practice of doing regional anesthesia without monitoring was potentially unsafe, that his reaction to stress could lead to poor judgment, and that his management of complicated cases was an area for improvement. Dr. Doran recommended that Dr. Straka not do on-call coverage in anesthesia until completion of education and a reassessment, and that he continue to be subject to clinical supervision with pre-operative review of his plans for higher risk patients and the supervisor's presence at intubation if he or she deemed it necessary. Dr. Doran expressed the view that the "gaps in [Dr. Straka's] practice are remedial."

Dr. Straka admits the facts set out above and admits that he failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*.

FINDING

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Straka's admission and found that he committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Straka made a joint submission as to an appropriate penalty and costs order. The proposed penalty order included a reprimand and a number of terms, conditions, and limitations on Dr. Straka's certificate of registration. Costs of the hearing as well as costs of the terms, conditions, and limitations imposed are to be paid by Dr. Straka.

The Committee received in evidence and considered four letters of reference from Dr. Straka's colleagues.

The Committee considered the accepted principles of penalty in determining the appropriateness of a joint submission. Of paramount importance is protection of the public. Other important principles include maintenance of public confidence in the integrity of the profession as well as the profession's ability to govern itself in the public interest; denunciation of the conduct; specific deterrence of the member; general deterrence of the entire membership; and rehabilitation of the member, where relevant. The penalty should also be proportionate to the misconduct. In the specific circumstances of this matter, the Committee believed that rehabilitation of the member was a central and important factor for consideration.

After consideration of the above principles, the Committee accepted the joint submission on penalty proposed by the parties as appropriate, fair, and reasonable.

Nature of the Professional Misconduct

The nature of the misconduct and any aggravating or mitigating circumstances is an important consideration in determining the appropriateness of a proposed penalty.

The evidence before the Committee was an Agreed Statement of Facts and Admission supported by expert reports by the College expert, Dr. Loeffelmann (April 2015) and the defence expert, Dr. Doran (May 2016). Dr. Loeffelmann's report was part of a comprehensive practice assessment resulting from a voluntary undertaking Dr. Straka had made.

The parties agreed that, although expert reports were filed, the parties had not agreed to accept all of the conclusions of each of the experts.

Nevertheless, the Committee concluded that the aspects of the reports referred to in the Agreed Statement of Facts demonstrate Dr. Straka's failure to maintain the standard of practice of the profession.

Dr. Straka's documentation was deficient in pre-anesthetic assessment, discussion regarding risks and benefits of invasive procedures, and recording of intraoperative care in multiple patient records.

There were also concerns regarding Dr. Straka's routine use of 100 percent oxygen when administering general anesthesia, his use of an inappropriately small dose of analgesia as indicated by certain respiratory parameters, and his ability to achieve an adequate level of anesthesia for repeated attempts at intubation.

In addition, concern was voiced regarding Dr. Straka's independent management of complex cases or where patients were critically ill.

The Committee noted that Dr. Straka's deficiencies are serious and constitute a risk to patients. This is particularly important because, with anesthesiologists, the patient does not usually have a choice of physician. Patients are left to assume that the anesthesia will be administered in a safe manner in a hospital setting and that their anesthesiologist will

have the requisite knowledge, skill, and judgment. Such an assumption by the public is a fair one.

Mitigating and Aggravating Factors

The above deficiencies, while serious, must be viewed in the context of the following mitigating circumstances:

- Dr. Straka has been practising under supervision pending the outcome of this hearing. The corresponding reports to the College have been positive;
- An integral part of his supervision was a review and approval of all pre-operative assessments, treatment plans, and observation of all intubations;
- In April 2016, Dr. Straka's documentation had improved significantly, his preoperative assessments were complete, and there were no issues in respect of technical tasks;
- Dr. Doran observed Dr. Straka in April 2016 discussing risks and benefits with patients about to undergo blocks;
- Dr. Straka has been cooperative throughout the investigation. His admission has saved witnesses from having to testify and a lengthy hearing; and
- The Committee was influenced by Dr. Doran's opinion that Dr. Straka was remediable. The Committee viewed Dr. Straka's improvement to date as a demonstration of his insight, motivation, and capacity to improve.

The Committee was concerned that there were remaining gaps in Dr. Straka's knowledge and management in some circumstances. In particular, the Committee was concerned about his management of high risk or complicated patients and his administration of regional anesthesia. In addition, the Committee was concerned that Dr. Straka's reaction to stress may compromise his judgment.

It remained clear to the Committee that a broad range of terms imposed on Dr. Straka's certificate of registration would be necessary to ensure public safety.

Proposed Remedial Plan

The plan proposed in the jointly-submitted penalty is comprehensive and sufficiently broad to achieve the goal of protecting the public.

The Committee noted that, in respect of his hospital based practice, Dr. Straka will practise only under the supervision of a Clinical Supervisor for six months, according to the proposed penalty. Dr. Straka will meet with his supervisor and develop a plan for obtaining and documenting informed consent. With his supervisor, Dr. Straka will pay special attention to nerve blocks, including pre-planning and direct observation of particular cases.

Dr. Straka will preoperatively review all cases deemed to be ASA 3 or higher anesthetic risk as well as cases where a difficult airway may be anticipated. During the clinical supervision, prior to intubation, Dr. Straka will ensure that another anesthesiologist is on the premises and available to assist him if required. These measures reassured the Committee that Dr. Straka will engage in safe practice going forward.

Dr. Straka shall not perform on-call anesthesia in a hospital. After four months of clinical supervision, and with the agreement of his Clinical Supervisor, Dr. Straka will be permitted to perform on-call anesthesia subject to a graduated program of direct observation during the balance of the supervision period. Once the clinical supervision is completed, Dr. Straka shall not perform on-call anesthesia until his final assessment is completed. These restrictions, in the view of the Committee, further ensure safe anesthesia practice.

Dr. Straka must undergo an evaluation of his practice knowledge, after which an individualized education plan acceptable to the College will be submitted within 90 days

from the date of the order and completed within six months. This education plan should identify and correct any further areas where education or remediation is needed.

In addition, Dr. Straka will complete a Simulator-based education course in anesthesia, education in regional anesthesia, and education in difficult airway management. All of these courses must be completed within six months from the date of the order.

The Committee viewed the proposed education plan as extensive enough to address a range of Dr. Straka's potential deficiencies. The Committee was especially concerned regarding Dr. Straka's ability to manage complex patients, and was comforted by the fact that the Simulator-based training would simulate problems encountered with high risk patients. This should provide Dr. Straka with the skill and confidence required to appropriately manage difficult situations when they arise.

Dr. Straka's retention and application of knowledge will be evaluated when his hospital practice is reassessed four months after his clinical supervision ends. This reassessment will provide both the Committee and the public with objective evidence regarding whether Dr. Straka is maintaining the standard of practice.

Case Law

The Committee understood that it is not bound by prior decisions and that, rather, each case has its own unique circumstances. However, similar cases should be treated in a consistent manner. The College referred the Committee to prior discipline cases where there were some factual similarities to the facts in Dr. Straka's case.

In *CPSO v. Huebel* (2015), the Committee imposed a reprimand, costs, as well as terms, conditions, and limitations on Dr. Huebel's certificate of registration. Dr. Huebel failed to maintain the standard of practice of the profession with regard to two patients he treated in the emergency room. As with Dr. Straka, the hearing proceeded by way of an agreed statement of facts and a joint submission on penalty. Evidence demonstrated that Dr.

Huebel, like Dr. Straka, had improved his clinical practice, was motivated, participated in remedial educational activities, and had positive assessments from his supervisor.

In *CPSO v. Shomair* (2012), the Committee imposed a penalty consisting of a reprimand and terms requiring supervision, educational programs, and an assessment after a suitable period. Dr. Shomair, a psychiatrist, was found to have failed to maintain the standard of practice in his documentation and treatment of a number of children with bipolar disorder. Like Dr. Straka's proposed penalty, the focus of the penalty in *Shomair* was to achieve safe practice by broad supervision and re-education.

In *CPSO v. Dr. Rosenhek* (2010), the Committee ordered suspension of Dr. Rosenhek's certification for four weeks, a reprimand, terms, conditions and limitations for an indefinite period, and education in record keeping, communications, and required CME. The Committee found that Dr. Rosenhek, a cardiologist, had widespread and serious deficiencies in his management of cardiac risk factors. These included his failure to order indicated examinations or diagnose conditions in an appropriate, timely manner. Dr. Rosenhek failed both to act when he should have and to maintain sufficiently-detailed records of his care and treatment. The Committee was of the view that *Rosenhek* was a more serious case than Dr. Straka's and warranted a more stringent penalty.

Lastly, the Committee was reminded by its independent legal counsel that a joint submission of this nature should be accepted by the Committee unless to do so would be contrary to the public interest and bring the administration of justice into disrepute.

Costs

The Committee agreed that this was an appropriates case to require Dr. Straka to pay the College costs for two days of hearing in the amount of $10,000.00, given the late timing of settlement.

Summary

After reviewing counsels' submissions, the Agreed Statement of Facts and Admission, the reference letters, and the case law cited, the Committee was satisfied that the proposed penalty was within the range of prior penalties of the Discipline Committee in similar cases. The administration of a reprimand denounces the conduct and provides specific deterrence to the member. The reprimand enabled the Committee to emphasize to Dr. Straka that there are serious consequences of failing to maintain the standard of practice and that he is responsible to make all efforts necessary to successfully complete the required education. The broad range of rehabilitative terms, conditions, and limitations, including further education and supervision, has been ordered to protect the public and maintain its confidence in the profession.

In conclusion, the Committee accepted that the penalty proposed is proportional and appropriate in the circumstances.

ORDER

Therefore, having stated the findings in paragraph 1 of its written order (the "Order") of June 2, 2016, on the matter of penalty and costs, the Committee ordered and directed that:

2. Dr. Straka attend before the panel to be reprimanded;
3. the Registrar impose the following terms, conditions and limitations on Dr. Straka's certificate of registration:

(i) Subject to paragraphs 3(ii)(f) and 3(vi) below, Dr. Straka shall not perform anesthesia in a hospital setting on an on-call basis;

(ii) Dr. Straka shall retain a College-approved clinical supervisor or supervisors (the "Clinical Supervisor") with respect to his hospital-based anesthesia practice, who will sign an undertaking in the form attached to the Order as Schedule "A." For a period of at least six (6) months commencing on the date of the Order, Dr. Straka may practise hospital-based anesthesia only under the

supervision of the Clinical Supervisor and will abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to practice improvements, practice management, and continuing education. Clinical supervision of Dr. Straka's practice may end after a minimum of six (6) months, upon the recommendation of the Clinical Supervisor and, in its discretion, approval by the College. Clinical supervision of Dr. Straka's hospital-based anesthesia practice shall contain the following elements:

a. Dr. Straka shall facilitate review by the Clinical Supervisor of twenty (20) patient charts per month or, should Dr. Straka treat fewer than twenty (20) hospital patients in any month, the charts of all patients treated in that month;
b. Dr. Straka shall have an initial meeting with his Clinical Supervisor regarding the process for obtaining and documenting patient consent, at which they will develop a plan regarding the same, and thereafter the Clinical Supervisor's consideration of Dr. Straka's consent process and documentation of the same shall form part of the monthly chart review described at paragraph 3(ii)(a) above;
c. Dr. Straka shall pre-operatively review with the Clinical Supervisor his plan for management of any patient who is a Class ASA 3 or higher anesthetic risk, as well as his plan for management of any patient with a known history of difficult intubation or whom Dr. Straka anticipates may have a difficult airway. During such review, Dr. Straka shall with his Clinical Supervisor identify when and how he will call for help during the procedure if required;
d. The Clinical Supervisor may be present for intubation of any patient, if deemed necessary or desirable by the Clinical Supervisor;
e. Dr. Straka shall have an initial meeting with his Clinical Supervisor regarding Dr. Straka's practice with respect to nerve blocks, and thereafter consideration of Dr. Straka's practice with respect to nerve blocks shall form part of the monthly chart review described at paragraph 3(ii)(a)

above, and if deemed necessary or desirable by the Clinical Supervisor Dr. Straka shall also engage in pre-planning with his Clinical Supervisor regarding particular cases and permit the Clinical Supervisor to directly observe his practice regarding nerve blocks;

f. After four (4) months of Clinical Supervision, if agreed to by the Clinical Supervisor (which agreement may be withdrawn at any time), Dr. Straka may perform anesthesia on an on-call basis for the remainder of the period of Clinical Supervision under Clinical Supervision consisting of the following:

    a) At least one (1) month during which the Clinical Supervisor shall directly observe Dr. Straka's pre-anesthetic assessment, induction and emergence, and the Clinical Supervisor shall be immediately available during the remainder of the procedure in order to assist or consult with Dr. Straka if necessary or desirable;

    b) Followed by, if the Clinical Supervisor is of the view that Dr. Straka is ready, at least one (1) further month during which Dr. Straka shall review the case with his Clinical Supervisor before its commencement and debrief the procedure with his Clinical Supervisor following its completion, with the Clinical Supervisor to observe the procedure if he or she deems it necessary or desirable to do so and in any case to be readily available to assist Dr. Straka if needed throughout the procedure.

(iii) Dr. Straka shall successfully complete and provide proof thereof to the College within six (6) months of the date of the Order:

a. Simulator-based education in anesthesia acceptable to the College;
b. Education in regional anesthesia acceptable to the College;
c. Education in difficult airway management acceptable to the College;
d. An evaluation of his practice knowledge acceptable to the College, to result in development and submission to the College of an individualized education plan within ninety (90) days of the date of the Order identifying any further education and remediation to be completed by Dr. Straka in

response to any deficiencies in his knowledge identified by the evaluation, with Dr. Straka to complete such education and remediation within six (6) months of the date of the Order.

(iv) During the period of Clinical Supervision, Dr. Straka shall ensure prior to performing intubation that another anesthesiologist is present on the premises and available to assist him if necessary.

(v) If Dr. Straka fails to retain a Clinical Supervisor as required above or if, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason, Dr. Straka shall retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached to the Order as Schedule "A," and shall cease to practise hospital-based anesthesia until the same has been delivered to the College.

(vi) Approximately four (4) months after the completion of Clinical Supervision, Dr. Straka shall undergo a reassessment of his hospital-based anesthesia practice by a College-appointed assessor (the "Assessor"). The assessment may include a review of Dr. Straka's patient charts, direct observations, interviews with staff and/or patients, and a formalized evaluation of Dr. Straka's knowledge base. The results of the assessment shall be reported to the College after which, should it be recommended by the Assessor, the College may in its discretion permit Dr. Straka to practice without restriction.

(vii) Dr. Straka shall consent to sharing of information among the Assessor, the Clinical Supervisor, the College, and any education providers under paragraph 3(iii) above as any of them deem necessary or desirable in order to fulfill their respective obligations.

(viii) Dr. Straka shall consent to the College providing any Chief(s) of Staff or a colleague with similar responsibilities at any hospital where he practices or has privileges ("Chief(s) of Staff") with any information the College has that led to the Order and/or any information arising from the monitoring of his compliance with the Order.

(ix) Dr. Straka shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen (15)

days of the Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.

(x) Dr. Straka shall cooperate with unannounced inspections of his hospital-based anesthesia practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of the Order.

(xi) Dr. Straka shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of the Order.

(xii) Dr. Straka shall be responsible for any and all costs associated with implementing the terms of the Order; and

4. Dr. Straka pay to the College costs in the amount of $10,000.00, within thirty (30) days of the date of the Order.

At the conclusion of the hearing, Dr. Straka waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND

Delivered June 2, 2016

in the case of the

COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO

and

DR. PAVEL FRANTISEK STRAKA

THE CHAIRPERSON: Dr. Straka, all failures to maintain the Standard of Practice are serious and potentially expose patients to harm. Further, these failures undermine public confidence in the profession. In particular, when an anaesthesiologist is involved and the patient's choice of physician is limited.

You are required to participate in an extensive remedial process along with your monitoring. This should provide you with upgraded knowledge, skills and improved judgment. Further it will allow you a period of time for reflection which should assist you in future management of complex cases.

Your [counsel] and counsel for the College have worked hard to create a safe plan under which will allow you to move forward. It is your responsibility to make all efforts necessary to be successful so you may return to full practice and so the public and the profession can be confident regarding safe patient care.