NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. David James Hill, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients under subsection 45(3) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

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 … 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. Hill, 2016 ONCPSD 39**

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. DAVID JAMES HILL

PANEL MEMBERS:

DR. P. TADROS (CHAIR)
MR. S. BERI
DR. P. CASOLA
MS. D. DOHERTY
DR. R. SHEPPARD

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MR. L. SOKOLOV

COUNSEL FOR DR. HILL:

SELF-REPRESENTED

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER
MR. R. COSMAN
MR. D. ROSENBAUM

Hearing Dates: February 16 and 17, March 1, 2, 28, 29, 30, and June 3, 2016
Decision Date: December 2, 2016
Release of Written Reasons: December 2, 2016

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 February 16 and 17, March 1, 2, 28, 29, 30, and June 3, 2016. At the conclusion of the hearing, the Committee reserved its finding.

ALLEGATIONS

The Notice of Hearing alleged that Dr. Hill 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 engaged in conduct or 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. Hill 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*, S.O. 1991 c. 18 ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. Hill denied the allegations in the Notice of Hearing.

BACKGROUND AND REFERRAL

Dr. Hill is a 69-year-old family physician who began a solo office practice in Toronto in 1975. According to his evidence, he retired from active practice in or about January 2015, but continued to see some patients at home until September 2015.

Patient A, Dr. Hill's former patient, made a complaint to the College that Dr. Hill had missed a diagnosis of colon cancer. Patient A's complaint led to an investigation by the College under section 75(1)(c) of the Code and the appointment of an investigator, Dr. Jeffrey Sloan.

Dr. Sloan reviewed Dr. Hill's clinical notes and records regarding Dr. Hill's care of Patient A and concluded that Dr. Hill failed to maintain the standard of practice of the profession in his care of Patient A. Dr. Sloan also opined that the care provided showed a lack of knowledge, skill, or judgment on the part of Dr. Hill.

The College then conducted a broader investigation of Dr. Hill's practice, which included a random chart review by Dr. Sloan of an additional 25 patients. Dr. Sloan also interviewed Dr. Hill in addition to reviewing the charts.

Dr. Sloan concluded that Dr. Hill failed to maintain the standard of practice of the profession with respect to 24 of the 25 patients whose care he reviewed. He also concluded that Dr. Hill showed a lack of knowledge, skill, and judgment with respect to these patents. In the course of Dr. Sloan's review of the charts, he also reported that he observed instances in which parts of charts were copied from one patient chart to another.

The College referred the matter to the Discipline Committee.

PROCEDURAL HISTORY AND SELF REPRESENTATION

The hearing in this matter was originally scheduled to begin in September 2015. Dr. Hill had legal representation prior to the commencement of the hearing. However, on the first scheduled day of the hearing, September 24, 2015, Dr. Hill's lawyer attended and informed the Committee that his retainer had come to an end and that he would not be representing Dr. Hill at the hearing.

Although Dr. Hill was not in attendance on September 24, 2015, his former lawyer advised the Committee that it was his understanding that Dr. Hill wanted an adjournment of the hearing. On its own motion, the Committee decided to vacate the September 24 and 25, 2015 hearing dates and adjourn the hearing to the next scheduled date, being October 5, 2015, in order to provide Dr. Hill an opportunity to retain new counsel and attend the hearing. At the request of the

College, the Committee ordered a suspension of Dr. Hill's certificate of registration pending the disposition of the hearing as a term of the adjournment.

On October 2, 2015, the Committee granted a further adjournment to February 16, 2016 at Dr. Hill's request to accommodate his stated intention to retain legal counsel.

On November 20, 2015, the Committee denied a motion by Dr. Hill to vary the Committee's order of September 24, 2015 suspending Dr. Hill's certificate of registration. The reasons for denying the request to lift the suspension are set out in the Committee's order of that date.

Dr. Hill never retained legal counsel following the withdrawal of his lawyer on September 24, 2015 and prior to the commencement of the hearing on February 16, 2016.

Dr. Hill did not attend the first day of the hearing on February 16, 2016. His wife, Ms. Anne Henderson, attended on his behalf and was granted permission to address the Committee. Ms. Henderson provided the Committee with two medical notes on a prescription pad of a Dr. Lewis. The first, dated 15 February 2016, (exhibit 2B) stated, "I have advised David not to undergo his CPSO hearing for medical reasons." The second, an undated note (exhibit 2A) had a notation for an appointment for Monday, February 15, 2016 at 12 p.m.

Ms. Henderson advised the Committee that Dr. Hill had asked her to request that the hearing proceed in his absence. Ms. Henderson was clear that Dr. Hill did not want an adjournment. College counsel requested that the matter proceed as scheduled. Given the prior adjournments and Dr. Hill's request as communicated through his wife, the Committee proceeded with the hearing on February 16, 2016. Ms. Henderson did not remain for the hearing that day.

During the February 16, 2016 hearing day, the College called its only witness, Dr. Sloan, who was qualified as an expert in family medicine. Dr. Sloan was not cross-examined and his evidence concluded on February 16, 2016. The College closed its case and the matter was adjourned to the following day to hear closing submissions.

On the morning of February 17, 2016, prior to closing submissions, the Committee's independent legal counsel ("ILC") informed the Committee that she had received an email from

Dr. Hill indicating that he now wanted to attend before the Committee to defend the allegations. Dr. Hill communicated, through ILC, that he was requesting a short adjournment. College counsel advised the Committee that he was prepared to consent to the request. The Committee adjourned the hearing to March 1, 2016.

On March 1, 2016, Dr. Hill attended the hearing. A lawyer briefly appeared on Dr. Hill's behalf, but advised the Committee (before any additional evidence was called) that he would not be able to continue as Dr. Hill's lawyer. He then left.

Dr. Hill then advised the Committee that he would be acting on his own behalf. Neither Dr. Hill nor the lawyer who briefly represented him made any application to recall Dr. Sloan to be cross-examined.

Dr. Hill provided evidence on his own behalf and was cross-examined on March 1 and 2, 2016. Dr. Hill called additional witnesses on March 28, 29, and 30, 2016.

At the completion of the evidence on March 30, 2016, it was agreed that the parties would exchange written submissions in advance of oral submissions. Oral submissions were scheduled for June 3, 2016.

At the conclusion of the evidence on March 30, 2016, Dr. Hill stated that he had retained legal counsel who would be assisting him with his submissions. At this point, the Committee reminded Dr. Hill that the evidentiary part of the hearing had concluded and that the Committee would only receive closing submissions.

Closing submissions were heard on June 3, 2016. Dr. Hill attended on that date and made his submissions. He was not represented by legal counsel.

WITNESSES

The Committee heard the testimony of two experts: Dr. Jeffrey Sloan, called by the College, and Dr. Paul Caulford, called by Dr. Hill. Both were qualified as experts in family medicine.

Dr. Hill also testified on his own behalf. With the exception of Patient A, Dr. Hill did not directly address in his evidence the specific care he provided to any of the other patients' whose care was at issue.

In addition, Dr. Hill called two patients, Patient B and Patient C, to testify. Each was dismissed, however, after it became clear that they had no relevant evidence to provide with respect to the allegations. Patient B and Patient C were not patients whose care was at issue.

Dr. Hill then called one further patient, Patient H, whose chart had been reviewed by Dr. Sloan. Patient H testified to the care provided to him by Dr. Hill.

Dr. Hill also called Dr. Thomas Burko, Director of Medvisit Doctors Housecall Visit Services, with whom Dr. Hill has worked for a number of years. Dr. Burko was also dismissed as he had no relevant evidence to provide with respect to the allegations. The Committee explained to Dr. Hill that evidence with respect to his general character was not relevant at this stage of the hearing.

BURDEN AND STANDARD OF PROOF

The burden is on the College to prove the allegations against Dr. Hill on the civil standard of proof of a balance of probabilities (*F.H. v. McDougall* 2008 SCC 53). The evidence must be clear, cogent, and convincing to satisfy the balance of probabilities standard.

The Committee's findings are based exclusively on the evidence admitted, including both oral testimony and exhibits. The Committee assessed the evidence in its totality and did not assess individual items of evidence in isolation.

ANALYSIS

(1) Failure to Maintain the Standard of Practice

Dr. Hill is alleged to have failed to maintain the standard of practice of the profession in his care of Patient A and of 24 other patients.

In assessing this allegation, the Committee considered what is reasonably expected of the ordinary competent practitioner in the field of family practice in Ontario. The Committee assessed Dr. Hill's care with respect to the specific patients whose care was at issue.

The College relied on expert evidence of Dr. Sloan with respect to the appropriate standard and Dr. Hill relied on the evidence of Dr. Caulford.

(i) Failure to Maintain the Standard of Practice With Respect to Patient A

Patient A was Dr. Hill's patient between September 1993 and December 2011. He complained to the College that Dr. Hill failed to diagnoses his colorectal cancer. Dr. Sloan's opinion was that Dr. Hill failed to maintain the standard of practice with respect to Patient A. Dr. Caulford, the expert called by Dr. Hill, did not provide any opinion with respect to the care Dr. Hill provided to Patient A.

Dr. Hill testified that he believed that his care of Patient A was "exemplary."

For the following reasons, the Committee agrees with Dr. Sloan and finds that Dr. Hill failed to maintain the standard of practice of the profession with respect to Patient A:

1. Although Dr. Hill saw Patient A on dozens of occasions, visits were devoted exclusively to treating episodic and chronic illness and minimal attention was paid to prevention of disease;
2. Dr. Hill's notes with respect to Patient A were vague and repetitive with little documentation of physical findings or specifics with regard to history, investigations, or treatment;
3. The cumulative patient profile (CPP) used by Dr. Hill was out of date and incomplete with important data on family history missing;
4. Dr. Hill failed to document a proper family history, which may have led to a screening colonoscopy; and
5. Dr. Hill failed to properly document or investigate Patient A's abdominal pain in 2010, which may have led to a delay in the diagnosis of his cancer.

Dr. Hill did not call any expert evidence to challenge Dr. Sloan's opinions with respect to his care of Patient A. The Committee was persuaded by Dr. Sloan's evidence and accordingly finds that Dr. Hill failed to maintain the standard of the profession in his care of Patient A.

(ii) The Other Patients

Dr. Sloan reviewed 25 additional patient charts and concluded that Dr. Hill failed to maintain the standard of practice in 24 of those cases. Dr. Sloan found that Dr. Hill's recordkeeping fell below the standard of care. He also found, in many instances, that Dr. Hill failed to maintain the standard of practice of the profession with respect to his patient care.

Dr. Hill's expert, Dr. Caulford, who had initially been retained at the time Dr. Hill had legal counsel, also reviewed the 25 patient charts and the expert report of Dr. Sloan. Dr. Caulford prepared a responding expert report dated June 23, 2015 which was admitted into evidence.

Dr. Caulford acknowledged and agreed with the charting deficiencies outlined by Dr. Sloan, but testified that Dr. Sloan's assessment of Dr. Hill was excessively harsh, focused mostly on finding fault. Dr. Caulford opined that Dr. Sloan's assessment of Dr. Hill did not reflect the challenges that a physician in private practice faces on a day-to-day basis. In his report, Dr. Caulford pointed out instances in which Dr. Sloan overlooked information noted in Dr. Hill's clinical records. Dr. Caulford often did not agree with Dr. Sloan with respect to Dr. Hill's alleged failures to maintain the standard of practice of the profession with respect to the care of individual patients.

Dr. Caulford was of the opinion that Dr. Hill's patient care was not adequately reflected in his charting. He believed that Dr. Hill's patient care overall was of a higher standard than what was reflected in his charting. Dr. Caulford also stated, however, that Dr. Hill's charting made it difficult to assess whether patient care fell below the standard of the profession.

Dr. Caulford's opinion about Dr. Hill's patient care was based in part on his interview with Dr. Hill, which consisted of a 5 to 6 hour meeting with Dr. Hill and his lawyers. At that time, Dr. Caulford conducted "a chart stimulated recall" of the care provided by Dr. Hill to each patient whose care was at issue. This interview was not recorded.

The College argued that, as a result, it was impossible to evaluate the accuracy of the information provided to Dr. Caulford, making it very difficult to assess the reliability of Dr. Caulford's opinion. The Committee agrees. None of the information which was apparently provided to Dr. Caulford during this interview is in evidence. Dr. Hill did not specifically address the care provided to any of these patients in his evidence before the Committee. Consequently, the representations that Dr. Hill made to Dr. Caulford during this interview about the care he provided to each patient were not in evidence and were not subject to cross-examination by the College. This seriously undermined the weight given to Dr. Caulford's opinion, though through no fault of his own.

It was clear to the Committee that both Dr. Sloan and Dr. Caulford had significant experience in family medicine and were amply qualified to provide expert opinion evidence. It was also clear to the Committee that both experts spent a considerable amount of time trying to decipher Dr. Hill's charts.

Many of the concerns identified by Dr. Sloan were common among the care provided to the patients. Dr. Caulford also agreed with a number (but not all) of the problems identified by Dr. Sloan. The Committee does not intend to address the patients one by one, but rather by issue, with examples provided from the charts reviewed.

Recordkeeping

Dr. Hill's charts were organized into three sections:

1. The CPP;
2. Narrative notes; and
3. A separate file for laboratory reports, x-ray reports, and consultant's reports.

Dr. Sloan found that Dr. Hill often failed to document a proper family history. He also found a consistent lack of recording of immunizations, laboratory reports, consultant reports or preventive care investigations (for sample PAP smears, fecal occult blood tests, mammograms) on the CPP. Dr. Sloan found the narrative notes lacking detail and containing diagnoses and

inclusions unrelated to the reason for assessment. He also found a chronological discrepancy between narrative notes, laboratory reports, and consultation notes.

Dr. Caulford agreed that Dr. Hill's charting fell below the standard of practice of the profession for recordkeeping. He described Dr. Hill's documentation of patient records as "unacceptably brief" and agreed with Dr. Sloan that there was a marked deterioration after 2010. Dr. Caulford added, "The documentation of patient encounters most often is too deficient to permit a full and fair determination of the quality of care Dr. Hill's patients receive." Dr. Caulford agreed that "some of these deficiencies generate risk to the patient and potential for medical error - e.g. not recording the medical dosages, durations and changes."

Although Dr. Hill acknowledged in his evidence that there were charting problems, he tended to minimize these deficiencies with rather obtuse arguments, which were often difficult to follow. Dr. Hill urged the Committee to view his practice on a more global scale which he believed reflected a different picture. Dr. Hill acknowledged that Dr. Sloan "had some valid points" with respect to his record keeping, but emphasized that out of the "60,000" files that he had amassed through his 42 years in practice, "99% of these were amazing."

The Committee based its decision on the evidence before it, and finds that Dr. Hill failed to maintain the standard of practice of the profession in his record keeping. Based on the evidence of both experts, it was clear that Dr. Hill's record keeping fell far below what is expected of a family physician.

Copying of Clinical Notes

The falsification of clinical notes is described in greater detail below, under the analysis of disgraceful, dishonourable, or unprofessional conduct. The accuracy of patient records, however, is also a standard of practice issue. For the reasons provided below, it was clear to the Committee that Dr. Hill failed to maintain the standard of practice of the profession with respect to his recordkeeping by copying sections of notes from one patient file to another.

Investigation of Patient's Complaints

The Committee also found that Dr. Hill failed to maintain the standard of practice of the profession with respect to his investigation of patient complaints and referrals for testing. In some cases, Dr. Hill under-investigated complaints. In other cases, he over-investigated.

For example, in the case of Patient D, Dr. Sloan noted that there were four clinical visits between 2010 and 2012 which documented abdominal pain, but this was not investigated or treated by Dr. Hill.

With Patient E, Dr. Sloan noted that Dr. Hill ordered numerous repetitive laboratory tests with no rationale or explanation.

With Patient D, Dr. Sloan observed repeated questionable lab tests involving H. pylori antibody levels. By contrast, Dr. Sloan noted that there were abnormal B12 and ferritin levels that were neither acknowledged nor addressed.

Dr. Caulford agreed with Dr. Sloan that Dr. Hill has a tendency to over-investigate with tests without documented indications for the tests (see, for example, the case of Patient F or Patient H).

Dr. Caulford also noted cases in which further investigation was warranted but it was not clear from the notes if such investigations took place. For example, in the case of Patient G, Dr. Caulford noted the need for gastrointestinal (GI) follow-up, but none of Dr. Hill's notes indicate if the GI investigation occurred. Dr. Caulford also noted that, with respect to Patient G, there was evidence that Dr. Hill treated anemia with iron, but there was no evidence that Dr. Hill investigated the cause for the anemia. Dr. Caulford concluded the management of anemia for this patient was substandard care for a new onset iron deficiency anemia.

Management of Diabetic Patients

With respect to Patient I, Dr. Sloan opined that Dr. Hill's diabetic control was "terrible with no indication of referral to a diabetes education program, discussions with the patient, or a referral to an endocrinologist." Dr. Caulford supported Dr. Sloan's concerns with respect to this patient.

In the case of Patient D, Dr. Caulford questioned whether or not there had been blood sugar screening, and indicated that Dr. Hill's notes for diabetes care and follow-up for this patient failed to maintain the standard of practice of the profession. Dr. Caulford concluded that the unacceptable documentation for this patient suggested substandard care.

Dr. Sloan and Dr. Caulford both agreed that Dr. Hill most often does not make any documentation that refers or advises his diabetic patient to attend for foot or eye care.

Both Dr. Sloan and Dr. Caulford found that Dr. Hill's poor documentation of his diabetic patients made assessment of his care very difficult (see e.g. Patient J and Patient D).

The Committee finds that Dr. Hill failed to maintain the standard of practice of the profession with respect to his treatment of diabetic patients.

The Committee finds that the College has proved that Dr. Hill failed to maintain the standard of practice of the profession in Patient A's case and in 24 of the other 25 patient cases that were reviewed.

(2) Disgraceful, Dishonorable, or Unprofessional Conduct

A finding of professional misconduct may be made where there is an act or omission relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The College alleges that Dr. Hill engaged in conduct that was disgraceful, dishonorable, or unprofessional in two respects: (1) in his communications with Patient A, and (2) in what the College has described as chart forgeries.

(i) Communications with Patient A

The College alleged that Dr. Hill's responses to Patient A's demands for financial compensation constituted conduct that was disgraceful, dishonourable, and unprofessional. The Committee agrees that Dr. Hill's communications with Patient A were unprofessional. Although Patient A's

behaviour following the diagnosis of his rectal cancer may have been inappropriate, Dr. Hill's response was not professional in trying to paint Patient A as a person with mental health issues.

(ii) Copying of Charts

Dr. Sloan testified that falsification of records by duplicating patient charts occurred in 11 of the 26 charts he reviewed. Chart pages were duplicated and reproduced in anywhere between one to five other patient charts. Dr. Sloan determined that for one chart (Exhibit 58, Volume 19), the entire clinical record was a forgery. Dr. Hill admitted to copying charts, and testified that this practice went on over a period of five to seven years. However, the Committee found that forgeries were evident in the charts going back to 2004.

Dr. Hill stated that he responded to the pressures of his practice by using chart entry duplication as an expedient means of cutting down his workload. Dr. Hill explained this practice to Dr. Sloan stating, "I was trying to find a way to survive a couple more years: I realized I was running out of gas."

Dr. Hill testified that the chart duplication occurred only in patients who he described as "frequent fliers" – that, is patients who were frequently seen in his office. Dr. Hill suggested that the College investigator who had removed the charts for review from his office had cherry-picked large charts for review, and thus this represented a skewed assessment of the degree of copying.

Dr. Caulford made brief reference to these chart falsifications in his review of the 25 patient charts (Exhibit 25, page 2). However, Dr. Caulford appeared surprised by and unaware of the extent of the forgeries when it was highlighted by College counsel.

Falsifying charts is dishonest and deceitful and reflects, in the Committee's view, a lack of moral fitness to discharge the obligations expected of a member of the College. Furthermore, Dr. Hill continued, throughout the hearing, to rationalize and justify such behaviour when there is no excuse for this type of behaviour.

The Committee determined that the College has proved on a balance of probabilities that Dr. Hill engaged in disgraceful, dishonorable and unprofessional conduct.

(3) Incompetence

Section 52(1) of the Code provides that:

> 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 of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted.

To prove an allegation of incompetence, the College must establish that:

1. The alleged incompetence relates to a member's professional care of a patient;
2. The member displayed a lack of knowledge, skill or judgment in his professional care of a patient; and
3. The lack of knowledge, skill or judgment was of a nature or to an extent that demonstrates that the member is unfit to practise or the member's practice should be restricted.

Incompetence differs from professional misconduct in that a finding of professional misconduct will be based on events that have occurred in the past. Incompetence is assessed based on the member's care of patients in the past, but the Committee must also assess the member's present status, i.e. whether the member is unfit to practise or should the member's practice be restricted.

Based on his review of the records, Dr. Sloan concluded that since at least 2010, Dr. Hill's level of practice has seriously degraded to the point where he believes Dr. Hill to be incompetent and engaging in substandard care. Following his interview with Dr. Hill, Dr. Sloan also concluded that Dr. Hill had significant knowledge gaps for common medical conditions and often under-investigated or over-investigated patients.

There was a chronological discrepancy between Dr. Hill's narrative notes, laboratory investigations, and consult notes. The Committee does not know why this occurred. Further, as described above, notes were duplicated from one patient's chart to the other. Copying notes in such a manner certainly displays a significant lack of judgment.

A physician may be found to have committed acts of professional misconduct for failure to maintain the standards of the profession, but if he has demonstrated insight into his failure and has shown that he has acquired knowledge, skill or judgment since the time of that failure and changed his practice to meet present standards, he should not be found incompetent. The Committee found that this was not the case with Dr. Hill. There was no evidence that Dr. Hill had any insight into his failures or had changed his practice to comply with the standards of practice of the profession.

The Committee determined that Dr. Hill's charting and patient care reflects a lack of knowledge, skill and judgment to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted. The Committee finds that Dr. Hill is incompetent.

4) Final Comments

The Committee recognized that Dr. Hill was unrepresented by legal counsel and attempted to give him as much leeway as possible in order to present his case. Despite these allowances, much of Dr. Hill's evidence in chief and his responses to cross-examination were completely irrelevant to the issues at hand. During his evidence, Dr. Hill frequently strayed away from the subject matter to unrelated subjects. This occurred to a point where it was difficult to recall, at least in cross-examination, the question that had been asked of Dr. Hill. The Committee often found it difficult to follow his logic. There were frequent references to personal matters, for example to family or friends' illness, working in underserviced areas of Ontario, and problems in paper charting versus EMR. His affect at times was labile. Dr. Hill would become tearful when speaking about his years of practice, his love of the profession, and his personal fulfillment in seeing patients. There was a definite theatrical nature to his presentation. Dr. Hill frequently contradicted himself within the same sentence. For example, while he acknowledged that others may have been critical of his charting and that this may be a problem, he went on to state that his note taking had been "very good." At times, there was grandiosity as he repeatedly described himself as an "amazing" physician and being "terribly proud" of the work that he had done in his career. There was a clear disconnect in how Dr. Hill saw himself and the clear inadequacies and shortcomings in his practice.

CONCLUSION

The Committee finds that:

1. Dr. Hill has engaged in an act of professional misconduct under paragraph 1(1)2 O. Reg. 856/93, in that he has failed to maintain the standard of practice of the profession;
2. Dr. Hill has engaged in an act of professional misconduct under paragraph 1(1) 33 of O. Reg. 856/93, in that he engaged in conduct or 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; and
3. Dr. Hill is incompetent as defined by subsection 52(1) of the Code.

The Committee requests a penalty hearing to be scheduled at the earliest opportunity.

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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. DAVID JAMES HILL

PANEL MEMBERS:

DR. P. TADROS (CHAIR)
MR. S. BERI
DR. P. CASOLA
DR. R. SHEPPARD

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. C. SILVER

COUNSEL FOR DR. HILL:

NOT REPRESENTED BY COUNSEL
APPEARED FOR HIMSELF

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER

Penalty Hearing Date: February 22, 2017, March 9, 2017
Penalty Decision Date: May 17, 2017
Penalty Reasons Date: May 17, 2017

PUBLICATION BAN

PENALTY DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario delivered its written Decision and Reasons on Finding in this matter on December 2, 2016, and found that Dr. Hill committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession and that he engaged in conduct or 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 Committee also found that Dr. Hill was incompetent.

The Committee heard evidence and submissions on penalty and costs on March 9, 2017, and reserved its decision and reasons on penalty.

SUBMISSIONS ON PENALTY

The College's Position

The College is seeking revocation of Dr. Hill's certificate of registration, a reprimand, and costs in the amount of $69,538.00.

Dr. Hill's Position

Dr. Hill did not attend the penalty hearing and no one attended on his behalf.

The penalty hearing was initially scheduled for February 22, 2017. Dr. Hill did not attend on that date. For reasons set out in the Committee's Order of February 22, 2017, the Committee decided it would adjourn the penalty hearing on its own motion until March 9, 2017 (exhibit #7 - Motion to Adjourn, Order and Reasons).

Dr. Hill did not attend the penalty hearing on March 9, 2017. The College led evidence (exhibits 11 and 12) that showed Dr. Hill had been given proper notice of the March 9th penalty hearing

date. The Committee also heard from two witnesses: Anne Trentadue, administrative assistant to Jennifer McAleer, Independent Legal Counsel ("ILC"); and Helen Navaratnaraja, screening coordinator, Hearings Office.

Dr. Hill had left telephone voicemail messages for ILC on February 25, 2017, which were transcribed subsequently (exhibit #5). In one of the voicemails, Dr. Hill indicates that he is aware the penalty hearing is proceeding on March 9, 2017. Ms. Navaratnaraja testified that Dr. Hill was provided with notice of the penalty hearing pursuant to the Committee's previous direction. Dr. Hill also had delivered to the College three Discipline Committee decisions for the Committee's consideration (*CPSO vs. Pontarini*, *CPSO vs. Paolone,* and *CPSO vs. Lo*). These cases were provided to the Committee by counsel for the College. Consequently, the Committee concluded that Dr. Hill had knowledge of the penalty hearing date of March 9, 2017, and proceeded to hear submissions on penalty despite Dr. Hill's non-attendance.

PENALTY PRINCIPLES

In determining an appropriate penalty, the Committee's responsibility is to give foremost consideration to protection of the public. The Committee also considers specific deterrence of the member, general deterrence of the profession, maintaining public confidence in the integrity of the medical profession and the College's ability to regulate the profession in the public interest and the prospect of member rehabilitation. The Committee also examines both aggravating and mitigating factors as discussed below.

PENALTY DECISION AND REASONS

In its Decision and Reasons on Finding, the Committee found:

1. Dr. Hill failed to maintain the standard of practice of the profession:

    - with respect to his care of Patient A;

- with respect to 24 patients whose charts were reviewed (the Committee noted problems with record-keeping, clinical care, over or under investigating of patients, chronological discrepancies between the narrative notes, lack of narrative notes, lack of adequate CPP, and inadequate family history);
- with respect to falsification of 17 patient charts.

2. Dr. Hill engaged in disgraceful, dishonourable or unprofessional conduct in two areas: (i) communication with Patient A; and (ii) falsifying charts.

3. Dr. Hill is incompetent based on (a) his care of his patients, and (b) his current lack of insight into the deficiencies in his care.

Throughout the hearing, Dr. Hill attempted to rationalize and justify his actions, demonstrating little or no insight into what the Committee found to be clear deficiencies in his practice. The discrepancy between the objective evidence and Dr. Hill's opinion of himself was so stark that the Committee was concerned that Dr. Hill was purposefully misleading the Committee and/or unable, for reasons that were not clear, to comprehend the seriousness of the impugned conduct. Lack of insight is important in terms of determining an appropriate penalty as it speaks to the potential for remediation. If a physician has no insight into his deficiencies and no willingness to change, remediation is not possible. Allowing this physician to continue to practise in any capacity without remediation would not serve the public interest and, in the opinion of the Committee, would pose a significant risk of harm to his patients.

Dr. Hill has not accepted responsibility for any of the wrongdoing that gave rise to the findings of the Discipline Committee. In his voicemail messages to ILC (Exhibit 5), he states that he had been treated unfairly by the College and that "every aspect of my case was trashed". He continues to blame the College's investigative procedures and the Committee for ruling that some of his witnesses had no relevant evidence to provide. He continues to blame Patient A for this patient's regrettable outcome. Further, he once more glorified his medical documentation, stating it was "phenomenal", despite the fact that he acknowledged having forged 17 patient charts. The Committee was frankly surprised that Dr. Hill was not rigorous in his review of the Committee's

decision and findings. His voicemail for ILC just prior to the penalty hearing strongly suggests to the Committee that his stance remains as it was throughout the hearing, one of denial. This stance, despite the plethora of evidence to the contrary, does not inspire confidence that Dr. Hill acknowledges or has any understanding of his own deficiencies.

The Committee recognizes that Dr. Hill had every right to deny the allegations. His decision to do so and his lack of acceptance of the Committee's findings are not aggravating factors on penalty. His lack of acceptance and insight, however, are important factors to take into account when considering the feasibility of remediation.

The Committee has no confidence that Dr. Hill would be able to make the changes in his practice that would be necessary to address the deficiencies that have been identified. Dr. Hill has not presented any evidence to this Committee that he is prepared to make changes or conduct himself differently. To the contrary, he continues to assert that he has provided exemplary care, and that the deficiencies lie with the College, the patients and expert witnesses.

Remediation of a physician requires the physician to look at his or her actions in an open-minded way. Dr. Hill has demonstrated that he is firmly entrenched in his beliefs and is not able to examine his own actions. Remediation requires humility and open-mindedness about one's deficiencies. The Committee has no confidence based on the evidence that Dr. Hill possesses qualities that would enable him to change his practice and nullify the risk to patients.

The Committee recognizes that revocation is a very serious penalty. However, the Committee concludes that revocation is warranted in this case in order to protect the public. The Committee is of the view that if Dr. Hill were permitted to continue to practise on any level, he would pose a risk to the public due to his incompetence, his inability to self-reflect, his ability to deceive, and his ongoing denial and lack of insight.

Dr. Hill has also been found to be dishonest. He falsified many charts. His integrity is impugned. This is a significant aggravating factor. Such dishonesty places the public at risk and leaves the

Committee with no other choice than to determine that revocation is the most appropriate penalty.

The Committee reviewed the three cases submitted by Dr. Hill (*CPSO vs. Pontarini, CPSO vs. Paolone, CPSO vs. Lo*). In each of these cases, the physician admitted his deficiencies and took steps to make changes. Thus, remediation was possible and the risk to the public was diminished. The Committee found no such mitigating factors in Dr. Hill's case. In the Committee's view, these cases bear no similarity whatsoever to Dr. Hill's case.

The Committee determined that revocation was appropriate in the circumstances and that Dr. Hill should present himself to the Committee for a reprimand so that the Committee can address directly in-person the serious nature of his misconduct and incompetence.

COSTS

The College submitted this was an appropriate case in which to order Dr. Hill to pay part of the College's costs and expenses under section 53.1 of the Code.

The College requests costs in the amount of $69,538. This comprises costs for eight days of hearing (February 16, 17, March 1, 2, 28, 29, 30 and June 3, 2016) at the former tariff rate of $5,000 per day for a total of $40,000, and the costs of cancellation due to a late adjournment requests by Dr. Hill in the amount of $29,538 (canceled hearing dates October 5 (half day), October 6, 7, 8, 9, 13, 14, 15, 2015, February 19 and 29, 2016 (half day), March 3, 4, 2016). The Committee determined that the quantum of costs submitted was appropriate. This is also an appropriate case in which to award costs. Dr. Hill's conduct resulted in repeated adjournments. Costs are not intended to be punitive in nature. It was clear, however, that Dr. Hill's conduct resulted in additional and unnecessary costs being incurred by the College. Furthermore, the College was successful in prosecuting all of the allegations in the Notice of Hearing.

ORDER

The Discipline Committee orders and directs that:

1. The Registrar revoke Dr. Hill certificate of registration, effective immediately.

2. Dr. Hill attend before the panel to be reprimanded, within 60 days of the date this order becomes final.

3. Dr. Hill pay costs in the amount of $69,538.00, within 60 days of the date this order becomes final.

OPSDT Ontario Physicians and Surgeons Discipline Tribunal

TDMCO Tribunal de discipline des médecins et chirurgiens de l'Ontario

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. David James Hill

The Tribunal delivered the following Reprimand
in writing on Wednesday, December 15, 2021.

Dr. Hill, the Discipline Committee found that you had committed professional misconduct by failing to maintain the standard of practice of the profession, and by engaging in disgraceful, dishonourable, or unprofessional conduct. The Committee also found that you were incompetent to practice medicine.

The evidence relied on by the Committee, in making these findings, revealed a range of very serious deficiencies in your care of multiple patients. These included many instances of poor clinical care, unprofessional communication with one patient, and egregiously poor record keeping with the outright falsification of multiple patient charts. By your substandard practice you exposed your patients to the risk of harm. Your lack of knowledge, skill, and judgement was so severe that the Committee was compelled to conclude that you were unfit to practice medicine.

Equally troubling to the Committee was your overall lack of insight into your deficiencies, and your ongoing attempts, throughout your hearing, to obfuscate, rationalize, and make excuses for your behaviour. You were unwilling or unable to accept responsibility for your failings.

The Committee recognized that you seemed to be struggling with health issues of your own. We sincerely hope that you have been able to address these. The primary concern of the Committee, however, is the protection of the public. The Committee finds it most unfortunate and regrettable that your career in medicine has come to such an unsatisfactory conclusion.