

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Ian Egbert Depass, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity and any information that would disclose the identity of the patients whose names are disclosed at the hearing 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.

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,

- (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: Depass, I. E. (Re)**

**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. IAN EGBERT DEPASS**

**PANEL MEMBERS:**

**S. DAVIS (Chair)  
DR. M. DAVIE  
DR. S. KAPOOR  
D. GIAMPIETRI  
DR. J. WATTS**

<b>Hearing Date:</b>	<b>July 10, 2012</b>
<b>Decision Date:</b>	<b>July 10, 2012</b>
<b>Release of Written Reasons:</b>	<b>August 31, 2012</b>

**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 July 10, 2012. 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. Ian Egbert committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, 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 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. Depass 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. Depass admitted the first allegation in the Notice of Hearing, that he failed to maintain the standard of practice of the profession. Counsel for the College withdrew the remaining allegations.

### **FACTS AND EVIDENCE**

The following facts were set out in an Agreed Statement of Facts, which was filed as an exhibit and presented to the Committee:

## **A. FACTS**

### **Background**

1. Dr. Ian Egbert DePass obtained his medical degree at Memorial University in Newfoundland in 1989. After completing his general surgery residency, Dr. DePass became a fellow of the Royal College of Physicians and Surgeons of Canada in General Surgery on June 17, 1997. Dr. DePass moved to Chatham and started practising general surgery in Chatham in 2002. Since early August 2008, Dr. DePass has only been practising as a surgical assistant.

### **Investigations**

2. On August 21, 2008, the College received a complaint regarding the care and treatment Dr. Depass provided to Patient A in the winter of 2006.

3. In September 2008, a section 75(a) investigation was commenced which involved a review of the treatment and care provided to seven patients identified by the [Hospital A] through complaints or concerns expressed to [Hospital A].

4. On July 24, 2009, the College received a complaint regarding the care and treatment Dr. Depass provided to Patient B in the fall of 2004.

5. On November 18, 2009, the College received a complaint regarding the care and treatment Dr. Depass provided to Patient C in the winter of 2006.

6. The College retained a general surgeon to review the three patient complaint charts and the seven patient charts retrieved in the s.75(a) investigation.

7. In response, Dr. DePass had two of the patient complaint charts and the six patient charts in the s.75(a) investigation reviewed by two general surgeons and an internist.

8. Based upon all of the expert reports, Dr. Depass is prepared to make the admissions set out below.

**Patient D**

9. Patient D was a 71 year old man who was referred to Dr. DePass with a complaint of a one month history of intermittent blood in his stools. Dr. DePass saw Patient D in his office in January 2006. Dr. DePass took a history and examined Patient D's abdomen. Dr. DePass did not carry out a rectal examination on that day. Dr. DePass' clinical diagnosis was haemorrhoids and his management plan was to "increase fibre and fluids". A colonoscopy was booked for March, 2006.

10. In March 2006, Dr. DePass carried out a colonoscopy and identified a rectal tumour which was biopsied. No abnormalities were noted in the rest of the colon.

11. Dr. DePass arranged for a CT scan to be done on May 1, 2006, and booked Patient D for an operation on May 3, 2006. The pelvic component of the CT scan did not show extension of the tumour outside of the rectal wall. A low anterior resection was carried out on May 3, 2006. Dr. DePass carried out the operation with a nurse assisting him.

12. Dr. DePass also saw Patient D in February 2007 for a routine follow up with respect to his rectal cancer. At that time, Dr. DePass was asked by Patient D about a hernia that had developed at the site of the incision.

13. A colonoscopy was carried out on May 11, 2007. An inflammatory area was noted at about 10 cm (the site of the anastomosis) and was biopsied. No evidence of malignancy was reported.

14. Patient D requested that the repair of his incisional hernia be delayed until October 2007. A repair of his incisional hernia was carried out by Dr. DePass at [Hospital A] on October 25, 2007. The operation was done laparoscopically with the assistance of one scrub nurse and one circulating nurse. The hernia was described as measuring 6x8 cm and a 8x10 cm composite mesh was used to carry out the repair. There were loops of

small bowel adherent to the abdominal wall which were taken down using sharp and blunt dissection. Patient D was discharged from [Hospital A] the same day.

15. Patient D then presented at the emergency department of [Hospital A] on October 30, 2007. The emergency physician recorded that the patient's presenting complaint was pain increasing since surgery that became severe the previous night. The emergency physician noted a bulge at the previous hernia site which he recorded as tender. The emergency physician recorded that the patient reported he had had no bowel movements and a small amount of flatulence had been passed. The emergency physician speculated in his notes whether it might be a recurrent hernia or fluid collection. Blood work showed Patient D's white blood cell count was 15.1 and his haemoglobin was 161.

16. Abdominal x-rays taken in the emergency department were reported as showing some air fluid levels in the bowel and a cross table view showed two gas filled areas immediately under the abdominal wall, anterior to the mesh repair. The abdominal x-rays report noted that the bowel gas pattern was not unusual, there was no gaseous distension and no apparent free air.

17. Dr. DePass was called and then assessed Patient D. Dr. DePass aspirated some blood-stained fluid and air from an area of subcutaneous swelling at the paraumbilical area of Patient D's abdomen. Dr. DePass ordered a CT scan to help determine if there was bowel adherent to the mesh.

18. Dr. DePass admitted Patient D to [Hospital A] with a working diagnosis of "postop ileus" in his admission orders. Dr. DePass considered the possibility of an intestinal perforation and fistula in his dictated note. Dr. DePass ordered a soap suds enema, clear fluids with a progression to diet as tolerated, and maintained IV of glucose and saline. He ordered 25 mg of Demerol and 30 mg of Toradol IM and Morphine 5mg IV as required.

19. Dr. DePass should not have aspirated an area of subcutaneous swelling at the paraumbilical area of Patient D's abdomen when he did not know if there might be a small bowel fistula. Dr. Depass failed to consider a more serious diagnosis, in spite of the documented clinical and laboratory evidence.

20. Patient D was admitted to [Hospital A] from the emergency department on October 30, 2007. Dr. DePass then saw Patient D before 8am on October 31, 2007 and noted increasing abdominal pain and distension. He wrote orders for another abdominal x-ray, increased the IV fluids to take into account any NG tube losses and transferred Patient D to a surgical service.

21. A CT scan done at 12:35pm October 31, 2007, but not reported until November 1, 2007 at 7:49pm, was reported as showing fluid in the right subphrenic space, a large air and fluid collection in the previous hernia sac and in the abdomen at the site of repair, suggesting that the repair may have become separated.

22. Dr. DePass next saw Patient D at about 6:00pm on October 31, 2007. He did not record the findings on his examination of Patient D. He ordered antibiotics and Heparin. Patient D had received five doses of morphine since the time of admission. The blood work showed his serum K was 3.3 (the normal range at the time on laboratory testing at [Hospital A] 3.6-5.2).

23. Recorded vital signs between 10pm and midnight on October 31, 2007 showed Patient D's heart rate between 114-120, respiration rate 20-28/min, blood pressure 125/71 to 132/78, and O2 saturation at 86%-93% on oxygen. The nurse's notes during that time period describe Patient D as "SOB, clammy, flushed, diaphoretic...abd pain continuous...distressing." A nurse phoned Dr. DePass just before midnight and gave him a report. Dr. DePass instructed the nurse to put the nasogastric tube in further and gave orders for Morphine and a bolus of one litre of normal saline.

24. Dr. DePass came in to see Patient D at 4:10am on November 1, 2007. He noted “persistent tachycardia and worsening abdominal distension”. His recorded plan included placement of a drain above the area of the mesh in the subcutaneous plane to allow for ongoing assessment of the type and amount of fluid collecting in this area. The drain was inserted at 4:21am on October 31, 2007. In his note at 4:10am, Dr. DePass did not record details of any physical examination or working diagnosis. Dr. DePass ordered another litre of saline, changed the antibiotic and increased the rate of the IV infusion.

25. Between the time of Patient D’s admission on October 30<sup>th</sup> and 7am on October 31<sup>st</sup>, 2007, he received a total of 1830 ml of IV fluid. The fluid balance sheet for the next 24 hours indicates that 1500 ml of IV fluid was administered during that time. No Foley catheter was placed to accurately monitor urine output.

26. Careful monitoring of fluid input and output should have been done, frequent vital signs should have been ordered and the detailed observations and clinical findings from examinations should have been recorded by Dr. DePass. The IV orders for fluid replacement were inadequate.

27. When Dr. DePass saw Patient D at 4:10am on October 31, 2007, he should have recognized that Patient D was critically ill and required an emergency operation. Dr. DePass should have implemented resuscitative efforts for fluid and electrolytes replacement and proceeded to take him to the operative room as soon as possible.

28. An operation was conducted by Dr. DePass on November 1, 2007 as an emergency with another general surgeon assisting. In the operative record, Dr. DePass described copious amount of small bowel content throughout the abdomen, an injury to the small bowel in the mid-jejunum and possible cautery burns. Dr. DePass resected the injured segment of bowel and anastomosed the proximal and distal bowel.

29. Patient D’s condition deteriorated after the November 1, 2007 surgery.



30. Following the November 1, 2007 operation, Dr. DePass should have recognized that Patient D had ongoing sepsis, should have diagnosed a subphrenic abscess and should have consulted another surgeon.

31. Patient D was transferred to [Hospital B] in [another city] on November 10, 2007, where he had a large subphrenic abscess drained and then required management in their critical care centre for two weeks.

32. Patient D was transferred back to [Hospital A] on November 24, 2007. It was noted in the [Hospital A] records on November 28<sup>th</sup> by Dr. X that Patient D was passing: “++ blood clots per rectum...quite red...looks like active bleeding.” The nursing record noted rectal bleeding occurred on the 28<sup>th</sup>, 29<sup>th</sup> and 30<sup>th</sup> of November 2007. Patient D was discharged home on December 4, 2007.

33. Dr. DePass visited Patient D daily between November 27<sup>th</sup> to December 1<sup>st</sup>, 2007, but did not make any note of rectal bleeding. Dr. DePass ordered a two unit transfusion on November 28<sup>th</sup>, 2007, and requested that stool be examined three times for occult blood. Three tests for occult blood in the stool all came back positive.

34. Dr. DePass should have made notes in the chart about the rectal bleeding and should have taken further steps to investigate the rectal bleeding. Rectal bleeding is of significant concern in a patient who has previously had a resection for colon cancer.

### **Patient A**

35. Patient A was a 54 year old man admitted to the emergency department of [Hospital A] on January 9, 2006. The emergency room notes record that Patient A was on Gilburide for diabetic control. He was noted to be hypertensive and to take Hydrochlorthiazide, Norvasc and Cozaar. He was noted to report losing sixty pounds over the previous two months. He was noted to report that he first noticed an ulcer on his foot and had become ill about a week prior to admission. He was noted to report progressive nausea and eating little for the rest of the week. He was noted to report

becoming so weak that he could hardly move his legs and he had fallen. He was brought to the emergency department in an ambulance. He was recorded to look unwell, have marked obesity, have peripheral edema and have a large decubitous ulcer on his left first metatarsal head.

36. Patient A was admitted to [Hospital A] on January 9, 2006, with a doctor other than Dr. DePass as the most responsible physician. He was admitted on maintenance IV fluid, Ancef, Cipro, Tylenol as well as his normal oral hypertension and his normal diabetes medications.

37. Dr. DePass was consulted and saw Patient A on January 10, 2006. In his note, he described examining Patient A's legs and finding bilateral pitting edema with "evidence of crepitus throughout the left foot and left leg." He described an ulcer on the sole of Patient A's left foot with significant undermining and "evidence of fractured metatarsals". Dr. DePass did a minor excision of the edge of the ulcer at the patient's bed. The procedure was not recorded in the chart. The pathology report later showed a full thickness ulcer, granulation tissue and suppuration. Dr. DePass's impression of Patient A at that time was that he had Type II diabetes, significant peripheral neuropathy, along with an ulcer on his left foot and osteomyelitis with multiple fractures. His orders consisted of a diabetic diet and normal saline dressings to the ulcer. He ordered Patient A's legs be wrapped in 6 inch ACE bandages "toes [to] knees", a decrease in Patient A's IV intake to 100ml/hr and four times daily blood sugar measurements.

38. Dr. Q saw Patient A and dictated a clinical note on January 11, 2006 which was transcribed at some point on January 12, 2006 in which he described the patient's history in detail and mentioned neck stiffness and pain in Patient A's posterior neck muscles on examination. Dr. Q also noted that a debridement of Patient A's foot ulcer had been carried out by Dr. DePass the previous day. Dr. Q's working diagnosis was septicaemia secondary to cellulitis of his foot secondary to diabetes, and pyelonephritis with renal failure secondary to septicaemia. He arranged for Dr. R, an internist, to see Patient A,

changed his antibiotics, ordered some potassium to be provided intravenously and arranged for an indwelling catheter in order to maintain his fluid balance.

39. Dr. R. saw Patient A on January 11, 2006, and recorded that he found Patient A to be ill and hypotensive with a blood pressure of 98/70 and a heart rate of 150. He noted that Patient A was hypovolemic and anaemic. He took Patient A off his hypertension medication and increased his fluid intake. He ordered cultures and ordered insulin based on blood sugar levels.

40. Neck x-rays taken and reported on January 11 showed no significant abnormality. A bone scan taken on January 11 and reported on January 12, 2006 showed marked uptake of isotope in both feet compatible with either osteomyelitis or severe neuropathic arthropathy associated with the patient's diabetes.

41. On January 12, 2006, Dr. DePass assessed Patient A, but did not record a general examination. With reference to Patient A's legs Dr. DePass wrote: "subcutaneous air still evident...?" settle with abc (antibiotic treatment)." He also stated in his note "sepsis? Getting better...primary focus on left foot...needs further debridement...surgical risk... Discuss with Dr. [R]." Dr. DePass in his January 12<sup>th</sup> chart entry, noted that Patient A was getting better.

42. Over the first four days in the hospital, Patient A's haemoglobin fell from 100 to 75, his white blood count rose from 2.7 to 14.7, his BUN rose from 36.5 to 39.2 and his creatinine came down from 283 to 197. His blood glucose (which had a normal range at [Hospital A] at that time of 3.9 -7.8) rose from between 8.6 and 9.4 on January 9<sup>th</sup> to between 15.4 and 20 on January 13<sup>th</sup>.

43. Nurses recorded during the first eight days of Patient A's admission to [Hospital A] that his left foot was draining, yellow, purulent, foul smelling, a black area was present by the wound, and the patient was grimacing and moaning. Throughout these

eight days, the nurses continued to use ACE bandages to wrap both feet and lower legs over the wound dressings.

44. There are no notations in the records that Dr. DePass saw Patient A or examined him on January 11, 13, 14 or 15<sup>th</sup>, 2006.

45. On January 16, 2006, Dr. DePass's note referred to worsening necrosis on Patient A's left foot and new ulcers on the right foot. The note did not provide any other details about the patient's condition. Dr. DePass suspected a GI bleed because Patient A's hemoglobin was 75 the previous day and arranged for consent forms to be signed for colonoscopy and gastroscopy.

46. An interdisciplinary conference took place on January 16, 2006. The orders by Dr. DePass on January 16<sup>th</sup> included, among other things, to obtain consent for debridement of feet tomorrow and to prepare Patient A for colonoscopy and gastroscopy three days after that.

47. On January 17, 2006 at about 6:20pm, Dr. DePass took Patient A to the operating room for left foot debridement. His operative note describes exploring the left foot ulcer and widening the opening of the sole of his foot. He described that there was an obvious fracture of the third and fourth metatarsals, however the bone appeared quite viable. He noted that there was considerable swelling of the left lower leg with evidence of underlying air and tense skin. He made a longitudinal incision over the tibia and noted that purulent material was evident. He felt that the underlying muscle was viable with bleeding. He reported that he carried out a similar procedure on the right leg where he found significant purulent material evidence throughout. The operative report did not provide any other details about the condition of the patient's lower limbs. He then packed the wounds open and re-applied the dressings, including the ACE bandages.

48. Patient A was transferred to the ICU postoperatively, but went into septic shock and respiratory failure at about 2:00am on January 18, 2006 and required re-intubation

and ventilation. He was hypotensive, hypoxic and had a severe metabolic and respiratory acidosis. He required Levophed and dopamine and at one point had a pO<sub>2</sub> of 83% on 100% oxygen. He was eventually stabilized by about 8:00am the next morning, but required ongoing ventilation and vasopressors and his blood pressure periodically dropped below 100 systolic.

49. A consultation note at 10:00am on January 18, 2006 by the wound care service described Patient A's left leg as "mottled, swollen and cold" with "yellow and grey tissue" exposed in the right leg incision. On January 20<sup>th</sup>, Dr. DePass requested that a consent form be obtained for amputation of Patient A's left leg above the knee and debridement of the right leg.

50. At about 7:00pm on January 20, 2006, Dr. DePass carried out an above knee amputation on the left leg and debridement of the right leg with the pre-operative diagnoses being ischemic left leg and necrotizing fasciitis in both legs. Dr. DePass described in the operative report that there was still some purulent material from the medial aspect and a significant amount of purulent material arising from the fascial edges of the right leg. The operative report did not comment on the status of the right foot. Dr. DePass completed medial and lateral fasciotomies of the right leg.

51. The pathology report from the tissue samples taken from the left leg on January 20, 2006 reported on January 26<sup>th</sup> extensive tissue necrosis with suppuration in skin, subcutaneous tissue and skeletal muscles, findings consistent with necrotizing fasciitis.

52. After the January 20, 2006 operation, Patient A remained in the ICU of [Hospital A] on a ventilator, receiving TPN, antibiotics, insulin and dressings to his right foot and leg.

53. On January 26, 2006, Dr. DePass carried out an amputation of one of Patient A's right toes which had become gangrenous.

54. On January 28, 2006, Dr. L, Chief of the Division of General Surgery at [Hospital A], saw Patient A in consultation and felt that his right leg was marginally viable, but needed more debridement and recommended a plastic surgery consultation.

55. On February 8, 2006, Patient A was transferred to [Hospital B]. On February 9, 2006, a right below knee amputation was carried out. His renal disease was severe enough that he required dialysis. He was eventually extubated and was transferred back to [Hospital A] on March 26, 2006.

56. Dr. DePass did not conduct an adequate debridement of the left foot in that all of the necrotic tissue was not resected soon enough.

57. Dr. DePass failed to record adequate details of his findings, provisional diagnosis and plans.

58. Dr. DePass failed to consult with another surgeon or make a diagnosis of necrotizing fasciitis as early as indicated in the patient's course of treatment.

### **Patient B**

59. Patient B was a 83 year old woman with a history of mild hypertension and had been on Prednisone for polymyalgia rheumatica. According to the [Hospital A] records, she came to the Emergency Department of [Hospital A] on November 20, 2004 reporting a one week history of burning discomfort in her stomach, a three day history of loss of appetite, loose stools, and non-specific abdominal pain and mild distension. Dr. A saw her in emergency and recorded that she was dehydrated with a blood pressure of 80/47 and a heart rate of 116. Dr. A noted that her abdomen was mildly distended and diffusely tender especially in the lower abdomen. Dr. A gave her two litres of saline and admitted her with a diagnosis of non-specific abdominal pain, hypotension and dehydration. Dr. A's admission orders included intravenous fluids, a Foley catheter and narcotics for pain.

60. Dr. DePass saw Patient B at [Hospital A] on November 21, 2004. His note indicated that she has “marked tenderness in the right lower quadrant with guarding and with rebound”. He noted that her abdominal x-rays showed dilated loops of small bowel. Her white blood count count was 7.1 on November 20<sup>th</sup> and 7.3 on November 21<sup>st</sup> and blood smears showed a left shift, Dohle bodies and toxic granulations. Her serum creatine was elevated at 2.26. Dr. DePass’s provisional diagnosis was diverticular disease, with other possibilities being malignancy in the cecum and ovarian pathology. The orders written by Dr. DePass that day were for a CT scan and clear fluids by mouth.

61. Dr. DePass did not record findings from any rectal or pelvic examination.

62. The nurses’ notes recorded that Patient B continued to have abdominal pain and distension on November 21, 2004. Patient B was noted to be disoriented to place and time and she was lethargic.

63. On November 22, 2004, the nurses noted that Patient B had abdominal distension, faint bowel sounds, abdominal pain aggravated by palpitation as well as guarding and moaning. Her pulse rate rose from 103 to 116 during that day, her respiratory rate was steady, and she had an elevated temperature. Her creatinine remained elevated and her white blood count rose to 12.2. Her serum Na and Cl were both elevated as well.

64. Dr. DePass wrote orders on November 22, 2004 for nasogastric suction to be instituted as well as IV orders. There was no note made of the assessment.

65. On November 23, 2004, the nurses’ notes record that Patient B’s abdomen was distended, tender and firm and that she had moderate abdominal pain and guarding. Her pulse rate had increased to between 115 and 133, her respiratory rate increased from 20 to 26/minute, and she was febrile. No blood work was ordered that day.

66. On November 23, 2004, Dr. DePass wrote a note which did not include details of any abdominal examination or her vital signs. Dr. DePass increased her IV intake. Dr.

DePass ordered a nasogastric tube be placed to give her contrast for her CT scan, but according to nursing notes she was restless and resisted nurses' attempts to insert it. Dr. DePass put the tube in himself and had Patient B put in restraints. The patient was started on IV antibiotics by another doctor that day.

67. On November 24, 2004 at about 9:00am, Dr. DePass noted that Patient B still had tenderness in her left lower quadrant of her abdomen. Dr. DePass speculated that she had diverticulitis and increased her antibiotics.

68. Dr. DePass did not order the appropriate (upright) x-ray exams or arrange CT scan investigations quickly enough in the face of deterioration in a patient who may have a bowel perforation.

69. During the course of November 24, 2004, Patient B's pulse was between 116 and 128 and her respiratory rate between 18 and 28. Her blood work showed a rise in her white blood count to 18.8 and her creatinine, Na and CI remained elevated.

70. Patient B had a CT scan just after 10:00am which was not reported until November 25, 2004. The CT report mentioned multiple intra-abdominal fluid collections as well as intraperitoneal air.

71. At 9:50pm on November 24, 2004, Patient B's blood pressure dropped to 98/60. Overnight she had increasing instability and respiratory difficulty and she was transferred to the ICU of [Hospital A] at about 6:30am on November 25<sup>th</sup> in septic shock. She was resuscitated with volume infusion along with Levophed and Dopamine. She was intubated and ventilated.

72. Dr. DePass operated on Patient B on November 25, 2004 and found multiple areas of purulent material and fluid in the abdomen and a perforation in the sigmoid colon. Within the sigmoid colon, Dr. DePass noted evidence of diverticula with omental caking within the pelvis. Dr. DePass did a Hartmann's colostomy with a loop ileostomy and



placed a feeding jejunostomy tube. Patient B was hypotensive in spite of large volumes of fluid infusion, blood transfusion and pressor drugs.

73. By the time of the operation on November 25, 2004, the patient had peritonitis with multiple abscesses and was suffering from septic shock.

74. The loop ileostomy and the feeding jejunostomy tube in the left upper quadrant at the November 25, 2004 operation were unnecessary and added to the risk of the operation.

75. Patient B required continuing ventilator support and inotrope support in the ICU of [Hospital A] following the November 25, 2004 operation, but seemed to be holding her own. An attempt was made to wean her off the respirator on November 28<sup>th</sup> but this was unsuccessful. She had an episode of sinus tachycardia on November 30<sup>th</sup> but this was corrected with medication. On December 1<sup>st</sup> she was restless and extubated herself. She continued to have respiratory problems, but in discussion with the family the decision was made not to re-intubate her. She was transferred to a palliative bed on December 4<sup>th</sup>. All acute therapy was withdrawn and she died later that day.

### **Breast Malignancy Cases**

76. With respect to Patient E and Patient F, Dr. DePass failed to adequately document patient history, physical examinations, provisional diagnoses, and failed to adequately document discussions with patients about management plans.

77. With respect to Patient E and Patient F, Dr. DePass failed to be specific in the terminology used to describe lumpectomy vs. quadrantectomy and axillary node sampling vs. axillary node dissection.

**B. ADMISSIONS**

78. Dr. DePass admits the facts set out in paragraphs 1-77 above. Dr. DePass admits that he failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 in his care and treatment of Patient A, Patient B, Patient D, Patient E and Patient F.

**FINDING**

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

**PENALTY AND REASONS FOR PENALTY**

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

Several penalty principles guided the Committee in its deliberations. First and foremost is the protection of the public. In addition, a penalty should serve to maintain the public's confidence in the integrity of the profession and its ability to effectively self-regulate. A penalty should serve to express the profession's abhorrence of wrongful conduct and uphold the honour of the profession while providing specific deterrence for the member and general deterrence for the membership at large. Finally, a penalty should endeavour to rehabilitate the member as much as possible.

The Committee reviewed the submissions of counsel and considered the proposed penalty. In considering the proposed penalty, the Committee is aware that the law requires that a joint submission be accepted unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute.

In considering the appropriateness of the proposed penalty, the Committee took account of the mitigating and aggravating factors of Dr. Depass' case. There was a contested

hearing before this Committee in 2009 in which Dr. Depass was found to have committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession in his care and treatment of three patients between 2005 and 2007. He was also found to be incompetent in his care of those three patients. As part of the penalty order in that case, the panel placed restrictions on his practice, such that, for an indefinite period of time, his practice of medicine is limited to surgical assisting in a hospital setting with CPSO-approved certified surgeons only. The Committee also took account of the fact that in 2007, Dr. Depass entered into a Settlement Agreement with the College of Physicians and Surgeons of Nova Scotia pertaining to his care and treatment of patients during the time period of 1997 to 2002, in which he admitted to various disciplinary matter violations and consented to restricting his practice to a group practice with another general surgeon or surgeons.

The Committee noted that the patient care that is the subject matter of this discipline hearing occurred in the same time period, late 2004 through 2007, as the patient care that was the subject of the previous CPSO disciplinary hearing. The Committee was also mindful of the fact that Dr. Depass' practice has been limited to surgical assisting since 2008, and that no complaints have arisen from that practice.

Through the Agreed Statement of Facts, Dr. Depass has admitted to a broad range of failures that span all aspects of his patient care. These very serious admissions are very concerning to the Committee. It is imperative that the public be protected in the future from such failures. Continuing and significant restrictions on Dr. Depass' certificate of registration, along with unannounced inspections of his practice to ensure compliance with those restrictions, will serve to protect the public.

The Committee accepted as a mitigating factor that Dr. Depass has demonstrated a level of insight into his misconduct, as evidenced by his entering into the Agreed Statement of Facts and his admission of professional misconduct. His admission has also spared his patients from having to testify and saved the College the time and expense of a contested hearing.

The Committee is satisfied that the proposed joint submission on penalty will protect the public while allowing Dr. Depass to continue in the limited role of a surgical assistant to approved surgeons in a hospital setting, as he has been doing since 2008.

As an expression of the Committee's disappointment in Dr. Depass' conduct with respect to his gross failure to maintain the standard of practice in his general surgical practice in the time period of 2004 through 2007, a public reprimand was ordered. This will also serve as a general deterrent to the membership at large.

The Committee agrees the proposed tariff cost of a one day hearing is appropriate in this case.

Therefore, the Committee accepts the parties' proposed penalty order in its entirety.

## **ORDER**

Therefore, having stated the findings in paragraph 1 of its written Order of June 26, 2012, on the matter of penalty and costs, the Committee ordered and directed that:

2. Dr. DePass appear before the panel to be reprimanded.
3. the Registrar maintain the following terms, conditions and limitations on Dr. DePass' certificate of registration:
  - (i) Dr. DePass' practice shall be limited to being a surgical assistant in a hospital setting, and he may only practise as a surgical assistant while a certified surgeon who has been approved by the College is performing the surgery and is in attendance. This means that he may only assist other surgeons on their cases and cannot be the primary surgeon in any case, and that he is precluded from providing pre-operative and post-operative care or any office practice.
  - (ii) That notice be placed in the operating room area so that all professional staff are aware of the restrictions noted in (i).

- (iii) That so long as the above terms, conditions and limitations are in effect, Dr. DePass shall co-operate with unannounced inspections of his practice and patient charts by a College representative for the purpose of monitoring and enforcing his compliance with them.
- 4. Dr. DePass pay costs to the College in the amount of \$3,650 within ninety (90) days from the date of this Order.

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