

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Robert Stewart Cameron, 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 or in the documents filed 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: Cameron, R.S. (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. ROBERT STEWART CAMERON**

**PANEL MEMBERS:**

**DR. M. GABEL (CHAIR)**  
**DR. A. JONES**  
**G. DEVLIN**  
**DR. F. SLIWIN**

<b>Hearing Date:</b>	April 4 and 5 and December 5, 2011
<b>Decision Date:</b>	December 5, 2011
<b>Release of Written Reasons:</b>	December 23, 2011

**PUBLICATION BAN**

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons heard this matter at Toronto on April 4 and 5 and December 5, 2011. 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.

### **ALLEGATIONS**

The Notice of Hearing alleged that Dr. Robert Stewart Cameron 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 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. Cameron 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”), in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

### **RESPONSE TO ALLEGATIONS**

Dr. Cameron initially denied all of the allegations in the Notice of Hearing. On December 5, 2011, Dr. Cameron changed his response and admitted the second allegation of

professional misconduct, 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. Counsel for the College withdrew the first allegation of professional misconduct and the allegation of incompetence.

## **THE EVIDENCE AND FACTUAL FINDINGS**

### **(a) Summary of the Findings of Fact**

The allegations of disgraceful, dishonourable or unprofessional conduct in this case arise from conduct by Dr. Cameron relating to a single patient, YZ, in August 2008 at the Tillbury Walk-In Clinic. The Committee accepted the testimony of the witnesses who testified and found that Dr. Cameron failed to see, assess, treat or respond to the two year-old boy when he arrived at the clinic with an anaphylactic reaction.

### **(b) Testimony of Witnesses**

#### **Mrs. X**

The Committee heard the testimony of Mrs. X, YZ's mother, on behalf of the College. At the time of the incident, YZ was two years old. He complained to his mother of an itchy bump on his neck. Within seconds, his body was covered in hives. He developed a cough and his forehead and ears started to swell. Mrs. X testified that she did not consider going to the hospital at this point, but instead put YZ in the car and headed for the Tillbury Walk-In Clinic. They lived a ten to fifteen minute drive from the clinic. The closest hospital to their house is in Chatham, which is a thirty-five minute drive, or Leamington, which is also a thirty-five minute drive. Mrs. X called her husband to ask him to inform the Tillbury Clinic that she was on her way with YZ. Her husband called her back and advised her that the clinic told him that she should go to the emergency department. Mrs. X chose to continue to the clinic as the hospital was too far away and YZ's condition was deteriorating; he was swollen, lethargic and his head was rolling to the side. Mrs. X

testified that upon arrival at the clinic, in her agitated state she did not see the sign on the door advising that the clinic did not provide emergency care. When she entered the clinic, the secretary asked if she would like to go to the hospital. The secretary went to see the doctor and returned and advised Mrs. X that there was nothing the doctor could give YZ, and again asked if she would like an ambulance. An ambulance was called, and Mrs. X and YZ were taken to a chair in the hall to wait.

Mrs. X gave evidence that at no point during her wait for the ambulance did the doctor come to see her son.

The ambulance arrived and the paramedic put them in the ambulance. He then put an oxygen mask on YZ and took his vitals. YZ was given epinephrine by the paramedic and they were rushed to the hospital. Upon arrival at the hospital, YZ was awake but still swollen and unrecognizable. He was treated further by the emergency physician and observed for ten hours in hospital. Mrs. X was told by emergency personnel that YZ had suffered a life threatening anaphylactic reaction.

### **Ms A**

The Committee heard the evidence of Ms A, the receptionist that was working at the Tillbury Clinic when Mrs. X and YZ arrived. Ms A was not the regular receptionist but was covering the desk over the lunch hour when a very distressed mother came in to the Clinic carrying her child. The child's lips were huge and his face was bright red. Ms A testified that the mother was quite distressed and concerned that her child would stop breathing. Ms A went to speak with Dr. Cameron, and advised him that the child's lips were huge, his face was red and the mother was concerned that the child would stop breathing. She asked him to come and see the child and he informed her that they were not equipped for infant distress, and the patient should go to the hospital. Ms A informed the mother that Dr. Cameron would not be coming out and asked if she would like an ambulance, which she then called. Ms A gave evidence that she spoke with Dr. Cameron about YZ twice. Dr. Cameron was at his desk, which has doors that obscure the view of the waiting room. He would not be able to see the reception area from his desk. He did

not leave that office area at any time during the discussion and he did not see YZ at any time.

Ms A testified that there are Epipens available in the pharmacy which is located three to five steps from the reception desk in the Clinic. There is also adrenaline in a drawer in the office, which is kept on hand for allergy shots.

**Mr. B**

Mr. B, the paramedic who responded to the call to the Tillbury Walk-In Clinic in August 2008, gave testimony on behalf of the College. Mr. B arrived at the Clinic and found a young boy with visible swelling of his hands, face and extremities, with a rash and urticaria. He had bilateral wheezing in his lungs. He was in his mother's arms and struggling to breath. There was no doctor present with the child. The child's vital signs included a pulse of 120, respirations of 24, and a BP of 50/25, which Mr. B interpreted as signs of life threatening anaphylaxis. He recognized that he needed to immediately administer epinephrine and salbutamol, he contacted the base hospital physician and was given the order to administer the medications which he proceeded to give.

Mr. B testified that administering these medications is a delegated medical act and there are specific criteria to be followed. If the allergen is unknown, the paramedic is required to try to reach a base hospital physician for an order to administer epinephrine. However, any physician can give the order. Mr. B stated that if he had been unable to reach the physician he would have given the epinephrine anyways. Mr. B gave evidence that had he not given the medication, YZ would have died, as he was hypotensive, he had swelling throughout his body, he had wheezing and urticaria and he was deteriorating rapidly. Mr. B testified that seven minutes passed from the time he left the station until the time the treatment was given. YZ improved with the first dose of epinephrine and salbutamol. He was then transported immediately to Chatham Kent emergency room with a Code 4, which is an urgent emergency call involving lights and sirens.

**Dr. C**

The panel accepted Dr. C as an expert witness in family medicine.

Dr. C testified that he reviewed the documents and formed an opinion about the events of August 2008. YZ was suffering a “waterfall of anaphylaxis” in that he had a rapid heart rate, a rapid respiratory rate and was hypotensive. He testified that “these are not reassuring signs.” During an anaphylactic reaction, the patient will have swelling, hives, wheezing, a swollen tongue which can lead to obstructed breathing, a rapid heart and respiratory rate, and low blood pressure which can lead to shock and ultimately result in death. The immediate treatment is administration of epinephrine, which is life-saving at the time and buys time to offer further treatment. The next step is a salbutamol mask and an intravenous to increase blood pressure, followed by immediate transport to emergency care. Timing is critical as the evolution of the reaction can occur in minutes. Epinephrine is the first treatment to stop the sequence, and there is minimal risk to giving epinephrine if it is not in fact required. Dr. C gave evidence that a similarly situated family doctor would have assessed the urgent nature of the situation and acted accordingly by administering epinephrine and calling an ambulance. Alternatively, a physician should, at the least, monitor and wait with the patient until the ambulance arrives.

Dr. C also testified that although the mother was advised to go the emergency room, in his opinion she made the correct decision in going to the closest medical facility.

**FINDING**

On the basis of the evidence heard, the Committee accepted Dr. Cameron’s admission and found that he committed an act of professional misconduct, 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.

## **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, which included a one month suspension, a one-to-one ethics course, a public reprimand and costs to the College at the tariff rate for two days of hearings.

Dr. Cameron failed to see, assess, treat or respond to YZ while YZ was in the clinic and suffering from a life threatening anaphylactic reaction. Dr. Cameron was aware that the child was in the clinic, and yet did not leave his office at any time to attend to the child or to assist the paramedic while a medical emergency was occurring in the immediate vicinity. Fortunately for the child, the paramedic was immediately available and arrived and provided life-saving measures within minutes of the receptionist placing the ambulance call. Although the clinic had advised Mrs. X to take YZ to the emergency room located thirty-five minutes away, Mrs. X correctly decided to take him to the nearest medical facility, as his condition was rapidly deteriorating.

The fact that Dr. Cameron had advised Mrs. X to go to the hospital emergency department, and the fact that the sign on the door advised that the clinic did not provide emergency services, does not absolve Dr. Cameron from providing life-saving care that was readily available to a patient who had arrived at his office.

The Committee considered the following mitigating factors in this case. Dr. Cameron changed his response and acknowledged the concerns of the expert. He admitted that he committed an act of professional misconduct that would be reasonably regarded by members as disgraceful, dishonourable or unprofessional. He has demonstrated that he has accepted responsibility for his conduct. As well, Dr. Cameron has no previous history with the Discipline Committee. This is an isolated case involving one patient.

The Committee considered the following principles relevant to the determination of an appropriate penalty:

- To express abhorrence of the behaviour that was found to be misconduct
- To uphold the honour and reputation of the profession



- To maintain public confidence in the ability of the College to regulate the profession in the public interest
- Public protection
- General and specific deterrence
- Rehabilitation of the member

The proposed penalty will satisfy these principles. The one-month suspension will provide general and specific deterrence. The one-to-one ethics course will provide an opportunity for Dr. Cameron to meet with an ethics instructor and discuss the particular issues in this case and the ethical response. This will serve to rehabilitate the member and provide public protection. The public reprimand will express the profession's abhorrence of Dr. Cameron's conduct and will serve as a specific and general deterrent. The penalty will provide public confidence in the profession's ability to self-regulate in the public interest.

The Committee considered the cases in the Book of Authorities provided. Although there is no case that is factually similar, the cases involve penalties for conduct that is unacceptable. The Committee agrees that the proposed penalty is in line with the penalties imposed in the cases provided. As well, the Committee is aware that a joint submission on penalty must be accepted unless it is contrary to the public interest and would bring the administration of justice into disrepute. The proposed penalty satisfies the requirement of justice in the circumstances of this case.

## **ORDER**

The Discipline Committee ordered and directed that:

1. the Registrar suspend Dr. Cameron's certificate of registration for a period of one (1) month, to commence December 19, 2011.
2. the Registrar impose the following terms, conditions and limitations on

Dr. Cameron's certificate of registration:

- a. Dr. Cameron shall, at his own expense, participate in and successfully complete a one-to-one educational program in medical ethics specifically tailored to the allegations in the Notice of Hearing organized and approved by the College.
3. Dr. Cameron attend before the panel to be reprimanded.
4. Dr. Cameron shall within 160 days pay the College its costs in the amount of \$7,300.00.

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