Hospital Appeal Board
Fourth Floor, 747 Fort Street, Victoria BC V8W 3E9
Tel: (250) 387-3464 Fax: (250) 356-9923
info@bchab.ca www.bchab.ca

DECISION NO. HAB-HA-20-A003(b)

In the matter of an appeal under section 46 of the *Hospital Act,* RSBC 1996, c 200

BETWEEN:	Dr. Malvinder Hoonjan	**APPELLANT**
AND:	Interior Health Authority	**RESPONDENT**
BEFORE:	A Panel of the Hospital Appeal Board: Stacy F. Robertson, Panel Chair Dr. R. Alan Meakes, Panel Member Dr. Ailve McNestry, Panel Member	
DATE:	Conducted by way of an oral hearing and written submissions concluding on January 26, 2022	
APPEARING:	For the Appellant:	Susan Precious, Counsel
	For the Respondent:	Kieran E. Siddall, Counsel Alexis Kerr, Counsel Louise D. McLeod, Counsel Elana Friedman, Counsel

Decision on the Merits of the Appeal

INTRODUCTION

[1] The Appellant, Dr. Malvinder Hoonjan, is an ophthalmologist with a subspecialty in vitreo-retinal surgery. Dr. Hoonjan has had medical staff privileges at Royal Inland Hospital ("RIH") in Kamloops since 2010. Initially, these privileges were locum privileges. In 2015 they became provisional privileges, and in December 2017 he was granted active medical staff privileges. Dr. Hoonjan has also had consulting medical staff privileges at Kelowna General Hospital ("KGH") since 2010. The KGH consulting privileges did not include surgical privileges.

[2] Dr. Hoonjan practiced with two other vitreo-retinal surgical specialists, Drs. A and C, at RIH, the only site within the entire Interior Health Authority ("IH") where this type of surgery took place, as it involved specialized equipment which was only available at RIH. When the senior vitreo-retinal surgeon retired, a decision was made by IH to relocate the vitreo-retinal surgeries from RIH to KGH. KGH

undertook a search and selection process for the positions of vitreo-retinal surgeons at KGH. Two surgeons were selected, one internal candidate and one external candidate. Dr. Hoonjan was not selected. Dr. Hoonjan then applied for active medical staff privileges at KGH as he was advised by senior management at IH that this was the only way his application would get before the IH Board of Directors and thus trigger appeal rights to the Hospital Appeal Board (the "HAB"). It is the rejection of that application for active medical staff privileges at KGH that led Dr. Hoonjan to file this appeal.

[3] On December 8, 2020, Dr. Hoonjan filed a Notice of Appeal pursuant to section 46 of the *Hospital Act*, R.S.B.C. 1996, c. 200 (the "Hospital Act") appealing the decision of IH on September 11, 2020 which refused his application for active medical staff privileges at KGH.

[4] The Respondent, IH, argues that this case is limited to Dr. Hoonjan's March 27, 2020 unsolicited application for privileges at KGH and the rejection of that application by IH on September 11, 2020. The attempt to limit this case to this decision by IH ignores the history and reasons why Dr. Hoonjan was forced to make the unsolicited application for privileges in the first place. In this case the history and IH's treatment of Dr. Hoonjan is important and essential.

BACKGROUND

How Did We Get to the Unsolicited Application for Privileges at KGH?

[5] As stated above, the history and background are important to this case. What follows is a chronology of key events which will assist in identifying the issues in this matter, which will be dealt with after the background is provided.

[6] Dr. Hoonjan has an extensive educational and training background. He obtained his B.Sc. in Engineering from Harvard University in 1992 and a B.Sc. at Rutgers University in Biology in 2003. In 2003, he also completed his M.D. degree from Rutgers Medical School. In 2004, he completed an internal medicine internship at the University of Texas in San Antonio. In 2007, he completed a residency training program in ophthalmology at the University of Texas in San Antonio. In 2009, he completed a two-year vitreo-retinal fellowship in Houston at the University of Texas. After his training, Dr. Hoonjan worked as a retinal surgeon with a group of ophthalmologists at a large clinic in Iowa for approximately 14 months. Dr. Hoonjan obtained Board certification in October 2008 by the American Board of Ophthalmology and is a Fellow of the Royal College of Physicians and Surgeons of Canada as of May 2009.

[7] In 2010, Dr. Hoonjan moved to Kelowna with his wife and children to be closer to elderly family members. He purchased the existing practice of a retiring ophthalmologist in Kelowna, while his wife also began working as a family physician in that community. Dr. Hoonjan then applied for medical staff privileges with IH. In 2010, he was granted locum medical staff privileges at RIH in Kamloops. He was moved to provisional on November 17, 2015 and then was granted active medical staff privileges on December 12, 2017. These privileges were renewed annually with no conditions or concerns until they were cancelled as of July 31, 2020 by a letter from Dr. B, the Chief of Staff ("COS") at RIH. From 2010 to the present, Dr.

Hoonjan was also granted medical staff privileges at KGH in Kelowna and Kootenay Lake Hospital in Nelson. These privileges have varied from locum to consulting privileges. His current privileges at KGH are for core ophthalmology but restricted to laser treatments, seeing hospital consults and emergency patients, including laboratory investigations and minor treatments of patients but limited to examinations and not requiring an operating room. He is currently a member in good standing of the College of Physicians and Surgeons of British Columbia and has no limits or restrictions on his registration. He is also a clinical assistant professor in ophthalmology at the University of British Columbia.

[8] Dr. Hoonjan is a South Asian Canadian, specifically, he is Punjabi and Sikh and speaks English, Punjabi, Hindi and Urdu fluently. Dr. Hoonjan wears a turban and is a visible minority based on his racial and religious background.

[9] Drs. Hoonjan, A and C were the only three vitreo-retinal surgeons in the entire geographic area serviced by IH. There does not appear to be a separate on call system for the vitreo-retinal surgeons in IH or at RIH and Drs. A and Hoonjan did not participate in any formal on call system at RIH for vitreo-retinal issues or general ophthalmological issues despite being active medical staff members.

[10] From 2010 to 2013, Drs. A and Hoonjan provided locum services to Dr. C which included OR time at RIH. After 2013, IH submits that Dr. Hoonjan fell out of favour with Dr. C, and Dr. C began to assign locum work almost exclusively to Dr. A. Dr. D, Executive Medical Director of IH North (which encompassed RIH), testified that, in 2015, IH became aware that Dr. C was using what he described as supervisory locums to Drs. A and Hoonjan in breach of the locum provisions of the Medical Staff Rules. Dr. D says that this was part of the reason that Drs. A and Hoonjan were offered their own privileges so they could operate and care for their own patients. In cross-examination Dr. Hoonjan stated that Dr. C would let him and Dr. A use the locums to operate on their own patients. This appears to be a misuse of the locum procedures, and in response IH granted Drs. A and Hoonjan each .2 FTE (full-time equivalent) of medical staff privileges to allow them to operate on their own patients. This was supposed to translate to 1 OR day per month each, with Dr. C having 2 OR days per month.

[11] The privileges at RIH were initially granted to Dr. Hoonjan as locum medical staff privileges on July 22, 2014, then interim medical staff privileges on August 28, 2015, then temporary medical staff privileges sometime after August 28, 2015, then provisional medical staff privileges on November 17, 2015 and active medical staff privileges on December 12, 2017. As noted above, Dr. Hoonjan's privileges were renewed annually without any concerns or conditions being identified.

[12] Dr. D stated that, sometime in mid to late 2018, IH learned that Dr. C was planning on retiring. This initiated a process of an evaluation of maintaining the vitreo-retinal surgery program/service at RIH. Dr. C gave IH formal notice of his retirement in the Fall of 2019. There was a Decision Brief prepared in March 2019 for the Senior Executive Team of IH titled "Relocation of Retinal Surgical Services in Interior Health". There was an additional Decision Brief in January 2019 for VP Medicine and Quality for IH. The Decision Brief identifies the top risks as: the insufficient access to specialized retinal services leads to delays in care, increased patient travel and worse patient outcomes; lack of retinal on-call service

jeopardizes after hours care for acute retinal conditions, resulting in poor patient outcomes; and limited physician availability impacts general ophthalmology call sustainability for Thompson-Cariboo-Shuswap and Okanagan.

[13] IH made a decision in July 2019 to relocate the retinal surgical services to KGH from RIH. This decision led to a letter being sent to Drs. Hoonjan, A and C on July 18, 2019 from Dr. E, Executive Medical Director of IH Central (who was responsible for KGH) and Dr. D informing the recipients of Dr. C's retirement and the relocation of the retinal surgical services to KGH. The letter indicated that IH was in the process of increasing the number of FTEs (positions) within the division of Ophthalmology, Department of Surgery at KGH to allow for the expansion and said that there would be a job posting out soon and invited them to apply. The letter concluded by saying "[w]e hope that Drs A and Hoonjan support this direction and wish to continue the journey with us in providing optimal retinal care for all of our citizens."

[14] On March 24, 2020, Dr. B sent Dr. Hoonjan a follow up letter to the July 18, 2019 letter regarding the relocation of retinal surgical services from RIH to KGH. The March 24, 2020 letter stated that "[a]s per IH Medical Staff Bylaws, 12 months advance notice is required if a service is being relocated. Therefore, as of July 31, 2020 RIH will no longer be providing retinal surgical services and no further OR time will be allocated to you for retinal surgical services." The March 24, 2020 letter was the first time that any reference was made to the Bylaws or any length of notice. The letter was also the first time that Dr. Hoonjan was advised that his OR time at RIH was being eliminated. Counsel for IH conceded for the first time in their opening statement at this hearing that neither the July 18, 2019 letter nor the March 24, 2020 letter was consistent with the notice of termination of privileges required under the Bylaws. IH submitted that the Appellant knew that his RIH privileges would not be renewed beyond July 31, 2020 and chose not to appeal that decision.

[15] IH posted the position for retinal surgeons at KGH on August 13, 2019. Dr. Hoonjan sent his application to IH in September 2019 and was interviewed on October 7, 2019. On October 16, 2019, the COS at KGH, the Executive Medical Director at IH Central, and the Ophthalmology Division Head at KGH met and prepared a preliminary short list of candidates. This occurred before Dr. Hoonjan's references were contacted. On November 1, 2019, the COS at RIH, Dr. B, gave a reference for both Dr. Hoonjan and Dr. A to the COS at KGH, Dr. F. Dr. Hoonjan learned through informal sources that he was not a successful candidate and that Drs. A and G were the only two successful candidates, the latter being an external applicant. Dr. Hoonjan never received any formal notification on the status of his application.

[16] On December 10, 2019, Dr. Hoonjan, at his initiation, had a meeting with the VP Medicine at IH, Dr. J, and Drs. E and F about his unsuccessful application for one of the retinal surgeon positions from the job posting at KGH. Dr. E said that Dr. Hoonjan was professional and amicable at the meeting. The notes taken by Dr. F indicate that Dr. Hoonjan wanted to work with IH to find some sort of compromise. However, at the end of this meeting, Dr. Hoonjan was left with the impression that he had no right of appeal of the unsuccessful application for the retinal surgical

services job posting at KGH and that there was nothing he could do about that situation. When Dr. Hoonjan asked about his privileges at RIH, Dr. E told him he understood he would have 12 months to finish up his waitlist and patients at RIH. The information provided to Dr. Hoonjan was not accurate. There was no mention that Dr. Hoonjan might have a right of appeal of IH's failure to make a decision on his application under the job posting, or that the purported notice of termination of his privileges at RIH was ineffective or that he may have a right of appeal of the decision to terminate his privileges at RIH.

[17] After the December 10, 2019 meeting, Dr. Hoonjan decided, based on the discussions at that meeting, to submit another application for privileges to the IH Board, as this was the only way that he understood that he could get a right of appeal from any rejection. On March 27, 2020, Dr. Hoonjan submitted an application for provisional/active medical staff privileges at KGH. Provisional medical staff privileges are normally a precursor to obtaining active medical staff privileges.

[18] On August 5, 2020, the Board of Directors of IH rejected Dr. Hoonjan's request for provisional/active medical staff privileges but confirmed his consulting privileges with the same surgical restrictions he had previously. By letter dated September 11, 2020, Dr. Hoonjan was informed of the Board of Director's decision.

[19] Dr. Hoonjan's application for active medical staff privileges at KGH proceeded as the receipt of an unsolicited application rather than as an appeal of a competitive hiring process or a consideration of the purported termination of his active medical staff privileges at RIH serving the same population base that was now being served at KGH.

Parties' Positions on the Issues

[20] IH argues that a specific internal process of IH for the creation of a new position needs to be followed to assess Dr. Hoonjan's March 27, 2020 unsolicited application for provisional/active medical staff privileges at KGH. IH argues that there is no need for a third vitreo-retinal surgeon at KGH, that there are no resources to support a third vitreo-retinal surgeon and that if there is need and the resources to support that position then a competitive search and selection process should be put in place and Dr. Hoonjan should not just be given the position.

[21] Dr. Hoonjan argues that there is need for a third vitreo-retinal surgeon at KGH, that there are the resources to support his appointment and that given the past circumstances, including the manner in which his privileges at RIH were cancelled and his treatment during the previous competitive search and selection process, this panel should grant Dr. Hoonjan the position without a further competitive search and selection process.

Legislative Authority of the HAB

[22] The HAB has a broad remedial authority which is set out in section 46(2) of the Hospital Act as follows:

> The Hospital Appeal Board may affirm, vary, reverse or substitute its own decision for that of a board of management on the terms and conditions it considers appropriate.

[23] In addition, section 46(2.3) of the Hospital Act provides that an appeal to the HAB is a new hearing. Therefore, the HAB cannot rely on any information submitted or considered by the IH Board unless that information is also submitted in the HAB proceedings.

[24] Section 46(3) of the Hospital Act provides:

> The HAB has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law and discretion arising or required to be determined in an appeal under this section and to make any order permitted to be made.

[25] The effect of sections 46(2.3) and 46(3) is that the HAB does not owe any deference to the decisions of the IH board and the HAB has the authority to make its own decision on all matters properly before it after consideration of the evidence presented at the new hearing.

[26] The panel made an order prior to the hearing that if IH was going to rely on any quality-of-care incidents it was required to disclose those so that the Appellant would be able to fairly respond at the hearing. IH only raised the patient X incident discussed below in this decision. Any other mention of quality issues that may have affected the hiring decision or treatment of the Appellant cannot be considered by this panel, otherwise, the Appellant's procedural rights protected under the Medical Staff Bylaws and Medical Staff Rules would be ignored.

ISSUES FOR THE PANEL

[27] In order to assess Dr. Hoonjan's unsolicited March 27, 2020 application for privileges at KGH, the panel will follow the process outlined by IH and used for the hiring of the two vitreo-retinal surgeons as part of the relocation of retinal surgical services from RIH to KGH. The issues that the panel must determine are as follows:

A. The panel must first determine if there is a need for a third vitreo-retinal surgeon at KGH. The panel will consider the evidence to analyze the factors identified by the parties and identified in previous case law before the HAB to determine whether there is a need for a third vitreo-retinal surgeon at KGH.

B. If the panel finds that there is a need for a third vitreo-retinal surgeon at KGH then it must determine whether there are the resources to support a third vitreo-retinal surgeon at KGH.

C. If the panel determines that the need and resources components are satisfied, then the efficacy of granting Dr. Hoonjan the position or having another competitive search and selection process will be examined. This determination is a discretionary determination of the HAB. In exercising its discretion, the HAB will consider the previous conduct of IH in relation to the Appellant's privileges to determine whether it is appropriate to allow IH to conduct a further competitive search and selection process involving the Appellant or whether this panel should grant the Appellant the privileges he is seeking. It is in this exercise of discretion that the background and previous dealings between IH and the Appellant are relevant. Those previous dealings are broken down as follows:

a. Should Dr. Hoonjan's privileges at RIH have followed the relocation of the retinal surgical services to KGH?

b. Were Dr. Hoonjan's privileges at RIH properly cancelled?

c. What duty does IH owe to Dr. Hoonjan and did IH comply with that duty?

d. Was the previous competitive search and selection process fair? Here the panel will consider the following deficiencies:
   i. Dr. Hoonjan's references were not contacted except the RIH COS reference;
   ii. Too much reliance was placed on the RIH COS reference and in particular his negative reference flowing from the patient X surgery in comparison to the complaint against Dr. A;
   iii. Improper conclusions were drawn from X surgery complications;
   iv. Too much reliance was placed on views/decision of the Ophthalmology Division at KGH;
   v. There was improper reliance on a new program when this was not a new program but the relocation of an existing program;
   vi. There was a failure to properly assess currency issues.

e. Differential treatment of Dr. Hoonjan

If the panel decides that Dr. Hoonjan is to be granted privileges, the panel will also look at how reintroduction should be handled.

ANALYSIS

A. Is there a Need for a Third Vitreo-retinal Surgeon at KGH?

[28] Dr. I, the Executive Medical Director for IH, explained the process that IH uses to get an additional position approved. He testified that the Medical Staff Resource Plan ("MSRP") is the starting document which identifies the current and historical community medical staff resource requests and needs by site and specialty. IH determines what is needed and whether there are any changes to be made to meet the needs of the communities that it serves. The addition of additional positions or FTEs are determined based on community needs. Dr. F described the MSRP as a wish list to meet all the needs of the communities. The MSRP requires IH Board approval. The MSRP is just the first step in a process which identifies whether or not there is a need for the service in the community. The second step is to determine if there are adequate resources to support any additional positions. This is done through a Medical Staff Impact Analysis ("MSIA"). This stage requires a business analysis and requires approval of the Executive Director, Executive Medical Director and VP. The next step is to open a Position Control Number ("PCN") which defines the practice and position identified. The next stage is Recruitment and Offer Letter Process and the final step is Credentialling and Privileging. The IH Board of Directors is involved at every step and their approval is required for all privileging matters.

[29] IH argues that the entire process outlined above is relevant to the manner in which the transition of the retinal surgical services from RIH to KGH was handled and also the determination of the current needs of, and resources available to, the Ophthalmological Division in respect of the delivery of the retinal surgical services at KGH. This definition of the process highlights one of the key errors in IH's submission and handling of the application. The focus is not on the needs of and availability of resources of the Ophthalmological Division merely at KGH; the needs analysis refers to the needs of the patient population base which IH serves as a whole, and the resources are the resources available to IH at the location where the retina services are going to be performed, which was RIH and now is KGH. The focus of the entire analysis on the division level places too much reliance on the views of division members rather than the views of senior IH medical staff who are responsible for the determination and larger planning at the health authority level. The IH Board approved an increase of 4 ophthalmology FTE to the MSRP at KGH which was in direct response to the Decision Brief and relocation of the retinal surgical services from RIH to KGH. However, IH submits that after consultation with the ophthalmological division at KGH, none of whom were providing any retinal surgical services, it was determined that there was only a need for two retinal surgical specialists when previously there were three performing those same retinal surgical services at RIH. This was mainly due to the fact that if a new retinal surgeon was hired, he would need more surgical time to have a competitive compensation package as the lucrative PHSA Medical Retina Program (the Provincial Retinal Diseases Treatment Program funded by PHSA), which does not require OR time, would not be available to a new applicant as that program is closed to new providers.

[30] As far as the MSIA and recruitment process, the process described by Dr. I was not followed for the competitive hiring process, which highlights the unique nature of this relocation of services within IH. The MSIAs that were produced by IH already had the two successful applicants' names on them and contain approval dates prior to the completion of the competitive hiring process. It is unclear if the MSIAs produced are complete, however, if they are, they do not contain much in the way of analysis or justification for the costs of the two new retinal surgeons at KGH. It also appears that Dr. J, VP Medicine at IH, approved the recruitment and PCNs prior to completion of the MSIAs because this wasn't really a new program or position but the relocation of positions previously held at RIH.

[31] There are several MSRP documents for 2019 and 2021 and they all show a need for more ophthalmologists. However, the MSRP does not break down ophthalmologists further into retinal surgical specialists. Not all ophthalmologists are retinal surgical specialists. However, this entire appeal is based on the relocation of the retinal surgical services from RIH to KGH. This relocation was the subject of a Decision Brief dated March 2019 which was presented to the Senior Executive Team at IH. This Decision Brief recommends that the Senior Executive Team approve of the relocation of retinal surgery to KGH from RIH with net one time startup costs of $134,000 and net ongoing operating costs of $223,000. The discussion section of the Decision Brief notes the additional changes at KGH as follows; increase MSRP for existing KGH Retinal Specialty to four and notes that this will require completion of a MSIA prior to open recruitment; and to establish a

formal retinal ophthalmological call service including Medical On-Call Physician Availability Program ("MOCAP") funding.

[32] The Decision Brief recommended four retinal surgeons, which was approved by IH Senior Executive Team, and the IH Board approved of the increase in the MSRP at KGH of 4FTE. However, there was only a posting for two retinal surgeons which appears to be driven by the views of the ophthalmological division at KGH. However, the Decision Brief recommendation for four retinal surgeons clearly identifies a need for four and authorizes an increase to the applicable MSRP. The IH Senior Executive Team's decision for four retinal surgeons satisfies the need stage of the analysis of Dr. Hoonjan's unsolicited application.

[33] The decision of the IH Senior Executive Team about the need for four retinal surgeons does not need to be considered in a vacuum. There was evidence available which supported their decision, which presumably was also relied on by them in reaching their recommendation in the Decision Brief.

[34] The IH Ophthalmology Surgical Services review of 2018/19 noted that in 2015/16 and 2016/17 47% and 46% of retinal surgery on IH residents was done outside of IH (40% at other BC hospitals and 7% and 6% out-of-province). These numbers excluded surgical daycare cases from IH performed in Alberta which were not recorded. The 50+% retinal surgery cases of IH residents done by the 3 surgeons at RIH equated to: 2015/16 311 cases; 2016/17 323 cases; and 2017/18 298 cases.

[35] The updated IH Ophthalmology Surgery Volumes & Referrals Analysis of 2020/21 shows the following for retinal surgical cases: 2018/19 212 cases; 2019/20 176 cases; 2020/21 525 cases. The Analysis stated: "Glaucoma and Retinal surgery have increase substantially in 2020/21 in IH, increase of 573% (86 cases) and 148% (313 cases) respectively." Chart 3 of the Analysis shows that retinal surgical cases performed at RIH in 2018/2019 and 2019/2020 are 212 and 176 respectively while the number of surgical cases performed at KGH in 2020/2021 after the retinal surgical services were fully relocated was 499. The document also showed that in 2019/20 only 31% of IH residents' retinal surgery (176 cases) was performed at RIH, an increase to 69% of IH residents receiving their retinal surgery outside IH. Again, these numbers excluded surgical daycare cases from IH performed in Alberta which were not recorded. The 2020/21 data, specifically the percentage of IH cases performed outside IH, was expected in approximately May 2022 and not available at the hearing. When Dr. E was presented with the fact that 69% of IH residents received their retinal surgery outside of IH he said he found that hard to believe but offered no other contrary evidence. He also indicated that he was aware of some burnout and on call concerns from the retinal specialists at KGH. Dr. F confirmed in emails with the Ophthalmology Division Head at KGH, Dr. K, that one of the goals of the retinal surgical services relocation to KGH was to have as many IH residents receiving care at KGH as possible and referring excess cases to Vancouver, which was suggested by Dr. K, was not a long-term viable option.

[36] The 2020/2021 Analysis concluded "volumes suggest that repatriation at some level has occurred with the retinal surgery service opening at KGH." It also supports Dr. Hoonjan's own calculation that if the retinal cases between 2015 and

2018 averaged just over 300 cases annually, and represented just over 50% of the IH caseload, then the total annual caseload was about 600 cases.

[37] Drs. A and G started work at KGH in April 2020. At that point, and continuing to date, they are the only vitreo-retinal surgeons practicing surgically in IH. The most recent Interior Health Authority summary of Medical Staff Resource Planning is the BN for the HAMAC meeting of July 17, 2020. This was presented by Dr. I, the Executive MD for Physician Engagement & Resource Planning. Appendix A of this document addresses the 5-year recruitment forecasts for each specialty, recognizing both the "new demand" FTEs as well as the "estimated turnover" FTEs. Ophthalmology shows 3.9 FTEs of new demand / 1.6 FTEs of estimated turnover. Ophthalmology is one of the 7 specialties (and one of only 2 of the surgical specialties) where the current workforce is below both BC and IH's FTE per 10,000 population. Ophthalmology has a deficit of 13.3 FTEs required to meet provincial benchmarks, the second highest in that group of 7 specialties.

[38] The evidence provided by Dr. Hoonjan supports that not only are 3 vitreo-retinal ophthalmologists currently providing services in Kelowna (albeit Dr. Hoonjan cannot provide the level of services that requires a fully equipped operating room) but that, in spite of that, a significant number of patients requiring those services continue to be transferred outside of IH.

[39] The January 14, 2021 KGH Division of Ophthalmology meeting minutes reflect the difficult issues facing a department trying to provide an on-call schedule that provides 24/7 access to several subspecialty areas within a department of relatively few specialists. Several witnesses have testified that a 1 in 2 on call is not sustainable, which is why the Decision Brief recommended 4 retinal surgical specialists to perform a 1 in 4 on call system.

[40] Dr. Hoonjan still has Consulting privileges at KGH and is still providing medical vitreo-retinal care to patients in IH. The piece that is missing is simply his ability to provide those surgical services that require a hospital OR. Dr. L, an expert vitreo-retinal surgeon who testified, explained that a vitreo-retinal surgeon typically practices medical treatment in 80 % of their cases and surgical treatment in 20%. At the time that his surgical privileges at RIH were cancelled in July 2020, Dr. Hoonjan estimated that he had 80 patients waiting for surgical treatment.

[41] When Dr. F was asked on November 18, 2021, whether a third vitreo-retinal surgeon was needed at KGH, he replied that "monitoring" did not indicate a need. He stated that ophthalmology was not a priority at that time. He described the subspecialty areas of the 7 ophthalmologists then at KGH, which included a glaucoma surgeon who had been privileged after recruitment of Dr. G in 2019 (and following the retirement of another doctor). This information did not seem to be congruent with the information provided at the HAMAC meeting of 16 months earlier, or with the Divisional minutes of 10 months earlier.

[42] Dr. E was asked about the level of satisfaction within the vitreo-retinal service (as of the date of his giving evidence in November 2021) and while he agreed that there were "complaints", he did not explain why he concluded that a service considered in March 2019 to require 4 surgeons did not, now in 2021, need a third. Dr. K has also agreed that there is still 1.0 FTE unfilled in the

Ophthalmology Division. Given that all the IH data to date would seem to support the need for 4.0 FTE, the evidence would appear to support that at least a third vitreo-retinal surgeon is needed by the community. It appears that it was the KGH Division of Ophthalmology who appear to have been responsible for amending the 4 FTE recommended by the Senior Executive Team at IH to 2.0 FTE. This is an example of the over reliance on the views of the KGH Division of Ophthalmology by IH senior medical management, who are responsible not only for patients served by KGH but for all of the patients of IH. This issue is discussed further in these reasons.

[43] IH argues that there is no objective evidence of a current need for a third vitreo-retinal surgeon at KGH. The evidence identified above refutes this bold statement. An issue for IH appears to be that the needs are determined by the Division itself, which is run by self-interested physicians, rather than the medical management team, who have the responsibility for meeting the provincial goals of providing all services. It seems to the panel that the medical management team at IH have abrogated their planning and resource role to the Division heads. Division heads provide critical information for consideration but when medical management defer to all views of the divisions then there is a critical failure of responsibilities.

[44] IH's main argument against need is that the wait times for retinal surgeries are not excessive. However, this ignores the fact that wait times for retinal cases are not a good indicator of need because retinal cases often require urgent intervention and cannot be put on a wait list but instead are referred to other health authorities in the Lower Mainland and Alberta. Dr. I admitted this issue and acknowledged that wait list information is not relevant for some specialties, particularly involving emergency care or critical treatments. He acknowledged that he would not expect retinal surgical cases to have a waitlist. IH's other argument against need is that the current retinal surgeons cannot fill their allotted surgical days, but there was evidence that these surgeons were experiencing burnout and needed to take time off.

[45] Given the type of specialty involved, retinal surgeries, the number of cases referred out or number of IH residents that are having retinal surgical services outside of IH is the best indicator of need. That evidence indicates a need for a third vitreo-retinal surgeon at KGH.

[46] In addition to IH Senior Executive Team's decision about the need for four retinal surgeons, it should be noted that the cases recognize that the assessment of need by the HAB can involve a broad list of factors as the HAB does not control the MSRP or other internal processes of the hospitals that they would use in assessing need or resources. The Appellant has listed the following factors in his submissions and the panel agrees that they are applicable in this case as well:

a. Whether the surgeon is already established in the community (*Behn v. Vancouver Island Health Authority* (May 19, 2010), para. 70);
b. Whether the surgeon needs to refer out his surgical cases in his practice because he does not have surgical privileges (*Walker v. Fraser Health Authority* (Decision No. 2013-HA-003(a)), para. 29);

c. The on-call schedule, coverage, and availability of the other sub-specialists during emergencies and other crises (*Behn* paras. 61-63, 67);
d. Whether the region's cases need to be referred outside of the health authority (*Behn*);
e. Support from other doctors in the community, including referring doctors (*Behn*, para. 35-44, 61-63, 67; *Walker*, para 13, 30; *Dr. Donna Cuthbert v. Royal Jubilee Hospital* (July 18, 1997), page 12);
f. Whether a doctor has a sub-specialization (*Walker* para. 13; *Dr. Braun v. Surrey Memorial Hospital* (January 23, 1989), page 14).;
g. The surgeon's ability to maintain their surgical skill obtained through reputable programs and deliver those skills in the community and the benefit of that education to the community where privileges are being sought (*Behn*, para. 70; *Walker*, para.31);
h. The preference of patients in the community for a doctor from a specific group (ex. Gender, ethnic community) (*Walker*, para. 13; *Dr. Doreen Aitkin v. Penticton Regional Hospital* (April 15, 1986), page 11);
i. Whether retinal surgery has "in the past been identified by the division of ophthalmology as an area of need" (*Behn*, para. 28);
j. Whether "the Canadian population is significantly aging" and whether the health authority and region has an older population than elsewhere in Canada. (*Behn*, paras. 29, 56);
k. The number of specialists per population (*Behn*, paras. 31, 59);
l. Manpower planning (*Behn*, paras. 30, 57; *Walker*, para. 13; *Dr. Fox v. Kelowna General Hospital* (July 18, 1997));
m. The availability, distribution and redistribution of operating room time (*Behn*, paras. 49, 68, 76-77);
n. Whether operating room time is used for cataract surgery (*Behn*, para. 76).

[47] The panel in *Walker* noted that this is not a closed list and an appellant is not required to satisfy each indicium of need. Dr. Hoonjan is already established in the community and was previously providing the exact service to the exact same IH residents that he is currently seeking privileges for at KGH. He currently has to refer out all of his retinal surgical patients. There is a definite need for another retinal surgeon to provide on call coverage at KGH. The difficulty with a 1 in 2 call was acknowledged by all IH witnesses. There was significant evidence that approximately 50% of IH residents were having retinal surgery outside of IH. Several local ophthalmologists indicated that they would refer retinal surgical matters to Dr. Hoonjan. Some patients have expressed a preference for Dr. Hoonjan given his ability to speak several languages. Patient X was one of those patients. The other factors have all been discussed and support the need for Dr. Hoonjan's appointment. However, given the findings of need from the IH Senior Executive Team's approval of the Decision Brief, it is not necessary to rely on these individual factors which exist because IH has found that there is a need.

[48] The panel finds that there is a need for a third vitreo-retinal surgeon at KGH in this case.

B. Are there Resources Available to Support the Position?

[49] The Decision Brief to relocate the retinal surgical services to KGH was acted upon, but IH's submissions make no mention of a completed MSIA or how that process was completed. In an email dated July 12, 2019, it is noted that Dr. J approved recruitment prior to the MSIA. The MSIAs for the two retinal surgical ophthalmologists at KGH were initially approved by Dr. K on October 15, 2019 with final approval on November 27, 2019. The MSIAs already had Dr. G and Dr. A's names filled in on the forms. This was before Dr. Hoonjan's reference, Dr. B, was even called and before the initial meeting to do a preliminary ranking of the candidates. As far as resources available for the position, Dr. I stated that the new retinal surgical specialists could share a surgical slate so there was no impact on costs.

[50] Dr. E stated in an email dated September 9, 2019 that KGH could accommodate at least one additional surgeon, assuming that the two incumbents are successful applicants implying that there are sufficient resources for three vitreo-retinal surgeons at KGH. This was an email to the representative at PHSA who was responsible for approving applicants to the PHSA Medical Retina Program, which funds a program for retinal procedures that are done in a medical office setting and do not require OR time or other hospital resources. Participation in the PHSA Medical Retina Program is controlled by PHSA and without their approval no remuneration can be received for this service. This email meant that there was enough surgical time for three vitreo-retinal surgeons as long as all three could also participate in the PHSA Medical Retina Program. Dr. E noted that the ability to have three retinal surgeons was affected by participation in the PHSA Medical Retina Program that would also be part of their work as without it IH would need to offer a new surgeon more OR time to make a competitive compensation package. The expert, Dr. L stated that the practice of a vitreo-retinal surgeon is typically 20% surgery requiring OR time and 80% in office medical retina procedures. It should be noted that at the time of hiring Dr. G, he was not approved in the PHSA Medical Retina Program and this was part of the reason why initially only two positions were approved. However, Dr. E gave evidence that Dr. G has now been approved in the PHSA Medical Retina Program. Therefore, his statement that there are resources and sufficient OR time for three vitreo-retinal surgeons is applicable and there should be no impact on compensation issues for the three vitreo-retinal surgeons.

[51] The next step taken according to the process described by Dr. I is the creation of a PCN (Physician Control Number) for the positions and starting the recruitment process and posting of the position. It appears that there was a request for a PCN of 1 FTE approved on July 12, 2019 by Dr. E. The PCN approval for the other 1 FTE does not appear to be before the panel but the offer letter to Dr. G refers to 1 FTE, therefore there must be 2 FTE for the two retinal specialists at KGH. There is an anomaly in relation to the FTE that was never fully explained by IH. There was only 1 FTE for vitreo-retinal surgeons at RIH and those retinal surgical services were relocated to KGH and suddenly there are 2 FTE. It is unclear how the FTE translates to OR time which is the critical commodity needed by surgeons. The 2 FTE could be equally divided amongst the three surgeons and each

surgeon would still have more FTE than the previous vitreo-retinal surgeons had at RIH.

[52] IH posted the position for a retinal surgeon on August 13, 2019. IH argued that the position posted at KGH was different from the position Dr. Hoonjan had privileges for at RIH. IH argues that the posting was for more general ophthalmology services and call coverage. However, a cursory review of the actual posting refutes this as does the entire rationale found in the Decision Brief which approved and justified the relocation of the retinal surgical services from RIH to KGH.

[53] The attempt to try to recharacterize the facts regarding the relocation of retinal surgical services from RIH to KGH by IH to justify the change in the posting requirements can be seen as a way to disqualify Dr. Hoonjan from the retinal surgeries that he had been performing for some years at RIH because he did not have experience in general ophthalmology on call work. The job posting specifically refers to elective and emergency vitreo-retinal surgeries and the primary focus in retina-based care. The job posting did note that there may be a requirement to participate in a more comprehensive ophthalmological care but the posting only listed vitreo-retinal problems requiring surgical procedures. In addition, the whole purpose was to relocate the retinal surgical services that Dr. Hoonjan was already performing so the suggestion that somehow this changed when the recommendation of the Executive Management Team was implemented by KGH is simply unsustainable. IH's argument that the on-call coverage contemplated the larger ophthalmological call coverage is also without merit. The Briefing Note contemplated a 1 in 4 retinal on call coverage not a participation in the larger ophthalmological on call coverage at KGH. The KGH already had 8 ophthalmologists on the call schedule at the time of the posting for the retinal surgical position so the 1 in 4 on call referenced must refer to specific on call for retinal surgical services. Again, this additional on call requirement for retinal surgical services was one of the rationales for the relocation of the retinal surgical services in the Decision Brief which was approved by IH Senior Executive Team.

[54] The offer letter to Dr. G states that a minimum of one day per week will be assigned to the retina program in a retina equipped OR to be shared amongst the retina specialists in the program. This one day a week of OR time for one surgeon was the same as the OR time for all the previous surgeons at RIH performing the same surgeries. Dr. F, COS at KGH, testified that the relocation of the retinal surgical services from RIH to KGH was not intended to add any retinal resources but was meant to transfer existing resources and OR time to KGH. It is unclear exactly why IH would move from three vitreo-retinal surgeons at RIH to two at KGH after the relocation of the retinal surgical services. It is clear that there was an increase in OR time at KGH available for vitreo-retinal surgeries after the relocation of retinal surgical services from RIH to KGH.

[55] Dr. K stated that the plan was always to do 1-2 days/week of retinal surgery. The OR schedule for the Eye Care Centre at KGH was submitted for 2021. The OR schedule shows that starting in May 2021 until December 2021 there were a minimum of four vacant days per month and a maximum of 13 vacant days per month. The 2021 OR schedule also indicates that Dr. A had 43 OR days and Dr. G

had 61 OR days. In contrast in 2019, the last full year of retinal surgery at RIH, Dr. A had 15 OR days and Dr. Hoonjan had 9 OR days. To be clear, the limit of OR days was not due to a lack of patients by Dr. Hoonjan but a specific lack of OR time available and allocated to him. The OR time allocated to the retinal surgical specialists at RIH previously was 4 OR days per month. The current OR time available for retinal surgical specialists at KGH is 8 OR days per month. This is more than enough OR time to keep at least 3 retinal surgical specialists current in the skill and procedures necessary to perform the vitreo-retinal surgeries.

[56] The IH Ophthalmology Surgery Volumes & Referrals Analysis of 2020/21 indicates that the retinal surgical cases went from an approximate average of 200 with three vitreo-retinal surgeons to over 500 in 2020/2021 with two vitreo-retinal surgeons. With over 500 retinal surgical cases a year there is enough need to have three vitreo-retinal surgeons simply spreading those cases over the three surgeons who all also have access to compensation from the PHSA Medical Retina Program for additional in office procedures.

[57] Between the overworked retinal surgical specialists and the unused and vacant OR time at KGH, there are sufficient existing resources to accommodate a third vitreo-retinal surgeon at KGH with little to no financial impact on the program. A third retinal specialist would also assist in alleviating the proposed 1 in 2 retinal on call coverage which IH witnesses have said is not sustainable.

[58] IH's argument regarding the availability of resources for a third vitreo-retinal surgical specialist are not so much an argument that the resources do not exist but more of an argument that IH has determined that any available resources are needed more elsewhere within KGH or the ophthalmological division. Again, this appears to be a finding driven by the ophthalmological division and rubber stamped by IH medical leadership staff. Dr. I admitted that if the division head did not support privileges or a particular candidate then all the other committees such as the credentialing and privileging committee or the candidate selection committee would follow along. Dr. I stated that these various bodies are supposed to provide oversight and not be a rubber stamp, however, his description of the practical application described a "rubber stamp" process driven by the division's decision/views. He stated everyone in an oversight role deferred to the views of the division. This appears to the Panel to be an impermissible abrogation of the responsibilities of those personnel and committees in relation to those decisions. Dr. I is not alone at IH with this view that the physicians in a division control the hiring and privileging process. Dr. E saw his role to support the physician groups and stated that the physicians at the site controlled the decision process.

[59] Dr. E also addressed the broader issue of IH's use of the search and selection processes in recruiting and privileging medical staff. The process was not followed rigidly in the competitive search and selection process in this case because this involved a relocation of services from another IH facility and posting and recruitment proceeded before the MSIA and PCN were approved. Dr. E also agreed that the process to grant privileges to a new physician was not used in every instance, citing the more recent hiring of a vascular surgeon and glaucoma ophthalmologist. Dr. I also acknowledged that the normal process was not followed for the hiring of the glaucoma specialist. Dr. E described these hires as "unicorns"

and explained that when these individuals arrived in IH, they possessed such qualifications that a search and selection process was unnecessary. It seems unreasonable that a process should be considered as relevant in this appeal when it was used inconsistently and, at least in this instance, seems to have played mostly a defensive role in order to justify a course of action already taken in relation to Dr. Hoonjan. There does not appear to be any criteria for determining whether an applicant is a "unicorn" or any special procedures for "unicorn" applicants. Depending on the criteria used by senior medical management of IH, it may be that a vitreo-retinal surgeon with significant experience in the health authority, surgically and non-surgically at several locations, who was established in the community and could speak multiple languages meets IH's criteria for a "unicorn" applicant.

[60] This panel finds that there are the resources at IH and KGH to support a third vitreo-retinal surgeon.

C. If There is a Need and Resources, Should Dr. Hoonjan be Granted Privileges?

[61] Having found there is a need for a third vitreo-retinal surgeon at KGH and that there are the resources to support such a position, the next question is whether this panel should grant Dr. Hoonjan privileges which are the subject of this appeal or whether this panel should refer the filling of the position for a third vitreo-retinal surgeon at KGH to IH to fill through its current search and selection process, which would require Dr. Hoonjan to participate in another competitive search and selection process.

[62] IH says that if the panel finds there is the need and resources for a third vitreo-retinal surgeon, then the appropriate process is a fair and transparent search and selection process pursuant to KGH's current search and selection policy.

[63] The Appellant says if the panel finds there is the need and resources for a third vitreo-retinal surgeon, then the panel has the authority to appoint Dr. Hoonjan to the active medical staff of KGH without having to go through another search and selection process. The Appellant relies on the cases of *Behn* and *Walker*, where ophthalmologists were successful in their appeals before the HAB and were granted hospital privileges without having to go through a further search and selection process.

[64] IH responds by submitting that in *Behn*, the panel found that Dr. Behn was an excellent candidate and there had not been any criticism of Dr. Behn's ability to fill this need, whereas in the present case there are criticisms and concerns involving the Appellant's currency.

[65] The HAB has the discretionary authority to either appoint Dr. Hoonjan to fill the third vitreo-retinal surgical position or refer the selection back to IH to fill the position pursuant to its search and selection process. In the cases of *Behn* and *Walker*, the HAB appointed the appellants to the respective positions rather than sending the matters back for a further competitive search and selection process. This panel is not aware of any case, and IH did not submit any case, where the HAB has sent the matter back to the hospital to conduct a completely new search and selection process.

[66] In determining whether it is appropriate to exercise our discretion in favour of a direct appointment to the KGH active medical staff or whether to refer the matter back to IH and rely on their search and selection process, the panel examined the previous dealings between IH and Dr. Hoonjan related to his privileges to determine whether IH dealt fairly with Dr. Hoonjan in those previous dealings. Those previous dealings are broken down as follows:

a) Should Dr. Hoonjan's privileges have followed the relocation of retinal surgical services to KGH?
b) Were Dr. Hoonjan's privileges at RIH properly cancelled?
c) What duty does IH owe to Dr. Hoonjan and did IH comply with that duty?
d) Was the competitive search and selection process fair?
e) Differential treatment of Dr. Hoonjan

a) Should Dr. Hoonjan's Privileges Have Followed the Relocation of Retinal Surgical Services to KGH?

[67] IH argues that the case of *Dr. Allan Groves v. Surrey Memorial Hospital* (July 20, 1994, BC Medical Appeal Board) stands for the proposition that when services stop being performed at one hospital and are moved to another, it is not, nor should it be, automatic that the physician's privileges get transferred to the recipient hospital. This is an overgeneralization of the findings in that case. In that case, the Appeal Board found that there was no evidence that there was a requirement of the Hospital to take any physician in order to obtain resources from Shaughnessy Hospital which was closing. If the Transition Team had made the requirement to take staff with any acceptance of resources, the outcome would possibly have been different. That case involved a unique situation which is different from the present case. In that case a general surgeon was looking to start a new practice at Surrey Memorial Hospital serving a completely different patient population need whereas in the present case, Dr. Hoonjan is looking to continue the same practice and serve the exact same patient population need for which his privileges were granted by IH at RIH. There is a substantial difference between the closure of a hospital and the relocation of a service within a health authority and therefore the *Groves* case is not applicable to the present case.

[68] The Bylaws in issue in this case are Bylaws for IH and not specifically for KGH or RIH. With the formation of regional health authorities, the administration of individual hospitals has been amalgamated by the regional health authority. The concept of individual hospital boards has been overtaken in B.C. by regional health authorities. There is only one Board in IH. Support for this is found in the wording of Bylaw 3.1.7 which specifically refers to Interior Health and not any individual hospital or facility and by the privileging approvals by the IH Board which are all done in one meeting for every site in IH. The privileges are granted by the IH Board to be exercised at specific sites.

[69] Bylaw 3.1.5 provides that privileges are granted depending on the needs of the population served by IH. The Bylaws specifically deal with site or program specific privileges at Bylaw 3.1.3 which allows the Board to make allowances for

site-specific and/or program-specific privileges. Privileges are granted by the Board in accordance with the existence of programs or services within the Health Authority. Where the Health Authority does not provide a service (e.g. pediatric cardiac surgery) it does not grant privileges. Where there are multiple sites where a service may be available, this clause permits the Board to assign a location within the Health Authority where such services may be exercised by a given practitioner.

[70] However, where there is only one site where a given service is provided (e.g. cardiac surgery, neurosurgery, retinal surgery) privileges are automatically restricted to the site providing such care. The key issue in the present case is that the privileges were granted to serve the needs of all patients in IH and simply because one location has moved to another location does not break the link that is established between the grant of privileges and the same patient population base being served within IH. There was no conflict in any of the witness testimony including senior IH medical staff that the privileges granted at RIH to Dr. Hoonjan for surgical retinal services covers the same needs of the same population base within IH that the privileges granted at KGH for retinal surgical services cover. This panel finds that when the IH Board grants privileges and the only aspect of a change in those privileges is a relocation of the sole site where the privileges were performed to service the same patient population in IH, the relocation of such a service automatically links existing privileges with the new site, subject only to the availability of the practitioner to relocate.

[71] When the sole site of such services changes, the panel finds that the Board is required to automatically assign existing privileges to the new site of service. Otherwise, the consequences are catastrophic for both the medical practitioner and the patients who are receiving the services. A practitioner could spend years building a practice, which could be effectively terminated by a decision of IH to move the location of the service, perhaps to a site across the street from the existing site. This would be unjustified and would serve no purpose other than to allow the termination of privileges for non-disciplinary factors and not in accordance with the Bylaws. Dr. E stated that privileges should not be transferred to a community "world's apart" from where the privileges were previously exercised. This statement does not make sense in the circumstances of this case. First, one of the rationales for the relocation of the retinal surgical services was that the two remaining surgeons both lived in Kelowna and were known entities in that community. Further, the retinal surgical services were already being provided by these same two surgeons for all patients in IH including Kelowna. Kelowna and Kamloops are both part of IH and serve much of the same population depending on the specialty involved.

[72] To the extent that IH senior medical staff viewed this as the closure of one program at RIH and the complete establishment of a new program at KGH, that view is not in accordance with the facts and situation in this case. Dr. Hoonjan testified that he was apprehensive about the competitive search and selection process because he did not think, given his historical treatment by IH, that he would be dealt with fairly. He also felt that he should not have to apply for a position that he had been doing for 10 years just because the location where those privileges were exercised within IH changed.

[73] This panel finds that Dr. Hoonjan's privileges at RIH should have been transferred to KGH with the relocation of the retinal surgical services. If IH had any quality-of-care concerns, which they raised in the competitive search and selection process, then those should have been addressed through the discipline process which affords basic procedural fairness protections to the medical staff. If IH determined that there needed to be a third vitreo-retinal surgeon, in addition to the two that already had privileges at IH at RIH, then the normal MSRP, MSIA, obtaining a PCN and recruitment and selection process should have taken place for that third position. That is not what occurred in this case for either of the two incumbent vitreo-retinal surgeons who already had privileges within IH at RIH.

b) Were Dr. Hoonjan's Privileges at RIH Properly Cancelled?

[74] IH submitted that following the approval of the relocation of the retinal surgical services from RIH to KGH by the Senior Executive Team, the July 18, 2019 letter went out to Drs. A, Hoonjan and C notifying them that the retinal surgical services were being relocated. There does not appear to be any Board approval of the relocation of retinal surgical services from RIH to KGH. The Senior Executive Team that approved the Decision Brief of March 2019 did not have the authority in the Medical Staff Bylaws to terminate the privileges of any physician. Bylaw 2.2 of the Medical Staff Bylaws clearly states the role of the medical staff organization to make recommendations to the Board regarding any privileging matters. There is no decision-making authority vested in senior medical management regarding privileging matters. The Board has the ultimate authority over all privileging matters. Surprisingly, the Decision Brief dated March 2019 notes that the presentation to the Board committee is not applicable. This demonstrates a significant lack of understanding of the roles and responsibilities of medical management staff and the Board.

[75] On the first day of this hearing IH admitted that neither the July 18, 2019 letter nor the March 18, 2020 letter constituted notice under any of the provisions of the Medical Staff Bylaws to terminate Dr. Hoonjan's Active Medical Staff privileges at RIH. However, IH senior medical leadership staff all maintained to Dr. Hoonjan up until the start of the hearing in these proceedings that the letters were effective termination of Dr. Hoonjan's privileges at RIH. Given the fact that IH senior medical leaders acknowledged in this hearing that there was not effective notice of the termination of Dr. Hoonjan's privileges, it is surprising that IH made the statement in its written opening statement that the privileges of Dr. Hoonjan were cancelled 12 months after the notice of July 18, 2019. IH changed its submission as part of its oral opening statement in this matter.

[76] The July 18, 2019 letter was purported to be notice of termination of Dr. Hoonjan's active medical staff privileges at RIH. The letter makes no mention of the termination of his privileges or states the provision of the Medical Staff Bylaws or Medical Staff Rules pursuant to which his privileges were being terminated. The Re: line of the letter states "Retinal Subspecialty Services with IH" and makes no mention of termination of privileges. In fact, the letter talks about an "exciting development" and states that Dr. E and Dr. D made a decision "that retinal surgical services should be relocated to KGH." It further notes that they are in the process of increasing the FTE at KGH to accommodate this expansion. The letter notes that

a job description will be posted shortly and invites both Drs. A and Hoonjan to apply. Finally, the letter concludes: "[w]e hope that Drs. A and Hoonjan support this direction and wish to continue the journey with us in providing optimal retinal care for all of our citizens." Given the importance of privileges to a surgeon, there is nothing in this letter which would suggest that a decision had just been made that could have devastating consequences to their practice and career. Dr. Hoonjan testified that he did not interpret the July 18, 2019 letter as terminating his privileges. The purported notice letter dated July 18, 2019 has fundamental flaws and is a completely ineffective notice. IH has admitted this point and there is no need to further detail or analyze the many flaws other than what has been said already.

[77] Dr. I became aware in early 2020 that the July 18, 2019 notice was not compliant with the Bylaws. He acknowledged in cross-examination that he did not notify Dr. Hoonjan that the notice was defective and that it would have been his responsibility to tell Dr. Hoonjan that fact and it would have been fair to notify Dr. Hoonjan about the defective notice. He said that his and IH's role is fair communications and that meant that communications should be clear. The July 18, 2019 notice was the opposite of fair or clear as it related to the termination of Dr. Hoonjan's privileges at RIH. Dr. I also stated that the Board was aware that the July 18, 2019 letter did not constitute effective notice of termination of Dr. Hoonjan's privileges but took the risk that Dr. Hoonjan would not appeal the issue. Dr. D testified that his understanding of the effectiveness of the July 18, 2019 notice evolved over time but that in the fall of 2019 he received advice from IH legal that the July 18, 2019 notice was not sufficient. Dr. E acknowledged that there was nothing in the July 18, 2019 letter which notifies Dr. Hoonjan or any of the other recipients that their privileges at RIH would terminate or stop on any particular date. He agreed that the July 18, 2019 letter was deficient notice of termination of privileges but said the legal department vetted the letter and advised him to send out something. The evidence on the involvement of the IH legal department is not entirely clear but it appears the issue of whether the July 18, 2019 letter constituted notice of termination of privileges pursuant to IH Medical Staff Bylaws was at least a live issue for IH management and Board.

[78] On April 29, 2020, the Board ratified the July 18, 2019 letter as notice of the relocation to Drs. Hoonjan, A and Dr. C. The only component of the relocation plan that the Board specifically approved was the increase in the MSRP in the KGH Ophthalmology Division from 4FTE to 8 FTE to accommodate the relocation which occurred at a Board meeting on July 30, 2019. The Board briefing note for the April 29, 2020 meeting, which sought to ratify the two purported notices previously sent by senior medical staff at RIH and KGH to Dr. Hoonjan, specifically noted that there was a risk the physician could challenge the decision to effectively terminate his active medical staff privileges at RIH. However, there was no specific Board decision to terminate Dr. Hoonjan's active medical staff privileges at RIH and only the Board has the ultimate authority to grant or terminate privileges pursuant to Bylaw 3.1.4 of the Medical Staff Bylaws. Dr. I acknowledged that the Board Briefing Note for the April 29, 2020 Board meeting did not seek to ratify the actual notice of termination of Dr. Hoonjan.

[79] The only actual decision in relation to the termination of Dr. Hoonjan's privileges at RIH was the decision of Dr. B that reduced Dr. Hoonjan's OR time at RIH to zero on July 31, 2020. This decision results in a constructive termination of Dr. Hoonjan's privileges which is ongoing to this date. Constructive termination of privileges through the allocation of no OR time was specifically accepted as a termination of privileges triggering appeal rights under section 46(1) of the Hospital Act in *PHSA v. Dr. Campbell* (Decision No. 2018-HA-002(f)). In light of the ineffective termination of his RIH privileges, Dr. Hoonjan could have brought an appeal of the ongoing constructive termination of his privileges at RIH at any time due to the ongoing nature of the refusal to provide any OR time.

[80] IH witnesses submitted that Medical Staff Bylaw 3.1.7 justified the termination of Dr. Hoonjan's privileges at RIH. It provides as follows:

> 3.1.7 The Board will give a member of the medical staff twelve months notice of any program or facility closure that will prevent the member from practicing within Interior Health.

[81] There are several problems with this position. First, it is clear that the Board must give the notice, and the July 18, 2019 letter was not from the Board. Second, the bylaw specifically identifies the closure preventing the member from practicing within Interior Health. The retinal surgical services were simply being relocated **within** Interior Health making this provision inapplicable to the relocation or transfer of a program within IH. Dr. I noted that in his discussions with the IH CEO, the IH Board thought Bylaw 3.1.7 meant the program closure had to be for all of IH, not just at a single site. Third, several IH senior medical staff argued that the retinal surgical services was not a program and was only a service. This makes any reliance on this bylaw provision completely ineffective and does not advance IH's justification for the termination of Dr. Hoonjan's privileges at RIH.

[82] Finally, the bylaw contemplates the termination of privileges essentially due to the inability to perform the member's services. If the interpretation of this provision leads to a termination of privileges then the Board, pursuant to Bylaw 4.5.8, must notify the member of the right to request a hearing before the Board. Dr. Hoonjan was never notified of this right even after pleading with senior medical staff in a meeting on December 10, 2019 and specifically asking if he could appeal to the Board. He was told he could not. While the meeting followed Dr. Hoonjan's unsuccessful appointment through the competitive hiring process, the senior medical staff were aware that Dr. Hoonjan still had active medical staff privileges at RIH and that issue came up in the meeting. It is astonishing that no one at IH ever advised Dr. Hoonjan of any right of appeal for the several decisions that ultimately led to the termination of his privileges at RIH.

[83] It is remarkable that the issue of the termination of Dr. Hoonjan's privileges at RIH was never specifically dealt with by the Board. The Board, through the relocation of the surgical services, must have known that Dr. Hoonjan's privileges at RIH would be affected but failed to properly address the issue in accordance with its Bylaws and failed to give Dr. Hoonjan notice of the termination or advise him of any of his rights of appeal. Even the September 11, 2020 Board decision under review did not make any statement that Dr. Hoonjan may have rights to a hearing before the IH Board or that he may have rights of appeal to the HAB pursuant to

section 46 of the Hospital Act. The Board has substantially breached its own bylaws which provide the most basic element of procedural fairness to Dr. Hoonjan.

[84] Given the special nature of the relationship between privileged medical staff and the governing hospital authority, basic notice of potential appeal rights to the Board and to the HAB is required to meet the basic concept of procedural fairness. This basic concept of procedural fairness was confirmed by Dr. I, the highest-ranking medical staff leader at IH.

c) What Duty Does IH Owe to Dr. Hoonjan and Did IH Comply with that Duty?

[85] IH submits that the HAB does not need to deal with any issues of procedural fairness of the underlying process as the hearing before the HAB is a hearing de novo. We are concerned that this submission by IH gives it a carte blanche to deny procedural fairness to a member of the medical staff with no consequences before this review body. We trust that IH takes its obligations under the Medical Staff Bylaws and Medical Staff Rules seriously and will take steps to ensure that the procedural fairness issues raised in this decision regarding proper notice of appeal rights and other issues will be addressed in the future. However, where there are serious breaches of procedural fairness by IH that affect the substantive rights of a member of the medical staff, such as a right of appeal before the HAB, then this body has an obligation to address those procedural fairness issues in exercising its discretion on whether to grant privileges to the Appellant or to direct IH to carry out a further search and selection process for a third vitreo-retinal surgeon at KGH.

[86] Whereas the Hospital Act defines the legislative agreement between the Health Authority and the Government of British Columbia, the Medical Staff Bylaws and its subordinate Medical Staff Rules form the legislative and regulatory relationship between the Health Authority and medical practitioners who wish to provide treatments using the facilities and services of the Health Authority in the care of their patients. The Bylaws form the social contract between the medical practitioner and the Health Authority through the granting of privileges, an authority granted solely by the Board of Directors of the Health Authority and enabled through the administrative leadership contracted or employed by the Board.

[87] In accordance with the Bylaws, members of the medical staff organize themselves into clinical departments identified by qualification to provide medical services. Representatives of these departments sit on advisory committees to provide advice to the Board through its medical administration. Individual medical staff members look to their department heads and administrative leaders to ensure they are in compliance with both the Bylaws and Rules. IH and particularly its senior medical leadership team have an obligation to make sure that the Medical Staff Bylaws and Medical Staff Rules are followed and that its medical staff members are aware of the application and effect of those Bylaws and Rules.

[88] Dr. Hoonjan was never provided notice that his application for privileges during the competitive search and selection process was not accepted by the Board. Dr. I stated that during the recruitment phase the person is considered a candidate and that only the preferred candidates are considered applicants during the

privileging phase. The preferred candidates are the ones that are put forward to the Board for approval of privileges and are the only ones considered applicants by IH. Therefore, under this formulation only successful applicants in the search and selection process would have a right to be approved or denied by the Board. This argument is non-sensical as successful applicants would not need a right of appeal and it is precisely the unsuccessful candidates (those that were not put forward by medical staff leadership as the preferred candidate and were just applicants as described by Dr. I) that would need a right of appeal. This is a significant problem for IH as Dr. Hoonjan at the December 10, 2019 meeting was seeking a right of hearing before the Board or appeal of his failure to obtain a position through the competitive hiring process and was told by senior medical leadership that he did not have any such right. This was wrong. Furthermore, Bylaws 4.3.5 and 4.3.8 require notice of any failed application to be given by the Board to the applicant. In this situation, notice of any appeal rights to the HAB would be a normal incident of procedural fairness expected of the health authority. Anyone who submitted an application for an open position and was interviewed and had references checked would be an applicant to which notice of any failure to appoint by the Board would be required under Bylaws 4.3.5 and 4.3.8. In fact, the *Guillen v. Island Health Authority* (Decision No. 2017-HA-001(a)) decision states that any clear expression of interest in obtaining hospital privileges is sufficient to constitute an application under section 46(1)(b) of the Hospital Act. Dr. I referenced the *Guillen* decision in his testimony but failed to provide Dr. Hoonjan the notice required pursuant to that decision and the Hospital Act.

[89] Bylaw 4.3.8 provides that if the Board fails to make a decision within 120 days of an application, the applicant may appeal to the Board for a hearing. There is no limitation period identified in this bylaw. Dr. Hoonjan could have petitioned the IH Board at any time 120 days after he submitted his application for a hearing before the Board. The limitation provisions of section 46(3.2)(a) of the Hospital Act would only apply after the Board made any decision after that hearing before the Board. Dr. Hoonjan was never advised by anyone at IH about his rights under the Bylaws and unfortunately was actually told that he did not have any right to a hearing before the Board when the Bylaws clearly identify that he did.

[90] Dr. I stated that following the *Guillen* decision they now ask people when they want the clock to start on their application because if they start it too early the application may be denied simply because the Board did not respond in sufficient time as set out in the Hospital Act. IH should not be able to opt out of the timelines set out in its Bylaws to consider an application and it is unfair to a potential applicant to ask them to forgo those timelines because IH may not get around to completing the application in the timelines set out in their Bylaws. The imbalance of power between IH and an applicant is substantial and essentially forcing an applicant to agree to extend these timelines when they are in the process of trying to get privileges with IH is quite frankly an abuse of power.

[91] Bylaw 4.5.8 provides a mandatory obligation on the Board if it alters the privileges of a member to provide the member with the right to request a hearing before the Board. The bylaw does not limit the types of situations involved in altering or terminating a member's privileges and this obligation would apply to all circumstances involving the alteration or termination of privileges whether for

disciplinary reasons or by virtue of the relocation of retinal surgical services which happened in this particular case. The Board did not provide Dr. Hoonjan any notice of his right to a hearing before the Board in relation to the termination of his privileges at RIH or in relation to the decision on September 11, 2020 to deny his application for retinal surgical privileges at KGH which lead to the appeal in this case. This panel finds that the Board did not comply with the notice provisions of Bylaw 4.5.8 regarding the privileges of Dr. Hoonjan.

[92] Medical Staff Bylaw 10 deals with the Medical Staff Association and provides at Bylaw 10.2 that elected members of the medical staff shall represent medical staff in general and, in particular, speak for the medical staff member. It also makes reference to informing the medical staff member of their rights under the Bylaws which would include any appeal rights regarding the termination of privileges. It is unclear from the evidence who was elected to the medical staff association at either RIH or KGH. However, there was no evidence of anyone assisting Dr. Hoonjan in determining what his rights were under the Bylaws. This issue was a focal point of the December 10, 2019 meeting with IH senior medical leadership who are the medical staff members responsible for ensuring the Bylaws and Rules are followed. No one at the December 10, 2019 meeting advised Dr. Hoonjan of any right either to a hearing before the Board, or to an appeal to the HAB, and in fact, erroneously advised him that he did not have any right of a hearing or appeal at that time. No one advised Dr. Hoonjan at the December 10, 2019 meeting or otherwise that he should consult with his elected medical staff association representative regarding his rights under the Bylaws. At the end of the December 10, 2019 meeting, after pleading for some avenue to reconsider his privileges or appeal, Dr. Hoonjan confirmed they were telling him that there was no pathway moving forward for any reconsideration of the issue of him continuing to provide the retinal surgical services that he was providing at RIH either at RIH or at KGH. The importance to Dr. Hoonjan of this meeting with senior medical staff leadership cannot be underestimated.

[93] Apart from the obligations of the elected representatives of the medical staff association, the responsibilities of Division Heads in the Medical Staff Rules, which follow the responsibilities of Department Heads, provide ample authority for Division Heads having a responsibility to look out for the interests of their medical staff members. For example, for communications and interactions with the Board, see Rule 15.3.12 and for compliance with professional standards, see Rule 15.3.5. There may be times, particularly related to a disciplinary matter, where the Department/Division Head's responsibilities to its members and senior medical staff conflict and this is where there needs to be clear notification of the members' rights by the Department/Division Head and involvement of the elected medical staff representative for the member. None of this happened in relation to the termination of Dr. Hoonjan's privileges in this case. At a minimum, several members of the medical staff leadership had a duty to advise Dr. Hoonjan to consult with his elected representative of the medical staff association. In the absence of doing that, the obligation fell to those same medical staff leaders to advise Dr. Hoonjan on his rights of a hearing and appeal pursuant to the Bylaws and Rules.

[94] Dr. Hoonjan had privileges at RIH and limited privileges at KGH and there was no evidence that any member of the medical staff leadership at either hospital

provided him any guidance on dealing with the Board or HAMAC or senior medical leadership regarding the termination of his privileges at RIH or the two unsuccessful applications for privileges at KGH. This is a significant failure of the system of organization of responsibilities in relation to the medical staff at IH.

[95] When the obligations detailed above are considered together, it establishes that IH has an obligation to provide a medical staff member with some assistance on the interpretation and application of the Medical Staff Bylaws and Rules, particularly as they relate to the alteration or termination of a member's medical staff privileges. In Dr. Hoonjan's circumstances, he received no assistance in relation to the termination of his privileges at RIH or the refusal of his two applications for privileges at KGH. Several people at IH owed Dr. Hoonjan this duty and every one of them failed to comply to any reasonable standard. These failures led Dr. Hoonjan to make his unsolicited application which was denied by the IH Board on September 11, 2020.

d) Was the Previous Competitive Search and Selection Process Fair?

[96] There were several significant deficiencies in the previous competitive hiring process by IH which rendered it unfair to the Appellant. Those deficiencies are as follows:

i. Dr. Hoonjan's references were not contacted except the RIH COS reference;

ii. Too much reliance was placed on the RIH COS reference and, in particular, his negative reference flowing from the patient X surgery in comparison to the complaint against Dr. A;

iii. Improper conclusions were drawn from X surgery complications;

iv. Too much reliance was placed on views/decisions of the Opthalmology Division at KGH;

v. There was improper reliance on a new program when this was not a new program but the relocation of an existing program; and

vi. There was a failure to properly assess currency issues.

i. Dr. Hoonjan's references were not contacted except the RIH COS reference

[97] Dr. I acknowledged that checking references is an important step in the search and selection process and is considered basic due diligence. He agreed that it would be a fundamental flaw not to check references in this process which would undermine all of the decisions of the decision-making bodies that relied on that basic due diligence all the way to the Board level. Dr. F, who was the COS of KGH at the time of the competitive hiring process, confirmed that he only contacted the RIH COS reference for Dr. Hoonjan and did not contact the other references. He stated that for internal candidates they relied on the COS at the site where the applicant was practicing. This is very problematic as it ignores what the other references, who were also members of the medical staff in IH, had to say, and their views may be very different from the view expressed by the relevant COS. In

addition, there could be some conflict, interpersonal or otherwise between the internal medical staff member and the COS which may unduly influence the COS's reference. The failure to even check these other references essentially elevates the COS reference to a deciding factor, particularly if it is not a favourable reference. That is what occurred in this process in relation to Dr. Hoonjan. The HAB had the benefit of hearing from an optometrist and two ophthalmologists who are members of the medical staff in IH who provided excellent references for Dr. Hoonjan. One of them was listed as a reference for Dr. Hoonjan during the competitive hiring process and confirmed that he was never contacted but definitely would have given a favourable reference. It is troubling that, in their submissions, IH mischaracterized the evidence of the two ophthalmologists who testified in favour of Dr. Hoonjan regarding their referral practice and preferences. Such mischaracterization does nothing to advance IH's argument.

[98] The testimony of the references included that: they would both refer surgical cases to Dr. Hoonjan; patients really liked Dr. Hoonjan; he was easy to get a hold of and was quiet and had a very calm demeanor; he would always take emergency cases and had taken some when the retinal surgeons with privileges at KGH were not available to perform in office emergency treatments and consultations; he was not technically on call but always available to deal with retinal emergencies; patients were seen very quickly and had positive experience; there were no issues with patients referred to Dr. Hoonjan; he went out of his way for patients; he was always accessible after hours; there were no patient care concerns; and patients remarked positively about his bedside manner. The panel was taken with the consistency of the positive feedback by practitioners that have worked with Dr. Hoonjan, including Dr. E, who testified that Dr. Hoonjan provided excellent care for a family member. It is difficult to accept that these references would not have been relevant to a search and selection process, particularly when the COS reference was negative.

ii. Too much reliance was placed on the RIH COS reference and in particular his negative reference flowing from the patient X surgery in comparison to the complaint against Dr. A

[99] The RIH COS reference for Dr. Hoonjan was not positive and was almost exclusively focused on the one patient case of X. Dr. F, who did the reference check with Dr. B, described the case in his notes as a case of surgical misadventure, a serious negative characterization flowing from Dr. B's reference. The conclusions about the case articulated by Dr. B are flawed and without reasonable foundation. The patient X case will be discussed in further detail below. Pursuant to Dr. F's request, Dr. B emailed Dr. F further documents of the investigation of the patient X incident, which included a letter from Dr. B to Dr. Hoonjan with Dr. B's findings and recommendations, the report of a member of the quality committee at RIH and the complaint, which involved the version of events of the nurses who submitted the patient safety learning system report. The actual patient never made a complaint to the hospital, or to anyone else. Dr. Hoonjan made several detailed responses to the issues raised in Dr. B's letter to him, and these were never forwarded by Dr. B to Dr. F. Dr. B noted that in retrospect he could have sent Dr. Hoonjan's responses but did not. The failure to send the complete set of documents regarding the

incident deprived the receiver of the full account of events and is very prejudicial to Dr. Hoonjan.

[100] Dr. B also noted in the reference that there were previous incidents documented in the quality folder, but no evidence was provided about these. It appears that Dr. F focused on the X incident and not any other quality issues. Every surgeon has cases where the process or outcome is not optimal and to base an entire career on one interpretation of that surgical outcome is misguided. As active members of the medical staff, Drs. B and F should know that. Despite the concerns identified by Dr. B, he still approved Dr. Hoonjan's active medical staff privileges at RIH after this incident without any conditions, restrictions or notations.

[101] The reference to other quality issues cannot be considered by this panel. The panel made an order prior to the hearing that if IH was going to rely on any quality-of-care incidents it was required to disclose those so that the Appellant would be able to fairly respond. IH only raised the patient X incident so any other mention of quality issues that may have affected the hiring decision cannot be considered by this panel, otherwise, the Appellant's procedural rights would be ignored. Therefore, to the extent that the reference of the RIH COS relied upon previous incidents in the quality folder, that reliance would be in error before this panel.

[102] The grave concerns identified by Dr. B regarding the one patient X incident stand in stark contrast to a patient complaint against Dr. A. The reference notes of the RIH COS for Dr. A say minimal interaction and no concerns raised to COS level. However, just several days after the reference was given for Dr. A, Dr. B received a patient complaint involving a surgical procedure performed by Dr. A. Patient LS identified problems with the procedure and indicated that it was devastating to his life. Dr. B forwarded this to Dr. F and others, as he was aware that the recruitment process was underway, and stated that he had not looked into this yet. Unfortunately, Dr. B never investigated the incident. Dr. F, the KGH COS, stated that the responsibility to investigate the complaint against Dr. A would fall to the RIH COS, but he never confirmed with Dr. B whether the complaint was investigated or the outcome of any investigation. Dr. B stated that because the program was moving and the complainant indicated in his complaint that he was also making a complaint to the College of Physicians and Surgeons, he made the decision not to investigate the complaint. Dr. B stated that he was skeptical of the complaint and, when asked in cross examination whether the complaint was serious, he was evasive and reluctantly stated that he took all complaints seriously. However, this is not entirely in line with his statement that he was skeptical of the complaint. He never stated why he was skeptical but said he did not take everything in the complaint as fact, yet he relied on the complainant's statement that he was making a complaint to the College. He stated that he was comfortable with the College of Physicians and Surgeons investigating the complaint but never took any steps to even determine if they were aware of the complaint. The College and IH have different interests to deal with and it appears unusual to the panel that the complaint was never addressed in any manner by anyone at IH. The fact that Dr. B took no steps to investigate this patient complaint against a member of his medical staff is surprising.

[103] The issue with the complaint is not whether or not there is merit to the complaint itself; the issue is that the complaint against Dr. A was handled very differently by Dr. B than the patient issue against Dr. Hoonjan, where the patient never actually made a complaint. The differences in handling the two complaints continued with Dr. F and the consideration of the complaints as part of the competitive hiring process. Dr. E confirmed that in the end the difference between Dr. Hoonjan and Dr. A always came back to quality-of-care issues. This panel can see no reasonable justification for the difference in treatment between two applicants regarding complaints that were brought to their attention in the search and selection process. One was essentially ignored and the other one was used to justify no further consideration for a position.

[104] What is clear is that the other references of Dr. Hoonjan had significantly more detailed and better information regarding his skills and abilities than Dr. B, who relied on one incident and otherwise was not involved in any patient care issues with Dr. Hoonjan. As the panel outlines later in this decision, Dr. B's handling of the patient X surgery was flawed. As noted above, Dr. F stated that IH has removed the requirement for references other than the COS for internal candidates. This sets a dangerous precedent. Other references provide a basic check on the accuracy and consistency of practice when the COS may be biased or particularly influenced by one event, or where there is some interpersonal or other issue between the two individuals.

[105] Dr. F noted in an email dated October 28, 2019, that they will complete reference checks for all three references of both the internal and external candidates to ensure all candidates are being treated equally, as this is a competitive process. However, in an email on November 3, 2019, after the RIH COS reference on November 1, 2019, Dr. F advised Dr. E and others that there was no need to proceed with the other references for Dr. Hoonjan. The failure to consider the other references for Dr. Hoonjan is a significant failure of the search and selection process which compromised the decision-making process all the way to the Board level.

iii. Improper conclusions drawn from X surgery complications

[106] The X incident arose from a patient safety learning system ("PSLS") report following the care of patient X on November 15, 2018. Evidence was given that the purpose of the PSLS is to learn and improve from patient events. It is not a punitive or disciplinary process. The PSLS report was submitted by non-medical staff employees of RIH. The concerns raised were with the operation of the Constellation equipment and the length of time the surgery took. The non-medical staff who made the report noted that the cataract was one of the most mature cataracts they had ever seen and was incredibly discoloured and hard, making this a very difficult case. There were issues regarding the operation of the Constellation machine and Dr. Hoonjan sought the assistance of the nursing staff who felt it was stretching their skill set. Patient X was referred by a cataract surgeon as it was beyond their scope of practice and the patient wanted Dr. Hoonjan because the patient only spoke Punjabi which Dr. Hoonjan also spoke.

[107] On November 26, 2018, Dr. B asked Dr. M, the Department of Surgery Quality Committee representative, to review the PSLS event. Dr. M is a general surgeon and did not hold active medical staff privileges at RIH at the time he performed the review of Dr. Hoonjan. Dr. M's initial response on November 28, 2018 was that the incident was more of a performance problem than a technical skill shortcoming and the evaluation would need to be done by another ophthalmologist. He also wanted to know if this was a one-off event or if there have been other difficulties. Dr. M sent a one-page report on the review of the case to Dr. B on December 3, 2018. Dr. M notes that he interviewed the two nurses who were present for the surgery and the anesthesiologist as well as reviewing the patient's chart. He acknowledges that he did not discuss the matter with Dr. Hoonjan. The failure to discuss the matter with Dr. Hoonjan is fatal to any conclusions from the report. Any basic investigation requires speaking to the person against whom issues have been raised. In addition, the report notes that Dr. M interviewed the anesthesiologist but there are no notes of these discussions, and the Appellant submits that there was no anesthesiologist by that name working at the time at RIH. The panel finds that the conclusions of Dr. M are just a form of recitation of the initial concerns noted by the nursing staff. Dr. M does note that neither the anesthesiologist nor the nurses indicated any problems around inappropriate language or anger. This would suggest that whatever problems Dr. Hoonjan may have had with staff he was respectful in his communications with all people involved in the care of the patient. Dr. M concludes that he did not identify a systems issue that would be a source of more general learning or quality improvement and he did not recommend a review by the quality committee. He recommended an accountability review as the difficulties centered around operative skills and knowledge and possibly the function of the Constellation equipment, and therefore, he recommended the review be conducted by an expert ophthalmologist with expertise on this particular equipment. It is clear by his use of the word "possibly" that he had reached no firm conclusion regarding the actual patient care or skill of Dr. Hoonjan and recommended further steps to investigate.

[108] After receiving Dr. M's report, Dr. B had a meeting with Dr. Hoonjan on December 10, 2018 and sent him a letter summarizing their conversation dated January 2, 2019. Dr. Hoonjan responded to that letter on January 27, 2019 and Dr. B sent a final letter to Dr. Hoonjan regarding the incident on February 11, 2019. Dr. B's letter does not make any recommendations other than additional training from the Constellation representative on the machine's operation and settings. Dr. B does make findings about the use of incorrect factory settings of the Constellation machine. This is the first time that the Constellation machine settings were raised by Dr. B in this review. It is unclear how Dr. B came to this conclusion as there was no information from the Constellation representative in the evidence, there being only the evidence of the nurses about the settings. However, the nurses issue arose because they were not as familiar with the machine settings as Dr. Hoonjan expected. Dr. Hoonjan testified that there is no such thing as factory settings as he had his own settings for the Constellation machine and he said the Constellation representative advised him that even if the factory settings were used it was not the problem. This panel prefers the evidence of Dr. Hoonjan over Dr. B on this point as Dr. Hoonjan is the expert on the use of the Constellation machine and Dr. B admitted that he is not familiar with the operation of the Constellation machine.

[109] The Constellation representative did attend after this incident and updated Dr. Hoonjan's settings for the Constellation machine; however, Dr. Hoonjan was not notified of this and was not present for the representative's site visit. In fact, once Dr. C found out about the attendance of the representative at RIH, he also requested that the Constellation representative update his settings to the most up to date available. There is no basis in the evidence for the conclusion that the difficulties in the case were due to Dr. Hoonjan's lack of knowledge of the Constellation machine settings. IH could have called the Constellation machine representative or provided some evidence from him but failed to do so.

[110] In addition, Dr. Hoonjan called an expert witness to testify regarding the X case. The expert qualifications were unchallenged by IH. The expert, Dr. L, found that the surgical care and management provided by Dr. Hoonjan in the X case were appropriately delivered. He also found that Dr. Hoonjan worked through the difficulties with the Constellation machine reasonably as the issues arose.

[111] In October 2021, prior to testifying in this matter on November 10, 2021, Dr. B asked for the PSLS items for patient X that were discussed at the RIH Quality Committee. The correspondence indicates that there was no record of anything going before the RIH Quality Committee. This accords with the recommendation of Dr. M that review by the quality committee was unwarranted and an accountability review was more appropriate. Dr. B did not follow the recommendations of Dr. M regarding the conduct of the accountability review which required expert opinions on the use of the machine. Dr. B said this was because he did not think he would get an unbiased review by one of the local vitreo-retinal surgeons. This was an astute observation but should have led to a review by a vitreo-retinal surgeon from the Lower Mainland, or somewhere outside of IH, who was not familiar with the interpersonal and historical issues amongst the surgeons.

[112] On the totality of the evidence adduced before this panel, we find that Dr. Hoonjan's care of patient X was appropriate and his use of the Constellation machine in the care of patient X was appropriate. Further, there were several significant flaws in the accountability review conducted by Dr. B which make it unreliable.

[113] IH has submitted that Dr. B was troubled by Dr. Hoonjan's lack of accountability and ownership of the quality improvement and also that he blamed the equipment and nursing staff. Dr. B was also troubled by Dr. Hoonjan's lack of insight into his case selection, experience, skillset and currency. Dr. B requested to be advised of any surgeries by Dr. Hoonjan involving the anterior chamber of the eye. In December 2019, Dr. Hoonjan performed two of these cases and Dr. B testified that there were no concerns with Dr. Hoonjan's handling of those procedures. There was no evidence that Dr. Hoonjan's case selection was not appropriate other than the nurses' statements that this was an unusual procedure and Dr. Hoonjan's expert stated that the case selection was appropriate and within Dr. Hoonjan's skillset. The panel accepts the evidence of Dr. Hoonjan's expert in this regard.

[114] RIH arranged for the nurses to receive training from the Constellation representative but did not notify Dr. Hoonjan of the time and date of the attendance by the Constellation representative so he would be able to take

advantage of the opportunity. Dr. Hoonjan testified that he was surprised to learn that the Constellation representative had attended RIH and provided training on the Constellation machine to the nursing staff and that he was not informed or invited, particularly in light of his expressed desire to Dr. B to participate in such training. The difference in treatment is evident as Dr. C easily obtained the available OR time to get updated training on the Constellation machine while Dr. Hoonjan had to battle for every piece of OR time that he could get, even when the training was further to the recommendation of the COS at RIH.

[115] In light of the difficulties Dr. Hoonjan had with Dr. C and booking OR time, he was apprehensive of making waves and appears to have wanted simply to avoid unnecessary conflict and work amicably with the medical staff. Dr. Hoonjan testified that when he raised the issues about OR bookings and scheduling training with senior medical staff at KGH, there was no resolution.

[116] Dr. B and others at IH thought that Dr. Hoonjan should not have deflected blame and responsibility for the patient X incident to the nursing staff and should have taken more responsibility. When he did not do so, they felt he lacked insight. This panel has found that Dr. Hoonjan did nothing inappropriate in the case of patient X, so the conclusions of others at IH based on Dr. Hoonjan's failure to accept responsibility are unfounded as are their conclusions that he lacked appropriate insight. As the HAB noted in the recent case of *Vedam v. PHSA*, issues of lack of insight need to be viewed in the context of any perceived biases against the Appellant. At paragraph 50 the HAB noted:

> PHSA notes that the Appellant raised issues of racial bias. At this stage, no determination can be made about the validity of those concerns. However, it is noted that racial biases are not always obvious, and parties need to be aware of any unconscious biases as well as system racism. In circumstances where unconscious and systemic bias exist, members of marginalized groups may be reluctant to make certain admissions for fear they will not be dealt with fairly. It does not appear that PHSA has considered this possibility when placing significant weight on the Appellant's lack of insight into her deficiencies.

[117] In fact, Dr. Hoonjan testified that in relation to the allegation of blaming the nurses, he was not happy with what he said about the nurses and could have chosen his words more carefully. However, he testified that he was defensive as he thought that if he gave an inch, IH would take a mile and he was worried any statement would be assessed punitively against him and this one case could be the end of his career. Given the historical differential treatment Dr. Hoonjan received from IH, it is understandable why he would be reluctant to provide too much information when it may be used against him. IH has failed to adequately consider this implicit bias factor in assessing Dr. Hoonjan's lack of alleged insight. Dr. B's reference for Dr. Hoonjan was based on the characterization of the surgical misadventure of patient X. He stated that Dr. Hoonjan was practicing outside the usual scope of his practice and did not seek help when trouble arose and was unwilling to accept responsibility and unwilling to change his practice. None of these statements were found to be true by this panel. Clearly this reference had a significant impact on the search and selection committee as it decided not to proceed with any further reference checks for Dr. Hoonjan.

iv. Too much reliance was placed on the views/decisions of the Ophthalmology Division at KGH

[118] Dr. I and Dr. E both stated that as IH medical staff leaders they would not go against the decision of the responsible Division Head in any hiring decision. The problem with this is that as a health authority grows and provides specialized care at only certain sites, a larger perspective than a local Division Head may be required and under their current procedures, which effectively rubber stamps the decision of the Division Head, these important considerations may be missed or not as fully developed.

[119] The Ophthalmology Division Head at KGH testified that he could not remember how the members of the division came to a unanimous conclusion about which candidates to select but they did come to a unanimous conclusion. He also stated that Dr. Hoonjan was a good guy and hardworking and noted that previously he used to call Dr. Hoonjan about retinal issues, but he was concerned about the limited scope of work he could perform. The Division Head appeared more concerned about whether he could participate in the general ophthalmological call schedule than whether he was a good fit for the needs of the patient population of IH. This is one example of why Division Heads' decisions cannot be elevated effectively to the decision of the Board as they may well (necessarily) have self-interested issues which may not be in line with other larger regional issues in what is best for the larger patient population of IH, specifically for retinal surgeries. The need for a vitreo-retinal surgeon within IH should not be determined by only those in the ophthalmology division at KGH. There is no evidence that other ophthalmologists within IH but outside of KGH were consulted about their referrals or what they were seeing. In addition, there is no evidence that the existing vitreo-retinal surgeons were consulted on what needs they were seeing within IH.

[120] The evidence from senior medical leadership that they could not go against the decision of the division members is troubling and raises questions around the level of effective oversight they are providing to the process.

[121] The problem is that Dr. K, the Ophthalmology Division Head at KGH, Dr. F, the COS at KGH, and other management are at odds with one another on certain issues. Dr. K is more concerned about how subspecialties are going to affect his practice and on-call obligations whereas management cares about service delivery across all subspecialties and the patient needs of all IH patients. They are not using the same data and analysis and while management has the ultimate authority, they have indicated that they would not make decisions against the Division Head. This is simply not the way a hospital authority is supposed to work, particularly one with central management. The email exchange in March 2021 between the two is a clear example of this. Dr. K wanted to limit the geographic area within IH that they accept retinal emergency cases and Dr. F responded that the answer is not to limit acceptance of IH retinal patients but if there are unexpected volumes then extra resourcing should be explored. In another email exchange in April 2021, Dr. K appears more concerned about how much money the retinal specialists make compared to other ophthalmologists on the call schedule and he does not want anyone being considered a second-class member of the Division whereas Dr. F is concerned about a solution that gives all patients of IH the best access to retinal

care over time. Dr. F is providing the oversight necessary when considering more global IH issues rather than simply accepting the views and recommendations of those in the ophthalmology division who have different interests at stake.

[122] The conflict is also evident in discussions about on-call obligations of the vitreo-retinal surgeons. Dr. K stated that the retinal surgical call was never supposed to be 24 hours 7 days a week coverage. However, that was exactly what the Briefing Note in March 2019 for the relocation of the retinal surgical services called for with a 1 in 4 retinal on-call coverage. This Briefing Note was approved by the Senior Executive Team of IH and should take precedence over the views of a local Division Head. Dr. E stated that 1 in 4 was a stable on call situation. Dr. E stated that the two retinal surgeons have expressed some call concerns as there are only two of them and their surgical targets are too high. Dr. E stated that a 1 in 2 on call was not sustainable and others have expressed similar concerns that a 1 in 2 on call coverage was not sustainable in the long run. Dr. K says that the only metric he cared about regarding need for an additional vitreo-retinal surgeon was unused OR time by the retinal surgeons; therefore, there is no need in the community because there is unused OR time. This is contrary to the concerns raised by Drs. G and A about burnout and that volumes were too high. The unused OR time along with refering patients out of IH for retinal treatment indicate that there is need for another retinal surgeon, not the opposite as Dr. K suggests.

v. Improper reliance on a new program when this was not a new program but the relocation of an existing program

[123] Dr. F, the COS of KGH at the time of Dr. Hoonjan's application, stated that the relocation of the retinal surgical services was not intended to add surgical retinal resources but just transfer existing surgical retinal OR time from RIH to KGH. This refutes the argument that the position listed at KGH was different than the position at RIH. The Decision Brief for the IH Senior Executive Team also supports that this was simply a transfer of the retinal surgical services that were being performed at RIH to KGH. The focus in the interview on program development for a program that was simply being transferred from another location is not a compelling factor in the selection process. The improper focus on program development was used as a negative for Dr. Hoonjan when it should not have been a significant factor and, as Dr. Hoonjan had been in the Division at RIH providing the retinal surgical services for years, it should have been a positive factor for him as he identified several areas to improve upon in the interview.

vi. Failure to Properly Assess Currency Issues

[124] Several senior medical staff leaders at IH were concerned about the currency of Dr. Hoonjan's surgical skills. Dr. D collected information about the number and type of surgeries performed by Dr. Hoonjan around the time the purported July 18, 2019 notice went out about the relocation of the retinal surgical services to KGH. It is unclear why Dr. D was collecting this information at this time or why Dr. Hoonjan was singled out for this review. There is no indication that similar information was being sought for the other retinal surgeon at RIH at that time. In July 2019, Dr. D sent an email to Dr. E, attaching information about Dr. Hoonjan's surgeries at RIH and saying that "[t]his is a lot more ammo for the open job competition". Dr. D

tried to downplay the use of the term "ammo" in this email and said it was not intended to be used against Dr. Hoonjan. Dr. E interpreted the comment that the information about surgical volumes related to Dr. Hoonjan's application at KGH. The panel finds that these comments were intended to single out Dr. Hoonjan for criticism and similar investigations were not done at that time by anyone else for the other retinal surgeon at RIH who was going to apply for the position at KGH. In general, the panel finds Dr. D's evidence was evasive and at times condescending. Where there is evidence that conflicts with his evidence, the panel accepts that opposing evidence. While the reason is not entirely clear, it is clear that Dr. D treated Dr. Hoonjan differently from OR time disputes, Constellation training and through the competitive application process.

[125] There are a series of emails in October 2019 started by Dr. D to members of the senior medical staff leadership at IH and members of the search and selection committee for the retinal surgeon position at KGH. These emails relate to the issue of Dr. Hoonjan's surgeries and whether he was current pursuant to the privileging dictionary. The underlying theme of these email exchanges is that senior medical leadership members of IH were relying on the surgical data of Dr. Hoonjan to argue that he was not current and therefore could not be successful in the competitive application process. The Manager of the OR Booking at RIH, who was assisting in providing surgical information to Dr. E in October 2019, noted that she had not been asked to provide the similar information for Dr. A but essentially took it upon herself to provide that information as well. In an email dated October 17, 2019, Dr. J concluded upon his review of Dr. Hoonjan's surgical volumes that he "obviously lacks currency to satisfy the privileging dictionary for retinal surgery".

[126] Given this statement by Dr. J, Dr. E sought the advice of Dr. N, Senior Medical Director of Credentialing and Privileging and she confirmed that the privileging dictionary focused on hours of surgery and not number of procedures. Dr. N quotes from the ophthalmological privileging dictionary as follows:

> Current experience thresholds suggested in this document were developed by practitioners in the field, and are *not* intended as a barrier to practice or to service delivery. They are *not* intended as rigid cutoffs, below which clinical privileges must be restricted or removed. Instead, medical/clinical leaders are encouraged to initiate discussions with those practitioners who are close to or below the thresholds, to ensure that mechanisms are in place to ensure adequate practitioner experience and patient outcomes.

[127] Dr. N stated that without knowing the exact length of each procedure it is difficult to come to any final conclusion but that, in theory, based on his allocated OR time, Dr. Hoonjan could have enough hours to satisfy the privileging dictionary guidelines. Unfortunately, the email exchange and clarification of the currency guidelines in the privileging dictionary obtained by Dr. E was not shared with the others who were involved in the previous email exchange, which concluded with Dr. J's statement that Dr. Hoonjan did not meet the currency requirements in the privileging dictionary for retinal surgery. This oversight is very surprising to the panel and significantly prejudiced Dr. Hoonjan in the competitive application process.

[128] Dr. Hoonjan testified that given his hours of surgical procedures he did meet the currency guidelines in the ophthalmological dictionary. The panel accepts his evidence in that regard. However, this is not a dramatic finding as the dictionary only talks about guidelines and specifically states that they are not intended as rigid cutoffs. Senior medical leadership at IH were using these as rigid cutoffs in the competitive application process and appeared to have ignored their obligations under the privileging guidelines quoted above. The currency issue was not addressed with Dr. Hoonjan until it was used against him the competitive application process. The panel would have expected that if there were currency issues that medical/clinical leaders would have initiated discussions with Dr. Hoonjan to ensure that mechanisms were in place to keep and develop his skills as the privileging dictionary requires.

[129] Dr. Hoonjan testified that he tried to get more OR days and was denied by Dr. C. The panel was also presented with evidence that Dr. Hoonjan had a waitlist, so the panel finds this was not a patient issue but an OR access issue. Dr. D said that Dr. C did not control the OR schedule, but that is not the evidence that was presented as to the current practice by Dr. Hoonjan, and this panel accepts Dr. Hoonjan's evidence over Dr. D's evidence. Dr. Hoonjan was not invited to the Constellation training organized for the nursing staff after the patient X incident. Dr. B says that is not his responsibility, but the panel finds that he does have an obligation as COS to ensure appropriate training opportunities for the medical staff. Medical/clinical leadership do have a significant role in promoting medical staff development and training pursuant to the section 15 of the Medical Staff Rules, which includes the promotion of professional development and continuing medical education as one of the fundamental purposes of establishing medical staff departments. Medical leadership also have obligations pursuant to the privileging dictionary as referenced above. IH failed to follow its own procedures regarding any currency issues with respect to Dr. Hoonjan, and the panel finds it would be unjust to allow IH to use its own failure as justification for a decision not to grant privileges to Dr. Hoonjan.

e) Differential Treatment of Dr. Hoonjan

[130] There are several instances where IH treated Dr. Hoonjan differently than other similarly situated physicians without an adequate explanation for this differential treatment. Examples of differing treatment are the allocation of surgical days at RIH, the training of Dr. Hoonjan on specialized equipment, the treatment of complaints against Dr. Hoonjan, the improper reliance on program development in the interview process and the misapplication of the currency issue. The different treatment of the complaints against Dr. Hoonjan, improper reliance on program development in the interview process and misapplication of the currency issue have been discussed above.

[131] Dr. Hoonjan testified that he always received complications in trying to book OR time to have the Constellation representative attend to do some training. This had been a long standing and documented issue of Dr. Hoonjan going back to 2015 when, because of the delays in setting up the necessary training, IH had to create a surgical reintroduction plan for Dr. Hoonjan. Dr. Hoonjan testified that the delays were caused by scheduling and other interpersonal conflict with Dr. C, who

controlled the retinal surgery OR time. It appears that IH accepts that the interpersonal conflict between Dr. C and Dr. Hoonjan started in 2013 when, as IH described it, Dr. Hoonjan fell out of favour with Dr. C. Perhaps this was due to Dr. C's inappropriate use of locum services of which IH became aware and did nothing to deal with any interpersonal conflicts which may have continued from that situation. Dr. Hoonjan appears to be the one that suffered from Dr. C's inappropriate conduct pertaining to the Medical Staff Bylaws.

[132] Dr. C was the senior surgeon and Dr. Hoonjan and Dr. A were supposed to get equal operating time for their patients. This is not what occurred. It is unclear whether there was a Division Head of ophthalmology at RIH, but Dr. C appears to have been to some extent responsible in terms of OR scheduling. Dr. Hoonjan personally testified that the surgical schedule was "controlled" by Dr. C's office, from whom he had to ask for information about OR availability. This was denied by Dr. D, who stated that this was done by the RIH Perioperative management committee, but he gave no information as to which of the ophthalmologists provided their division's input to that committee, or again who was the ophthalmology division head. There has been no evidence as to whether the five ophthalmologists at RIH held or participated in regular departmental or divisional meetings as required by the Medical Staff Bylaws 6.2.5 or whether they participated in an on-call schedule required by Bylaw 6.2.4. There was evidence that Drs. Hoonjan and A did not participate in the on-call schedule at RIH and there was no evidence providing a reason for this.

[133] Regarding OR time, it seems clear that Dr. Hoonjan received less OR time at RIH than others with his same .2 FTE allotment such as Dr A. The reason for this was never clear. IH had the authority to provide evidence from the RIH perioperative management committee regarding OR scheduling and did not do so. Dr. Hoonjan testified that he always requested extra days and whatever OR time he could get and yet was consistently given less OR time than Dr. A. Dr. Hoonjan and Dr. A were both .2 FTE and this translated into 1 OR day per month. The records show that Dr. A consistently received more OR time than Dr. Hoonjan. Dr. Hoonjan testified that the OR schedule was set a month prior by Dr. C, that he got the last pick of day and that there were no emails or consultation. He also testified that he was very eager to pick up whatever extra time he could but was never given any extra days or the opportunity to bypass Dr. C to pick up these extra days. He stated that he did not even get the mass emails about the take back days until Dr. C retired. This would have prevented him from knowing about any extra days. Dr. Hoonjan was asked why he did not say anything and responded that Dr. C controlled the OR schedule and no senior management at IH would challenge that reality.

[134] IH submitted that Dr. A took the initiative and picked up give back OR time from other surgeons as and when it was made available. In support of this submission, IH relies on an email from the manager of the OR booking at RIH that Dr. A picked up 3 ENT OR days that were given back in March of 2020. Dr. Hoonjan's evidence was that he was not receiving the emails regarding take back days until Dr. C retired. IH did not forward any evidence to refute this evidence in reply. It seems that Dr. A was either getting the emails from the manager of OR booking regarding take back days or perhaps he was getting them forwarded from

Dr. C. What we see is different treatment between the two similarly situated surgeons, and the reason is not the initiative of one of them as submitted by IH.

[135] There is a telling email exchange between Dr. Hoonjan and Dr. C in 2013 where Dr. Hoonjan is requesting assistance to schedule OR time to have the Constellation machine representative attend so he could be trained on one of the machines used for vitreo-retinal surgeries. Dr. Hoonjan had been corresponding with Dr. C's assistant but was not getting any clear responses. Dr. C responds that Dr. Hoonjan should stop constantly asking his assistants for available OR time when none is available. Dr. C stated that he would contact Dr. Hoonjan when time was available. While it is unclear exactly what happened after this email exchange, and it is not relevant to the privileges determination in this matter, it is relevant to the regular mistreatment of Dr. Hoonjan by IH. It appears that the issue of training on the Constellation machine was not picked up again until 2015 and 2016 when Dr. Hoonjan finally received the training. Dr. Hoonjan testified that he sought the assistance of the Executive Medical Director and the COS at RIH at the time and they essentially ignored him. Dr. Hoonjan stated that he had to rely on other doctors to advocate for him until he received the OR time for the necessary equipment training, which came about due to Dr. C's inappropriate use of locum services and not anyone responding to Dr. Hoonjan's requests. Dr. A was given this training a couple of years before Dr. Hoonjan, was still doing locum services for Dr. C and appears to not have had the conflict with Dr. C that Dr. Hoonjan did. Dr. D testified that sometime in 2015, IH discovered Dr. C was inappropriately using the locum services. Dr. D says that Dr. C did not have the ability to select or change OR days. This evidence directly conflicts with the evidence of Dr. Hoonjan. IH could have called someone from the perioperative management committee to refute this and did not. It is clear that IH did not fully appreciate what Dr. C had been doing for years with his misuse of locums, and the panel is prepared to accept Dr. Hoonjan's evidence on this point regarding Dr. C's control over OR days for Constellation or other machine training. This is supported by Dr. Hoonjan's testimony that he did not get the mass OR take back emails until Dr. C retired. If Dr. C did not control the OR time for the retinal surgeons then Dr. Hoonjan, as a member of the active medical staff would have received these emails and his evidence was that he did not.

[136] Furthermore, in reply IH submitted that Dr. C may have taken responsibility for scheduling the three vitreo-retinal surgeons on particular OR days, but that he did not control the actual allocation of the number of OR days. This is essentially an admission that Dr. C did in fact control the scheduling, which is why Dr. Hoonjan did not get any extra days and Dr. A did. This submission corroborates the testimony of Dr. Hoonjan that he did not get the mass OR take back emails and that he was always requesting additional days from Dr. C and never received them. The fact that IH allowed Dr. C to have control over the OR scheduling for two vitreo-retinal surgeons that he had improperly used as locums is troubling and should not have occurred. Dr. Hoonjan was regularly providing locum services to Dr. C and it took more than 2 years to schedule OR time to do training so he could continue to provide those services, while the other retinal surgeon in the same position as Dr. Hoonjan appears to have received the OR time and training without any delay. Where was the RIH COS or Department of Surgery Head to step in to

protect Dr. Hoonjan and comply with their obligation for training for medical staff? As a locum medical staff member, Dr. Hoonjan should not have had to wait over 2 years for basic training. The only reason that Dr. Hoonjan ultimately received the training appears to be the intervening event of Dr. C's misuse of the locum services and intervention of IH medical management at RIH, which led to privileges being granted to the two retinal surgeons Dr. C had improperly used as locums.

[137] In 2017, when both Dr. A and Dr. Hoonjan received active medical staff privileges at RIH, the discrepancies in OR time between them continued. Dr. A received 14 days in 2017, 13 days in 2018 and 15 days in 2019, while Dr. Hoonjan received 10 days in 2018 and 9 days in 2019. This discrepancy was never adequately explained by anyone at IH. Dr. Hoonjan's evidence was supported by the testimony of an Ophthalmologist, who observed Dr. Hoonjan's operating room access diminish over time.

[138] Dr. Hoonjan testified that he called Dr. B before the first competitive search and selection process one night around 6:00 pm to discuss the reference, and Dr. B was mad at him for calling his cell phone. After that, Dr. Hoonjan testified that he was reluctant to call him again or discuss issues with him. In a subsequent conversation, Dr. Hoonjan felt Dr. B essentially just shut him down and did not want to discuss things any further. Given this interaction along with Dr. B's treatment of Dr. Hoonjan during the performance review of patient X, it is understandable why Dr. Hoonjan felt isolated and that he would not be dealt with fairly by senior medical leaders at IH.

[139] Dr. Hoonjan stated in the December 10, 2019 meeting with senior medical leaders that Dr. C had bullied him over the years. There was no investigation into those allegations and no apparent concern about whether that bullying led to some of the OR scheduling difficulties that Dr. Hoonjan indicated he had with Dr. C or obtaining OR time for Constellation or other machine training. IH's disregard for a member of their medical staff in the face of these statements is troubling.

[140] While this panel does not need to make a finding regarding the reason for the differential treatment of Dr. Hoonjan, there are sufficient instances of differential treatment over a sustained period of time for this panel to have serious concerns about allowing IH to conduct a competitive hiring process where Dr. Hoonjan was involved. Dr. Hoonjan has experienced repeated differential adverse treatment by IH at almost every level, yet almost all of the evidence and witnesses who appeared before the panel stated that he is a very good doctor who was always available and willing to help out and had a calm and compassionate demeanor.

[141] This panel has found that there is a need for a third vitreo-retinal surgeon at KGH and there are the resources to support that position. However, this panel declines to refer this to IH to conduct a further competitive search and selection process to fill the third vitreo-retinal surgeon position which has been found to exist in IH at KGH.

Is Dr. Hoonjan Qualified for the Position?

[142] It is appropriate to confirm that Dr. Hoonjan is qualified to fill the position for a third vitreo-retinal surgeon at KGH. First, he had been performing the exact same

position at RIH for many years and IH has approved of his renewal of privileges every year without any qualifications, restrictions or notations. The non-renewal of Dr. Hoonjan's privileges at RIH was not related to any conduct or quality of care issues but was solely related to the relocation of the retinal surgical services from RIH to KGH.

[143] The principal impediment to Dr. Hoonjan's success in the previous search and selection process was the patient X incident and this panel has found that he acted appropriately regarding that patient. Finally, Dr. E testified that IH would not have interviewed him for the position in the search and selection process if they did not think he was competent or able to do the job.

[144] This panel finds that Dr. Hoonjan, subject to the reintroduction issues raised below, is qualified and competent to be granted active medical staff privileges for the third vitreo-retinal surgeon at KGH.

Interpretation and Application of *Sanghera*

[145] Given that this panel has found the need and resources for a third vitreo-retinal surgeon at KGH, is it not necessary to make any findings regarding remedies available to Dr. Hoonjan for the failures of IH in the competitive search and selection process. The failures were considered to determine whether it was appropriate for this panel to exercise its discretion to refer the selection of a third vitreo-retinal surgeon back to IH or whether the HAB should grant Dr. Hoonjan privileges to fill that position.

[146] However, IH has argued that the HAB does not have the authority to revoke the privileges from the successful candidates and appoint the Appellant in place of the otherwise successful candidate and relies of the HAB's decision in *Sanghera v. VCHA* (Decision No. 2017-HA-002(a)).

[147] The case of *Sanghera* decided that regardless of the circumstances of any alleged failures in the search and selection process, an unsuccessful applicant for privileges could not, on appeal to the HAB, seek to remove the successful applicant. The appellant in that case said he would argue that the selection process was biased and presumably that is not why he was selected.

[148] In *Campbell v. PHSA* (Decision No. 2018-HA-002(d)), the HAB questioned whether *Sanghera* should be followed and noted that *stare decisis* does not apply to administrative tribunals. The key distinction in the *Campbell* application was that the substantive hearing was nearing its conclusion and PHSA agreed to take all legal and financial responsibility for any consequences of hiring a replacement for Dr. Campbell and the HAB found that an interim injunction preventing any such hiring was not necessary in those circumstances.

[149] The panel is troubled by the practical effect of the *Sanghera* decision and is compelled in the public interest to provide some further comments. The HAB in *Sanghera* recognized that there is a right of appeal under section 46(1) of the Hospital Act for an unsuccessful applicant in a search and selection process. At paragraph 20 the panel stated:

> However, VCHA has advanced what in my view is an unduly restrictive interpretation of section 46(1). It is apparent that there is a right to appeal a

> "refusal" of privileges. Nowhere in the Hospital Act is a refusal made to apply only to holders of existing privileges.

[150] This panel agrees with the analysis on that point. However, this panel diverges on the ultimate finding of the panel in *Sanghera*. If the successful applicant on a search and selection process cannot be removed, then there is no remedy for an appellant who has a legitimate right of appeal. This simply cannot be so. Just because decisions are difficult or have subsequent adverse impacts, this does not mean they cannot or should not be made. For instance, in fraudulent transfers of property the law recognizes that the innocent purchaser is deprived of the property even though they have arguably done nothing wrong. Sometimes the law has difficult outcomes. For an appellant who was unjustly denied privileges when they have done nothing wrong the absence of a remedy is equally as devastating as removing a successful candidate. Having a right of appeal without a remedy is contrary to the rule of law.

[151] The *Sanghera* decision notes that the successful applicant would have appeal rights if he was removed by order of the HAB. This already happens in relation to cases involving an appellant who seeks additional OR time. In both *Behn* and *Walker*, the granting of OR time to a new surgeon resulted in the reduction of OR time to the existing incumbents who presumably would have a right of appeal regarding that reduction, particularly if they did not participate in the hearing of the initial appeal. There were no such appeals from those affected medical staff members, but the answer to any such appeal may simply be that the justification for the change in privileges is in the decision of the HAB. There is nothing impermissible in that process by the HAB regarding OR time and this panel sees no reason why a remedy should be denied in a search and selection case before any hearing on the merits which may involve the inclusion of the successful candidate in the appeal process.

[152] The practical difficulties with this appeal process can be dealt with by the hospital delaying the actual start date of the successful applicant until it can be determined if there are any appeals to the search and selection process. This is under the control of the hospitals. Successful applicants could seek contractual protections against the hospitals against any adverse effects of an appeal of the search and selection process.

[153] The outcome of any appeal of a search and selection process must be dependent on the facts and circumstances that exist in each particular case and simply denying a remedy in every case regardless of the underlying circumstances is unjust. The panel could think of an example where there was significant racial discrimination or other bias involved or an even more egregious circumstance if the successful applicant was somehow involved in misconduct in the search and selection process. The current application of the *Sanghera* decision is to insulate hospitals from all decisions involving the search and selection process with the appointment of a successful candidate. This allows that decision of a hospital to go unchecked and would be a serious derogation of jurisdiction by the HAB.

How Should Reintroduction be Handled?

[154] As previously detailed in this decision, this panel has found that any currency issues regarding Dr. Hoonjan are largely due to IH's failure to follow its obligations under the privileging dictionary and Dr. Hoonjan's repeated issues with OR scheduling. In addition, the improper termination of Dr. Hoonjan's privileges at RIH and failure to properly grant privileges to Dr. Hoonjan as part of the relocation of the retinal surgical services from RIH to KGH have exacerbated Dr. Hoonjan's current currency issues as he was forced to seek a remedy before the HAB.

[155] The HAB noted in *Campbell v. PHSA* (Decision No. 2018-HA-002(f)) that when currency issues are the result of the hospital's conduct in breach of its Bylaws, then it has to take responsibility for the decline in any skills and currency issues, and therefore, must work with an appellant to accommodate return to a full surgical slate with the appropriate skills.

[156] Dr. Hoonjan gave evidence that he is agreeable to do additional training and that in several incidents over his career he was prevented from that by IH and a lack of accommodating OR time for equipment set up and training. Dr. Hoonjan testified that he was willing to seek some training opportunities in Toronto with a retinal specialist and observe and scrub into surgeries. There may also be opportunities more locally in Calgary or Vancouver. Dr. Hoonjan recognizes that he needs to refamiliarize himself with the retinal surgical procedures and the equipment.

[157] This panel is not going to order a specific reintroduction plan for Dr. Hoonjan, but it will require IH to work with Dr. Hoonjan and accommodate any necessary steps to facilitate Dr. Hoonjan's reintroduction to performing retinal surgical services at KGH. Access to OR time for any training on equipment or scrubbing in with other vitreo-retinal or ophthalmology surgeons would be the minimum accommodation expected to be provided by IH. The other two vitreo-retinal surgeons at KGH can offer any assistance to Dr. Hoonjan but there has been evidence that KGH is not a teaching hospital and this panel is not going to force any requirement on the other two vitreo-retinal surgeons in that regard. The parties are encouraged to find the assistance of an outside expert to create a reintroduction plan that is suitable and appropriate for Dr. Hoonjan's circumstances and satisfies any requirements for Dr. Hoonjan's reintroduction.

[158] If the parties are unable to agree on a reintroduction plan, the HAB will remain seized to hear any further disputes regarding the implementation of this decision.

ORDER

[159] This panel orders that the parties have 60 days to reach a mutually agreeable reintroduction plan for Dr. Hoonjan, unless this deadline is extended by mutual agreement of the parties.

[160] Subsequent to the parties agreeing upon a reintroduction plan for Dr. Hoonjan, this panel grants Dr. Hoonjan active medical staff privileges at KGH as a

third vitreo-retinal surgeon with an equal access to OR time as the other two vitreo-retinal surgeons at KGH.

"Stacy F. Robertson"

_____

Stacy F. Robertson, Panel Chair
Hospital Appeal Board

"Dr. Ailve McNestry"

_____

Dr. Ailve McNestry, Panel Member
Hospital Appeal Board

"Dr. R. Alan Meakes"

_____

Dr. R. Alan Meakes, Panel Member
Hospital Appeal Board

December 7, 2022