Date: 2009 01 30
Docket: S-0001-CV2007000180

IN THE SUPREME COURT OF THE NORTHWEST TERRITORIES

IN THE MATTER OF A DECISION OF THE MEDICAL BOARD OF INQUIRY OF THE NORTHWEST TERRITORIES DATED JULY 27, 2007

BETWEEN:

DR. RICHARD BARGEN

Appellant

- and -

MEDICAL BOARD OF INQUIRY
OF THE NORTHWEST TERRITORIES

Respondent

Appeal by a medical practitioner, pursuant to the *Medical Profession Act*, R.S.N.W.T. 1988, c.M-9, from a finding of improper conduct by a Board of Inquiry. Appeal dismissed with costs.

Heard at Yellowknife, NT, on December 10, 2008.

Reasons filed: January 30, 2009.

REASONS FOR JUDGMENT OF THE HONOURABLE JUSTICE J.Z. VERTES

Counsel for the Appellant: Allan A. Garber

Counsel for the Respondent: Craig D. Boyer

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IN THE SUPREME COURT OF THE NORTHWEST TERRITORIES

IN THE MATTER OF A DECISION OF THE MEDICAL BOARD OF INQUIRY OF THE NORTHWEST TERRITORIES DATED JULY 27, 2007

BETWEEN:

DR. RICHARD BARGEN

Appellant

- and -

MEDICAL BOARD OF INQUIRY
OF THE NORTHWEST TERRITORIES

Respondent

REASONS FOR JUDGMENT

[1] This is an appeal by a medical practitioner, pursuant to the *Medical Profession Act*, R.S.N.W.T. 1988, c.M-9, from a finding by a Board of Inquiry that he was guilty of improper conduct.

[2] The appellant was employed as a family health practitioner by the Yellowknife Health and Social Services Authority. In February, 2004, the Authority received a complaint alleging that the appellant, among other things, had improperly obtained confidential information about a person who was not his patient and had disclosedthat information to a third party. The appellant's license to practise medicine was suspended because of this complaint. He was eventuallydismissed from his job. After an investigation, the President of the Medical Board of Inquiry referred a charge of improper conduct for a hearing pursuant to the provisions of the *Medical Profession*

Act. The Board found the charge proven and imposed a penalty that required the appellant to undergo remedial training. The penalty is not a subject of this appeal.

[3] Unfortunately the original complaint made in February, 2004, contained a number of other disreputable allegations. These, more than the actualsubject matterof the hearing, appear to have had severe negative consequences for the appellant's reputation and continued employment. None of those allegationswere found to have a basis in fact. The hearing before the Medical Board of Inquiry concerned only an allegation of improperly obtaining medical information about an individual who was not a patient of the appellant. It did not allege disclosure of information to third parties. The focus was only on how the appellant obtained the information.

[4] The appellant raised a number of issues. He framed them as issues of law involving the duty of confidentiality, waiver of confidentiality by a patient, and error by the Board in failing to draw an adverse inference due to the failure to call material witnesses. For the reasons that follow, I conclude that the Board's decision was a reasonable one available to it on the evidence. Therefore the appeal is dismissed.

Statutory Framework:

[5] The *Medical Profession Act* stipulates that a medical practitioner may be disciplined for improper conduct. The term "improper conduct" encompasses a number of things, outlined in s.20 of the Act, includingwhere the practitioner"engages or has engaged in unbecoming or criminal conduct, whether in a professional capacity or otherwise" or "engages or has engaged in conduct that is inimical to the best interests of the public or the medical profession": ss. 20(a) and (d).

[6] The Act establishes a Board of Inquiry for the purpose of conductingany inquiry concerning the improper conduct of a medical practitioner: s.21(1). The Minister of Health is required to appoint at least two, and no more than four, members to the Board: s.21(3). In addition to the Board, the Minister also appoints a President of the Board of Inquiry: s.21(2).

[7] The composition of these positions is weighted in favour of medical practitioners, as set out in s.21(4):

> (4) Of the persons, including the President, appointed to the Board of Inquiry under this section,
>
> (a) at least one person shall be a medical practitioner who is entitled to practise medicine in the Territories under this Act and is nominated by the Northwest Territories Medical Association;
>
> (b) at least one person shall be a medical practitioner registered in a medical register of a province; and
>
> (c) at least one person shall not be a medical practitioner who is entitled to practise medicine in the Territories under this Act or a person registered in a medical register of a province.

[8] The President is the initial recipient of any complaints and acts as a "gatekeeper" to the disciplinary process. On receiving a complaint, the President must review it and may either dismiss it, if of the opinion that the conduct does not amount to improper conduct, or refer the complaint to a Board of Inquiry: s.25(1.1)(a). If the President cannot adequately review the complaint, he or she shall refer the matter to an investigator: s.25(1.1)(b). The investigator reports back to the President with a recommendation to either dismiss the complaint or refer it to a Board of Inquiry: s.25(1.3). The President then decides whether to dismiss or to refer: s.25(1.4). If a complaint is referred to the Board, it must proceed with a hearing into the matter: s.26(1). That hearing must be conducted in accordance with the rules of natural justice: s.36.

[9] There is also a right of appeal given to the medical practitioner from an adverse finding. The powers of the court on appeal are broad, as set out in s.40 of the Act:

> 40. (1) Where an order is made against a medical practitioner under section 38, the medical practitioner may, within 30 days after receipt of the notice sent under subsection 39(1), appeal to the Court.
>
> (2) On hearing an appeal made under subsection (1), the Court may
>
> (a) quash, alter or confirm the order; or

> (b) suspend the operation of the order until the appeal has been heard and ruled on.
>
> (3) Where the Court on appeal quashes, alters or confirms an order of the Board of Inquiry, the Court shall notify the Minister of the decision and the Minister shall do whatever is necessary to give effect to the decision.

[10] In this case, the President, upon receiving the complaint, appointed an investigator. After receiving the investigator's report, the Presidentconcluded that the matter should be referred to a Board of Inquiry.

[11] This statutory framework raises a question as to who is the proper respondentto this appeal. The style of cause names the "Medical Board of Inquiry". The respondent to this appeal, however, designates itself as the "President of the Medical Board of Inquiry". The respondent submits that the *Medical Profession Act* differentiates between the role of the President as investigator and gatekeeper from the role of the Board of Inquiry as the adjudicative body. Case law states that an adjudicative body should not be a party on an appeal going to the merits of the decision. Therefore, according to the respondent, the proper party is the President. I agree with the respondent on this point.

[12] While nothing turns on this question as far as the merits of the appeal are concerned, it is a question of importance as to the appropriate practice in statutory appeals.

[13] The governing rule, as enunciated by the Supreme Court of Canada in *Northwestern Utilities Ltd.* v. *Edmonton*, [1979] 1 S.C.R. 684, is that, in the absenceof statutory provisions as to standing, an adjudicative tribunal whose decision is under review or appeal cannot appear and argue the merits. Its role is confined to arguments as to its jurisdiction or to explain the record. That this is still the governing rule can be seen in the commentary by Côté J.A. in *Brewer* v. *Fraser Milner Casgrain LLP*, [2008] A.J. No. 460 (C.A.), at paras. 29 - 39.

[14] The Act, as noted by the respondent, distinguishes between the roles of President and the Board. The President acts in an investigativecapacity. His decision-making is limited to whether the complaint should be dismissedor whetherit should be referred to a hearing. It is a preliminary gatekeeping function. An analogy can be

drawn to the role of a prosecutor who examines a complaint to see if there is a *prima facie* case. It is the President who initiates the hearing process. The President, however, does not adjudicate. It is therefore the President who is the proper respondent to an appeal under the Act.

Background:

[15] The appellant has been a physician since 1976. He began employment with the Yellowknife Health and Social Services Authority in 2003.

[16] In November, 2003, the appellantcame to know sociallytwo young people,R.F. and B.S., both of whom worked at a local restaurant. R.F. was a young woman, 17 or 18 years old, who lived with B.S. and his roommate, one B.L.

[17] B.S. had started to make claims that he had cancer. He told everyonethat he had cancer, including R.F. and B.L. B.L. did not believe that R.F. had cancer and thought that it was simply a ploy to get attention. R.F., however, believed him. The appellant told R.F. on a number of occasions that he did not believe that B.S. had cancer based simply on his observations of him. It should be noted that at no time was B.S. a patient of the appellant.

[18] R.F. also told the appellant things that led him to believe that B.S. was taking advantage of her, both financially and sexually, because of her sympathy for B.S. due to his medical condition. The appellant became concerned that B.S. was not only taking advantage of R.F. but also abusing the health care system by trips to the emergency ward and demands for prescription drugs.

[19] In late 2003, the appellant took his concerns to Dr. Andre Corriveau, the chief medical health officer, who advised him to speak with Dr. John Morse, the hospital medical director. The appellant then spoke to Dr. Morse. The appellant told him that he had knowledge of a patient who might be coming to the emergency ward looking for prescription narcotic drugs on the pretext of having cancer. Dr. Morse advisedhim to speak with Dr. Jyl Radwell who was, at the time, the emergency ward chief physician. Dr. Morse thought it was quite appropriate for a physician to come to him with a concern as expressed by the appellant.

[20] It is the interaction between the appellant and Dr. Radwell that is the subject matter of these proceedings.

[21] At the Board of Inquiry hearing, Dr. Radwell testified as follows about her meeting with the appellant:

> Back on the date in question, I think it was - - I can't remember the exact date. It was either November or December of the year, I was working a day shift at Stanton emergency where I worked, and I received a phone call and I'm not sure it was a call or a message and I returned it and spoke to Dr. Bargen, a physician who I didn't know. He stated that he was directed to me by Dr. John Morse, the director at the hospital, and he mentioned that he worked with Dr. Andre Corriveau at - - with public health at the department, and that he was also working as a part-time physician at the family medical clinic so I was quite happy to know that there was more physicians there.
>
> He told me he was investigating a claim of a youth that was going around town claiming that he had terminal cancer and he was requesting narcotics. He asked me if I knew any information regarding this and I said I did not know but I could investigate and find out, which didn't seem like an odd request. So he wanted to meet and I said my shift was over at three and I was happy to meet with him after the shift and so our conversation ended and he came in at 3:00 when my shift was over. We met in the back room, which was a private room.
>
> In the meantime, I tried to investigate this allegation of narcotic seeking. The name that - - as I mentioned in the letters, the name that was given to me was not a name that was in the hospital file. I couldn't find that name on the computer but it just happened that a nurse who was helping me use the computer recognized a similar name and recognized - - and was there the day that this individual came in, so we were able to figure out his name and pull the file of that individual.
>
> Once I read the file I was reassured that this youth's claim of having a terminal illness was not believed by the physician at all by what he had written and it seemed quite unbelievable, his story, so he was not given any narcotics from our department.

> And so then when Dr. Bargen came in I reassured him that this person did not receive narcotics and we had a slight conversation about it. I recall him being concerned about the youth and even commenting that he hoped that he could seek appropriate help to help him with his problems, mental health and psychiatric, and we chitchatted, you know, had a normal conversation. He told me where he had worked prior and that was kind of the end of our dealings that I recall.

[22] The appellant confirmed this version of the events. There was no suggestion that the appellant was making his inquiry, or passing along his concerns, because of some doctor - patient relationship. Dr. Radwell did say, however, that she assumed that the appellant was making this inquiry in a professional capacity. For his part, the appellant testified that he assumed that Dr. Radwell knew that he was not B.S.'s physician.

[23] A few days after this encounter, the appellant met R.F. and told her that he had been to the hospital and, when she asked him if B.S. did have cancer, he told her that he had not changed his mind about anything they had talked about. A month or so later R.F. left Yellowknife.

[24] R.F. and B.S. did not testify at the hearing. Their whereabouts were unknown. Their roommate, B.L., did testify. He confirmed his belief about B.S. faking his illness. It turned out that it was B.L. who made the initial complaint about the appellant, a complaintthat the appellanthad disclosedconfidential medicalinformation and that the appellant was guilty of other disreputable conduct. B.L. acknowledged that these allegations were based on hearsay, on things that he was told by R.F. As noted previously, subsequent investigations, by both medical authorities and police, found no basis for the other allegations.

[25] Eventually, a notice was issued by the President to the appellant on December 22, 2006:

> YOU ARE HEREBY NOTIFIED that it has been reported to the President of the Medical Board of Inquiry of the Northwest Territories, that you may be guiltyof unbecomingconduct, improper conduct and/or conduct that is inimical to the best interests of the public or the medical profession in that:

> 1. in or about December of 2003, you did inappropriately obtain personal health care information about (B.S.), from Dr. Jyl Radwell;
>
> And that your conduct in this regard ought to be investigated.

[26] The focus of the inquiry was therefore the circumstances of the interaction between the appellant and Dr. Radwell. The inquiry proceeded over two days before a panel consisting of two medical practitioners and one lay person (as required by s.21(3) of the Act). On June 15, 2007, the chair of the panel delivered its decision:

> As has been said repeatedly, the charge in this matter was extremely narrow. We believe that there is no dispute that Dr. Bargen did obtain, in or about December 2003, personal health care information from Dr. Jyl Radwell about (B.S.). That we think is a given. Thus the remaining point at issue in the charge is whether it occurred inappropriately.
>
> Generally, the panel feels that it is wrong to seek such information if one is not the patient's treating physician and if it is not done for professional reasons. We recognize exceptions to that general principle.
>
> Information of this sort may be obtained in the course of research or academic activities but in such cases the patient's consent is necessary, especially now and also in December 2003. Additionally, it is justified when one is required by law to search out such information. More specifically, we believe that Dr. Bargen did not have a right to access (B.S.'s) personal health care information. Other avenues were available to Dr. Bargen in order to satisfy his concerns about possible abuses of an underage female and of the health care system.
> In any event, Dr. Bargen ought to have told Dr. Radwell in clear and explicit terms the facts of his having no relationship with (B.S.), professional or otherwise. It was not reasonable, we think, for him to assume that Dr. Radwell would infer it from his not knowing (B.S.'s) name correctly, neither do we agree with those who suggest that there was a duty on Dr. Radwell to determine Dr. Bargen's authority to ask for such information.
>
> Therefore, we find that the charge is proven.

[27] It is from this finding that the appellant appeals. His factum stipulates the following grounds of appeal:

> 1. The Board erred in failing to draw an adverse inference for the failure of the Board to call key witnesses.
>
> 2. The Board erred in finding that the Appellant obtained personal medical information about (B.S.). Dr. Bargen already knew the information he was given by Dr. Radwell.
>
> 3. The Board erred in finding that the Appellant inappropriately obtained personal medical information about (B.S.). (B.S.) made his health care a matter of public discussion and therefore he was owed no duties of confidentiality.
>
> 4. In the alternative, if (B.S.) was owed a duty of confidentiality, the Board erred in failing to find that the duty of confidentiality was overridden by the fact that (B.S.) was lying about his health, was using his lie to sexuallymolest a young woman, and was defrauding the health care system.
>
> 5. The Board erred in finding that Dr. Bargen committed a serious error.

[28] In my respectful opinion, as I will discuss below, the issues raised in these grounds miss the point that was the subject of the inquiry, that being the professional interaction between the appellant and Dr. Radwell.

Standard of Review:

[29] The first issue that must be addressed on any review of a tribunal's decision, whether by way of judicial review or statutory appeal, is the appropriate standard of review. The object is to determine the degree of deference to be accorded by the court to the decision-making body with regard to the type of question under review.

[30] The test for selecting the standard of review was comprehensively set out in *Pushpanathan* v. *Canada*, [1998] 1 S.C.R. 982. It was recentlyrefined in *Dunsmuir* v. *New Brunswick*, [2008] S.C.J. No. 9, which confirmedthe relevant factorsbut held that it is not necessary to perform a fresh standard of review analysis in every case if the standard of review has already been determined by the jurisprudence.

[31] The appellant argues that the appropriate standard of review is one of correctness. This would require the court to undertake its own analysis of the issue to decide if the tribunal decision is the correct one. This is particularlyimportant on some types of legal questions, such as jurisdiction, so as to promote consistency in the application of law: see *Dunsmuir*, at para. 50.

[32] The appellant submits that there are a number of factors that point to correctness as the standard: the lack of a privity clause; a full appeal right where the court may quash, alter or confirm the decision under review; and, the nature of the questions before the Board, questions which the appellant described as ones that raise legal questions for which the Board has no expertise.

[33] The respondent argues that the appropriate standard of review is that of reasonableness. This standard was described as follows in *Dunsmuir* (at para. 47):

> Reasonableness is a deferential standard animated by the principle that underlies the development of the two previous standards of reasonableness: certain questions that come before administrative tribunals do not lend themselves to one specific, particular result. Instead, they may give rise to a number of possible, reasonable conclusions. Tribunals have a margin of appreciation within the range of acceptable and rational solutions. A court conducting a review for reasonableness inquires into the qualities that make a decision reasonable, referring both to the process of articulating the reasons and to outcomes. In judicial review, reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process. But it is also concerned with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law.

[34] The respondent points to the fact that many cases, including several from the Alberta Court of Appeal, have held that the standardof review under legislationsimilar to the *Medical Profession Act* is one of reasonableness: *Huang* v. *College of Physicians and Surgeons*, [2001] A.J. No. 1197 (C.A.); *Litchfield* v. *College of Physicians and Surgeons*, [2008] A.J. No. 482 (C.A.). Furthermore the respondent characterizes the issue as one of fact or mixed fact and law. In *Dunsmuir,* the Court held (at para. 53) that where the issue is one of fact, discretion or policy, or where the

question under review is one where the legal and factual issues are intertwined, then deference will usually apply and reasonableness will be the standard.

[35] In my opinion, the standard of review is one of reasonableness. I say this for a number of reasons.

[36] First, the existence of a statutory right of appeal, even a broad one as here, is only one factor in the standard of review analysis. Other factors may still compel deference.

[37] Second, the purpose of the provisions in the *Medical Profession Act* respecting the Board of Inquiry, the investigation of complaints, and the conduct of hearings into allegations of improper conduct, is essentially the self-regulation of the medical profession in the public interest. The Supreme Court of Canada has held on a number of occasions that disciplinary bodies of self-governing professions should be given deference and reviewed on a standard of reasonableness: *Dr. Q* v. *College of Physicians and Surgeons of British Columbia*, [2003] 1 S.C.R. 226 (at paras 36-39); *Law Society of New Brunswick* v. *Ryan*, [2003] 1S.C.R. 247 (at para. 42).

[38] While it is debatablewhether the medicalprofession in the NorthwestTerritories is a completely self-governing profession — considering the statutory role played by the Minister in the licensing of physiciansand in appointingmembers of bodies such as the Board of Inquiry — it is nonetheless clear that the aim of the legislation, insofar as discipline is concerned, is that a doctor whose conduct is under question should be judged by a group made up primarily of his or her peers who are themselves subject to the same rules and standards that are being enforced. So the principles applicable to the review of disciplinary decisions by self-governing professions apply equallyto the Board of Inquiry established by the Act. In *Re Milstein and Ontario College of Pharmacy (No. 2)* (1977), 13 O.R. (2d) 700 (Div.Ct.), Cory J. (as he then was) articulated the rationale behind the need for deference towards self-governing disciplinary bodies as follows (at p. 707):

> One of the essential indicia of a self-governing profession is the power of self-discipline. That authority is embodiedin the legislation pertaining to the profession. The power of self-disciplineperpetuated in the enabling legislation must be based on the principle that members of the profession are uniquely and best qualifiedto establish

> the standards of professional conduct. Members of the professioncan best determine whether the conduct of a fellow member has fallen below the requisite standards and determine the consequences. The peers of the professional person are deemed to have and, indeed, they must have special knowledge, training and skill that particularly adapts them to formulate their own professional standards and to judge the conduct of a member of their profession. No other body could appreciate as well the problems and frustrations that beset a fellow member.
>
> Given such unique qualifications for judgment and discipline of fellow members, the decisionsand penaltiesof professional discipline committees ought not to be lightly interfered with.

[39] Third, the composition of the Board of Inquiry, while it had a lay person on it, was still dominated by a majority of medical practitioners. What is or is not improper conduct by a fellow doctor is an area where they have more expertise than a court.

[40] Finally, the nature of the question in my opinion is one that the Board, with its majority of professionals, was uniquely well-positioned to address. The appellant described the issues as questions of law. The respondent described them as questions of fact or at most mixed fact and law. I would describe the question that confronted the Board as one of professional ethics. Did the appellant act inappropriately in his approach to Dr. Radwell?

[41] The facts were not really in dispute. And there is no legal question intertwined with that issue. It is a question that calls for professional judgment. What is required of a doctor when he or she approaches another doctor to discuss a patient? And when does an approach become improper conduct? These are questions that call for professional expertise as provided by the medical practitioners on the Board.

[42] I therefore conclude that the standard of review is that of reasonableness.

Analysis:

[43] I previously said that, in my opinion, the appellant missed the point in framing his grounds of appeal. The essential question before the Board concerned how the appellant approached Dr. Radwell and whether it was improper. The facts concerning

that question were not disputed in any material way. It is the interpretation to be placed on those facts that is the crux of the inquiry.

[44] I want to address each ground of appeal, as set out by the appellant, to explain why I do not think there is a question of law. I have already mentioned some of these points earlier in these reasons.

[45] The grounds are interconnected in that they revolve around what I understandto be the thrust of the appellant's argument. The Board erred, it is argued, because it failed to consider (a) that B.S.'s health status was not confidential due to the fact that he had been telling everyone and anyone that he was suffering from cancer; (b) that B.S.'s lies amounted to a waiver of confidentiality; (c) that the appellant was concerned about a fraud on the health system and wanted to present his concerns to officials in the health system; and, (d) that had the Board put their minds to these issues it would have realized the frivolous nature of the complaint.

[46] The first ground of appeal alleges that the Board failed to draw an adverse inference from the failure to call key witnesses. The appellant argues that the Board should have heard from B.S. and Mr. Greg Cummings,then the healthauthority's chief executive officer. The appellant says that B.S. would have confirmed that he made his health a matter of public record. He also says that Mr. Cummings,who receivedB.L.'s complaint, did not pass along the information that B.S. had been lying about having cancer.

[47] The difficulty with this argument is that the evidence about B.S. lying about having cancer was before the Board. There was evidence from B.L. to that effect as well as from Dr. Radwell. The allegation that Mr. Cummings may have withheld information so as to support *ex post facto* the firing of the appellant, as argued in the appellant's factum, is something that is not connected to the questionbefore the Board. Further, neither R.F. nor Mr. Cummings could testifyas to the substanceof the subject of the appeal, that being the interaction between the appellant and Dr. Radwell.

[48] Generally speaking, an adverse inference may be drawn against a party who does not call a material witness over whom it has exclusive control and does not explain it away. The implication is that the evidence of the absent witness would be contrary to that party's case. Here, it is arguable whether either B.S. or Mr. Cummings

were in the "exclusive control" of the Board. More important, I do not think that either B.S. or Mr. Cummings had material evidence to give that was not otherwise available.

[49] The second and third grounds relate directly to the question of whether B.S.'s health information was impressed with confidentiality. I recognize, as the appellant argues, that confidentiality over a patient's health information can be lost or implicitly waived by the patient by talking about it. But that is not what the Board was asked to consider. The Board was asked to look at the circumstances of the appellant's interaction with Dr. Radwell, and only those circumstances, and determine whether that was improper. There is no question that the appellant obtained personal health information about B.S. Dr. Radwell told him that B.S. did not have cancer. The issue was how the appellant obtained that information.

[50] Dr. Radwell testified that the appellant approached her by saying he was "investigating a claim" and that he had been directed to see her by Drs. Corriveau and Morse. She assumed that he was contacting her for some professional reason. The appellant said he assumed she knew he was not B.S.'s doctor and that his motive was simply to impart information. But he did not make this clear to Dr. Radwell. And, by his manner of approach, he was given information about someone who was not his patient.

[51] That, as I read it, is the substance of the Board's decision. The panel said that the appellant did not have a right of access to B.S.'s health information and that there were other ways available to him to satisfy his concerns about B.S.'s abuse of the health care system. But the significant point in the Board's decision was that the appellant was under a professional obligation to tell Dr. Radwell in clear and explicit terms that he had no professional relationship with B.S. It is that point that led to the Board's conclusion that the appellant's actions amounted to improper conduct.

[52] It is speculation on my part but if the appellant had fully explained his relationship or lack of it *vis-à-vis* B.S. to Dr. Radwell, and that he was not acting in a professional investigative capacity, then perhaps he and Dr. Radwell could have considered whether B.S.'s records were subject to confidentiality or not (especially since confidentiality is presumed). But that question never arose because of the way the appellant approached Dr. Radwell. It was that approach that the Board was asked to investigate, not the question of confidentiality.

[53] The fourth ground of appeal is that the Board erred by failing to find some higher public purpose to overriding the confidentiality of B.S.'s health information because of his lying and using those lies to "sexually molest a young woman" and to defraud the health system. Most of my earlier comments apply here as well. In addition, however, there was no evidence of B.S. "sexually molesting" R.F. The appellant may have thought that was what B.S. was doing but he had no direct evidence of that. B.L., who was their roommate, did not testify to that. To the contrary B.L.'s testimony indicated that R.F. and B.S. had a consensual relationship.

[54] On the question of defrauding the health system, while this was a legitimate concern, it is apparent that the appellant did not ask for a formal investigation of B.S. He passed along his concerns to Drs. Corriveau and Morse and did what they advised him to do. But he did not raise with them the prospect that any confidentiality belonging to B.S.'s health information was now lost. His discussions with them were on a very general level.

[55] The final ground of appeal challenges the Board's conclusion that the appellant committed a serious error. Yet, as I noted before, this is exactly the type of question that a professional discipline body is well qualified to answer. This is an issue of the standard of conduct to be expected of a medical practitioner. That is why I prefer to call it a question of ethics. In my opinion, the Board of Inquiry is much better able than a court to say whether this conduct is improper.

[56] Many times before the Board references were made to this being a misunderstanding and a minor transgression. That may be so but then it becomes a question of penalty.

Conclusion:

[57] To sum up, and as I said previously, I do not see these issues as either questions of law or fact. It is fundamentally a question of how one doctor should interact with another doctor when either seeking or imparting information. That in my view is a question of professional ethics. And it is a question that the Board, with its expertise, was best positioned to answer.

[58] Is the decision under appeal a reasonable one, that is to say, is it one that falls within a range of possible, acceptable outcomes defensible in respect of the facts and the law? I have concluded that it is.

[59] The appeal is dismissed with costs to the respondent based on the tariff set out in the *Rules of Court*.

[60] Since s.40(3) of the Act requires that the Minister of Health be notified of the decision of the court, I direct that a copy of these reasons and the formal order dismissing the appeal be forwarded to the Minister by counsel for the respondent.

J.Z. Vertes
J.S.C.

Dated this 30 day of January, 2009.

Counsel for the Appellant: Allan A. Garber

Counsel for the Respondent: Craig D. Boyer

Docket: S-0001-CV-2007000180

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