Summary of Discipline Committee Hearing

DR. RAVI WALIA

Hearing Date: April 12, 13, 18, 19, 20, 25 & 26, 2017

ALLEGATIONS OF PROFESSIONAL MISCONDUCT

- failed to properly interpret or adequately discuss pre-operative blood test results with the client prior to surgery, if the results were obtained prior to surgery
- failed to obtain informed consent for the surgery and treatment
- failed to advise the client he was inexperienced performing cherry eye surgery
- performed the surgery without proper training and/or experience
- failed to perform cherry eye surgery properly or competently
- used improper suture material
- used inappropriate surture knot placement
- failed to provide proper and/or adequate anesthesia for surgery
- failed to properly manage the dog following surgery
- failed to properly document the dog's healing and response post-operatively
- failed to document the use of an Elizabethan collar while the dog was hospitalized
- failed to properly examine the dog post-operatively
- failed to provide appropriate post-operative care through inadequate monitoring and inappropriate medications
- failed to create or maintain adequate records
- failed to maintain the standard of practice of the profession
- an act or omission relevant to the practice of veterinary medicine that, having regard to the circumstances, would be regarded by members as disgraceful, dishonourable or unprofessional
- conduct unbecoming a veterinarian

BRIEF SUMMARY

The member performed surgery on a dog which suffered from a bilateral eye condition, colloquially called cherry eye, which involved prolapse of the gland of the third eyelid.

The member did not inform the client he was inexperienced with this kind of surgery. The member's records are incomplete, unclear and inconsistent with respect to how the surgery was performed, how long it took and what medications were administered.

During the surgery, the anesthesia wore off and the dog woke up in distress. After the surgery, the member informed the client the dog had to stay overnight because of unspecified, pre-existing infections. The dog remained at the clinic overnight on IV fluids and was not monitored overnight. The next morning, the dog's eyes were swollen which the member attributed to unspecified infections. The dog was later discharged with various medications but it is unclear in the records what those medications were.

The dog's eyes did not improve over the next two weeks so the client sought a second opinion. Corrective surgery was performed 17 days later by another veterinarian.

Member's Representation: The member was represented by his daughter, who to the best of the panel's knowledge, did not have any formal legal training. The panel was aware of the member's right to be self-represented and made every effort to accommodate his lack of legal representation. The panel realized a self-represented member might not be fully cognizant of the law and the hearing process and therefore extended additional patience and direction. The panel listened intently to all information provided to them, and in fairness to the member, College Counsel and the panel frequently allowed more latitude in questioning witnesses than would normally occur.

Preliminary Issues: At the outset, the member's representative raised many preliminary matters, made several objections and brought forward numerous reasons the hearing should be quashed. Although there were many preliminary matters addressed, it was the panel's opinion there were nine major ones.

1. Audio recording of the hearing by the member as a substitute for note-taking.

Panel's decision: No action required

Reasons: Counsel for the College had no objection to this request explaining that audio recordings could be undertaken as a substitute for handwritten notes. Independent legal counsel confirmed that while there was a general prohibition in the *Veterinarians Act* on recording proceedings, this option was available to the member if the purpose was as a substitute for note-taking.

2. Affidavit from the member describing that a family member would act as his representative.

Panel's decision: Request to submit affidavit denied; permission granted to the member's daughter to represent the member.

Reasons: Counsel for the College shared the opinion of independent legal counsel that the affidavit was not necessary. Furthermore, this document contained medical information about the member that was irrelevant to the proceedings. The panel had no interest in receiving the affidavit for fear of developing bias or prejudice. The member stated his daughter would be representing him, and this was sufficient for the panel to be satisfied that this was his wish.

3. Affidavit against a member of the hearing panel of Discipline Hearing of CVO for the second time. Motion to remove the member from the hearing panel.

Panel's Decision: Request to submit affidavit accepted, subject to removal of medical information; motion to remove the panel member was denied.

Reasons: The member's representative raised multiple concerns: that the *Veterinarians Act* had been breached, the panel member had a conflict of interest, he was biased, and that the College was guilty of applying a double standard to the member. Her objections stemmed from the participation of the panel member in a previous motion hearing involving the member's case.

Counsel for the College stated the previous hearing involved scheduling, and dealt with a motion to postpone the hearing. He pointed out that consideration of subject matter was not involved in that process and merely serving on another panel was not sufficient grounds to have the panel member recused.

As advised by independent legal counsel, the panel member read paragraph 28(11) of the *Veterinarians Act* and sections of the decision Wewaykum Indian Band v. Canada (2003), which speaks to the reasonable apprehension of bias. After reviewing the documents, the panel member stated that he felt he could participate in this hearing in an open-minded manner with no bias.

It was the panel's decision to deny the motion since the panel member had considered only a scheduling motion and was not part of the consideration of the subject matter, was not involved in any investigation of the member and had stated on the record that he would continue to conduct himself in a nonbiased manner.

4. Motion to have the panel accept into evidence two binders from the member that contained all aspects of the member's interpretation of the case, and all materials he forwarded to the College.

Panel's Decision: Denied

Reasons: The panel was advised by College Counsel that some items in these binders were inadmissible, and could potentially taint a panel if all materials were marked into evidence at one time. The panel advised the member's representative that she would have more appropriate opportunities to present these documents, such as during cross examination of witnesses. She was advised that she would have to introduce each document individually as opposed to all in one binder.

5. Motion to quash the hearing because the College failed to provide the member with the reasons this matter was referred to the Discipline Committee from the Complaints Committee, thus negating the member's right to appeal to the Health Professions Appeal and Review Board.

Panel's decision: Denied

Reasons: Counsel for the College advised the panel that for all matters, except for the referral of a case from Complaints to Discipline, reasons are given by the Complaints Committee. Independent Legal Counsel advised the panel that there was nothing in

the *Veterinarians Act* that requires reasons for the referral from Complaints to Discipline to be made available to the member, as no decision other than the decision to refer was rendered, nor was an order made.

6. Motion to quash the hearing because the complaints process was flawed as the original three complaints described in the Complaints Committee's letter to the member seeking a response from him were expanded to 19 allegations as reflected in the Statement of Allegations appended to the Notice of Hearing.

Panel's Decision: Denied at this time

Reasons: Counsel for the College advised the panel it is the responsibility of the College to investigate a complaint, thereby actually providing particulars to the member, describing what the actual concerns are. Independent legal counsel confirmed this was a normal procedural issue.

The panel at that time had not seen the Notice of Hearing, thus was unable to comment specifically, but understood the drafting of allegations was the usual way of proceeding with a letter of complaint coming through the Complaints Committee where the matter was referred to the Discipline Committee.

7. The member's representative raised a concern regarding the College's proposed expert witness. Independent legal counsel was of the opinion that procedurally, this concern could be dealt with during the qualification process. The panel agreed.

Panels' decision: Deferred

8. Motion to consider only the allegations that corresponded to the three complaints originally mentioned in the letter to the member.

Panel's decision: Denied

Reasons: Upon receiving clarification, College Counsel submitted to the hearing that the panel cannot replace the Notice of Hearing nor change or alter the issues. Although the principle raised by the member's representative, namely that allegations must be related to the complaint, was a legitimate principle, it had not been violated in this case. He reiterated that every allegation arose from the owner's complaints. One purpose of self-regulation is to allow specialized tribunals to conduct their investigations and hold hearings. Independent legal counsel advised that the panel does not have the ability to restate allegations and that what the member was asking for was that the panel quash any elements of the allegations that did not arise from the complaint.

The panel concluded that it did not have the authority to alter the allegations in the Notice of Hearing and, it did not agree with the member that to deny this motion would be prejudicial.

9. Motion: That the involvement of two individuals who both sit on the College's Discipline and Complaints Committees was unreasonable, unfair, and has the potential for bias, thus all allegations against the member should be quashed.

Panel's Decision: Denied

Reasons: College Counsel reviewed for the panel Section 28(11) of the *Veterinarians Act*, which states that "Members of the Discipline Committee holding a hearing shall not have taken part before the hearing, in any investigation or consideration of the subject matter of the hearing other than as a member of the Council or Executive Committee considering the referral of the matter to the Discipline Committee....". The two individuals' involvement in this matter came to an end as soon as the referral to the Discipline Committee occurred. They sat on the same committees, and neither of these individuals are on this panel of the Discipline Committee addressing the allegations against the member.

Independent legal counsel, citing from the *Veterinarians Act*, stated there was nothing in the Act preventing individuals from sitting on both committees, once again referring to the test for reasonable apprehension of bias.

It was the panel's opinion the College did not do anything incorrect in selecting members for this panel or the Complaints Committee panel. All statutes were observed, and nothing was contravened.

PLEA & DECISION

The member pleaded not guilty to the allegations of professional misconduct. The member was found guilty with respect to the allegations.

PENALTY

- Reprimand
- Suspension of the member's licence to practise veterinary medicine for three months.
- During the suspension, the member is required to complete a five-day mentorship to review the issues that arose in this case. Following the mentorship, the member will prepare a paper outlining learnings. All costs associated with the mentorship are the member's responsiblity.
- Impose a condition requiring the member to work with a practice coach, appointed by the Registrar, one day a month for six months. All costs associated with the coaching are the member's responsibility.
- The member will undergo five unannounced record reviews within two years. Each review will be conducted by a peer reviewer and include a review of medical records of up to eight patients. Following each review, the member is required to implement recommendations of the peer reviewer. The results of the reviews may be reported to the Executive Committee for possible action. All costs associated with the reviews are the member's responsibility.
- The member will pay costs to the College of $142,000
- Pursuant to legislation, this matter is published including the member's name

PANEL'S REASONING

It was the panel's opinion that many hours were spent not on the substance of the allegations, but on attempts by the member's representative to have allegations quashed because of procedural irregularities and the lack of "natural justice".

The panel was struck by the persistence of the member and his representative to attack the hearing process as being unfair, biased, and illegitimate. It was the panel's opinion that the statutes and procedures that have been established to govern these hearings have been in place for many years, and are founded on the principle of fairness while being respectful of the mandate of protection of the public interest.

The panel understood the member elected to be self-represented and respected his right to make that choice. The panel also understood that his being represented in this manner could not be considered as a mitigating factor in the determination of innocence or guilt. The panel had to base its findings on the evidence presented at the hearing, even though the member and his representative on many issues chose not to introduce any contravening evidence, nor did they call an expert witness to testify on the member's behalf. The panel was convinced that no governing procedure or process had been breached and that the hearing was fair and unbiased.

Allegation: failed to properly interpret or adequately discuss pre-operative blood test results with the client prior to surgery, if the results were obtained prior to surgery

Decision: guilty

Reasons for Decision: The College's expert witness testified there were concerns with

the timing of the pre-anesthetic bloodwork. It was clear from the blood analyser stamp that the blood results were obtained after the surgery had ended. Pre-anesthetic bloodwork is important to identify potential problems that may affect anesthesia. The member admitted during cross examination that bloodwork had not been done prior to induction of anesthesia.

The panel was concerned the member misled the client and the College by stating recommended pre-operative bloodwork was done. These statements appeared to the panel to be lies. The panel found the member's conduct to be unbecoming of a veterinarian.

Allegation: failed to obtain informed consent for the surgery and treatment

Decision: guilty

Reasons for Decision: The College's Companion Animal Medical Record Standard requires that "Records indicate that informed consent is provided."

Although the client signed a consent form, she testified she did not read nor understand what she was signing and no one discussed the forms with her. She testified no one discussed the purpose of pre-operative blood work, the possible complications of the anesthesia/surgery, nor the post-operative care requirements. The member testified he had discussed these matters with the client but he presented no evidence to support his assertion.

The panel was of the opinion the member had failed to meet the standard and his actions would be regarded as unprofessional. The panel agreed a signed consent form as part of the medical record was not sufficient proof the client was fully informed. There were no notes in the medical record confirming that prior to surgery the procedures, potential complications, and post-operative care were discussed. There were no notes that indicated the informed consent sheet was provided to the owner and discussed.

Allegation: performed the surgery without proper training and/or experience

Decision: the College failed to prove its case against the member with regard to this allegation

Reasons for Decision: The panel was aware the onus was on the College to prove any allegation. It seemed obvious the member did not advise the owner he was inexperienced because in his opinion, he was not inexperienced. Although the member did not provide any specific evidence of having recently performed cherry eye surgery successfully in dogs, he testified that he was trained, qualified, and experienced. Beyond the expert opinion that the member's surgical technique was incorrect, the College did not provide any contrary evidence regarding his level of experience, his surgical training, or lack thereof and thus the panel agreed the College had not proven its case.

Allegations: failed to perform cherry eye surgery properly or competently/used inapprioriate suture knot placement

Decision: guilty

Reasons for Decision: The College's expert witness and a veterinarian witness agreed the dog's eye sutures were placed incorrectly and that resulted in corneal ulceration. The medical records of the clinic the dog was taken to for the second opinion stated corneal ulcers were found in both eyes adjacent to knots of suture.

The member's own records document the use of an inappropriate suture material. The College's expert witness testified suture migration was possible but unlikely. It was her opinion that the surgery was performed in a manner below the standards expected of a competent member.

The member testified he performed the surgery correctly and the fact that the cherry eye condition never reoccurred was proof of his proper technique. It was his opinion that suture migration likely occurred because of the dog rubbing at the eyes post-operatively or the owner cleaning around the eyes with water.

The panel agreed the member's surgical technique failed to meet the practice standard.

Allegation: used improper suture material

Decision: guilty

Reasons for Decision: The College's expert witness testified the manufacturer's monograph for this product and independent ophthalmic surgery texts warned against using this suture material for ophthalmic surgery and suggested another suture material and sizes for this procedure. The member's records indicate he used 3/0 monocryl and he confirmed this during his testimony. His rationale for this suture size was that the dog's condition was chronic and therefore required a large suture. It was unclear to the panel what his rationale was for the use of this particular product. In this regard, the panel agreed the member had failed to meet the practice standard.

Allegation: failed to provide proper and/or adequate anesthesia for surgery

Decision: guilty

Reasons for Decision: The medical records indicated that intravenous Propofol was used for anesthetic induction and the anesthesia was maintained via an endotracheal tube with isoflurane inhalant gas. A veterinary assistant testified the dog seemed to be lightly anesthetized and still had reflexes. She said the dog awoke during surgery and was barking and seemed to be having spasms. She testified the member left the room to obtain more anesthetic and gave the dog another intravenous injection. This observation was consistent with the medical record.

The College's expert witness testified she thought the plane of anesthesia was too light as the dog's respiratory rate as recorded on the monitoring log was very high. This opinion was consistent with notations in the anesthetic record from the second clinic which showed a much lower respiratory rate without evidence of response to surgical stimulation.

The member claimed the reason for the dog's movement and vocalization during the procedure was surgical stimulation. The panel was of the opinion that an animal should not exhibit movement due to surgical stimulation if properly anesthetized, and it certainly should not exhibit vocalization if properly intubated and maintained on an inhalant gas anesthetic.

The panel was of the opinion the member's actions in this regard fell below the standard of practice and would be regarded as unprofessional.

Allegation: failed to provide proper and/or adequate supportive medications post-operatively/failed to provide appropriate post-operative care through inadequate monitoring and inappropriate medications

Decision: guilty

Reasons for Decision: The College's expert witness said there was no evidence in the medical record of any rationale for the use of all of the various antibiotics which the member had prescribed. There were no clear entries in the medical records which spoke to the precise timing of the post-operative medications.

There were three occasions during the post-operative period where the member saw the dog and his comments did not indicate a proper examination was performed. The member's notes did not indicate any supportive testing, such as culture and sensitivity, nor did he document any thought process or clinical findings that would have justified the use of multiple or aggressive antibiotics, such as intravenous cephazolin. Despite the member's claims of staff entry errors, the matter of the Baytril dose (15 mg vs. 50 mg) and the apparent error in the recording of the drugs Maxidex vs Maxitrol, were not explained and

added to the confusion over post-operative care.

The panel was of the opinion the member failed to meet the standard of practice and his actions would be regarded as unprofessional with regard to his level of post-operative care and his use of post-operative medications.

Allegation: failed to properly manage the dog following surgery by hospitalizing the dog overnight on IV fluids without any monitoring

Decision: guilty

Reasons for Decision: The College's expert witness said that IV fluid administration during unsupervised overnight hospitalization fell below the standard of care. The panel could find no corroborated evidence of even intermittent monitoring. The member testified he told the owner the staff would stay late, but there was no notation in the medical record of the last time anyone saw the dog nor any indication of medical checks being done overnight.

The member testified he did monitor his patient with a camera system. The testimony was the first mention of such a system. When the member was questioned about the system, he could not provide any details about the camera's location, whether the camera had an audio component, if he monitored the system continuously while away from the clinic, and was his overnight location close enough to respond to a problem observed on the monitoring system.

The member refused to tell the panel his physical location throughout the night. The panel Chair explained this was important to determine if his potential response time was reasonable. The panel Chair ordered the member to answer the question but he refused and became angry and combative.

The panel agreed the member's actions regarding the overnight management of the dog's hospitalization would be regarded as unprofessional and fell below the practice standard. The panel further agreed the member's action would also be regarded as dishonourable in that the panel believed he was deceitful in his conversation with the client and in his testimony about the existence of a camera system to monitor the dog's overnight hospitalization.

Allegations: failed to properly document the dog's healing and response post-operatively

failed to properly examinde the dog, including his eyes, post-operatively

Decision: guilty

Reasons for Decision: The post operative medical records displayed a consistent and profound absence of any details related to the dog's ophthalmic condition. The member provided no evidence he did more than a cursory observation when he examined the dog; there are only four comments in the medical record between discharge on July 30 and transfer to the second clinic on Aug 13 that are associated with the member's evaluation of the eyes.

The College's expert witness said there is no submission to suggest the member attempted to thoroughly examine the dog's eyes as this would have necessitated the use of a topical ocular anesthetic and staining the corneas to detect the presence of corneal ulceration. Further, there is no indication the member attempted to obtain a culture swab from the eyes to guide treatment choices; and there is no documentation to indicate a thorough physical examination was performed.

The member testified there were several post-operative appointments scheduled but the client did not show up. The panel saw no evidence of those appointments in the medical record.

It was the panel's opinion the member's record keeping during the dog's post-operative healing period failed to meet the standard of practice. In addition, the panel agreed his lack of proper ocular examinations following the dog's surgery failed to meet the standard of practice and would be regarded as unprofessional and was unbecoming a veterinarian.

Allegation: failed to document the use of an Elizabethan collar while the dog was hospitalized

Decision: guilty

Reasons for Decision: While it was evident that an Elizabethan collar was sent home with the client, nothing in the medical record documented its use while the dog was in the clinic – either immediately post-operatively or during his overnight hospitalization. Considering the importance the member placed on the use of the Elizabethan collar after the dog was discharged (i.e. alleged possible cause of infection, ulceration, and suture migration), it seemed to the panel that documenting its use in the clinic was important and should have been recorded in the medical record.

The panel agreed the member failed to meet the practice standard and he had not created a proper medical record.

Allegation: failed to create or maintain adequate medical records

Decision: guilty

Reasons for Decision: The College's expert witness pointed out numerous examples of where the member's medical records were either completely absent, or when present, showed a consistent absence of detail (i.e. anesthetic inadequacy, use of an E Collar, rationale for antibiotics, corneal evaluations, IV fluid selection and administration rates, catheter placements). In many instances, the records and logs were contradictory and confusing (i.e. drug identification, drug dosages, pre-anesthetic scores). Although the member claimed he evaluated the eyes on multiple occasions, the medical records only noted cursory observations of the eyes on three visits. Important details such as remote monitoring through the night were not recorded in the record. The College's expert witness said the standard benchmark of whether another veterinarian could take over the case – i.e. understand what had happened, what the dog's condition was, what needed to be done ongoing and why - was not met. The panel agreed the member's medical records did not meet the standard of practice.

Of concern to the panel was the member's late submission of a document entitled "Treatment List". The panel was suspicious of the authenticity of this document. This page was filed with the College after the report of the College's expert witness had been received, in spite of the fact that the member had ample opportunity (and had been asked by the College on multiple occasions) to submit all documentation concerning the case before the College's expert witness was asked to provide an opinion. In addition, the page appeared to be inconsistent with what would be expected in a handwritten list that had been compiled with entries at many different times over a two-day period. For these reasons, and applying the standard of balance of probabilities, the panel concluded this document had likely been fabricated after its listed dates of July/2014. The panel found this conduct would be regarded as dishonourable and was unbecoming a veterinarian.

Reasons for Decision on Penalty:

During the course of the misconduct hearing, the member insisted he had done no wrong and refused to accept responsibility for his actions. Even after the panel delivered its findings and moved on to the penalty phase, he continued to place the blame on erroneous and discriminatory prosecution by the College. The panel was disappointed that he did not express any remorse for the pain and suffering he caused his patient, nor for the worry and stress he had inflicted upon his client.

The panel took into consideration that the member is a solo practitioner, and that he has already taken a record keeping course. The panel also noted the member has not had any previous disciplinary findings.

The panel agreed that it must denounce the member's actions in the strongest of terms. The professional misconduct exemplified by the

member has placed the profession in disrepute, and the panel's decision must provide a clear indication that such behaviour is abhorrent to the College and its members.

Of exceptional concern to the panel is the blatant refusal of the member to take any responsibility for his actions and to constantly attempt to find fault in the process, the College, and the panel itself. Although the panel believes that the many concessions afforded to the member concerning time taken, help given, clarity and redirection required by the unfamiliarity of the process, were necessary to move the hearing forward, it also has a concern that these actions may have been somewhat prejudicial to the College, who also chose to provide ample latitude to the member.

It is the panel's opinion that in no manner whatsoever did it fail to treat the member fairly, deny his fair rights, breach protocol, or disregard "the law of natural justice". The panel hopes the strong rehabilitative component of this penalty will provide a framework for the member to appreciate, understand, and address his deficiencies, and provide assurance to the public that the standards of quality of practice are preserved and their interest is well protected.

The primary function of the College is to protect the public interest and the panel was of the opinion that the conditions of the imposed penalty fulfilled that mandate. In this case, the public interest was protected by the strong rehabilitative focus of the penalty, and it offered the member ample opportunity to improve his practice and his knowledge.

General and specific deterrence were provided by publication of the facts of the case and by the licence suspension and rehabilitative financial obligations imposed. Specific deterrence was provided by the reprimand that served to impress upon the member the seriousness of his misconduct and the disrepute that it brought to the profession.

Reasons for Decision on Costs:

The panel was convinced the member took many steps to prolong the hearing. Examples of this would be the barrage of preliminary matters and objections, the continuing strategy of rearguing the allegations of professional misconduct long after that portion of the hearing was complete, and the necessity of calling the College Registrar for cross-examination during the cost phase, to name a few. The defence at many times appeared to be disorganized, sometimes leading to long periods of silence in the hearing while papers were shuffled, sorted, and re-examined. Questions were often repetitive or irrelevant to the topic under discussion. Throughout the costs phase of the hearing there was little substantive evidence or argument presented by the defence to help guide the panel to formulate its order for costs. The help, guidance and direction offered by the panel Chair (and at times ILC and College Counsel) was often ignored. Also ignored by the member were the guilty verdicts pertaining to 13 of the 15 allegations.

The panel agreed the position adopted by the defence was unreasonable. The defence presented no expert witness to refute the testimony presented by the College, and no credible evidence to support its assertion that the member had done no wrong. The defence strategy was almost totally an attack on the College and the Discipline procedure.

The College was obligated to prepare, research, and respond to the preliminary matters, motions and objections presented over the eight and a half day hearing. The panel agreed those responses came with a justifiable cost. The panel found that, considering the prolonged and unnecessarily adversarial nature of this hearing, the allocation of College resources appeared to be quite reasonable.

Some of the allegations were very serious. One example would be the allegation which addressed the monitoring of his patient overnight. The member either refused to answer questions or would only provide testimony that was deliberately evasive, and the panel did not believe him. The member was found guilty of professional misconduct that was deemed to be regarded as not only unprofessional, but dishonourable. Another allegation spoke to the complete absence of required portions of the medical records. Any records that were present had a consistent lack of detail. In many instances records and logs were contradictory and confusing. The member was found guilty under three separate paragraphs including conduct that would be regarded as dishonourable. The panel was in full agreement that the charges were most serious.

The panel was aware the member is a solo practitioner. Other than that, the member did not provide any substantive evidence that he had any further mitigating circumstances that were relevant to the costs portion of the hearing.

The panel studied all the materials provided, carefully listened to all arguments, and actively deliberated, while realizing it did have wide discretion in the assignment of a costs award. They were also cognisant of the large cost being sought by the College. It is the panel's view that the member had been made aware of the potential for a large costs order. The magnitude of these costs was, in large part, due to the tactical line of defence he had chosen to follow. The member had at least two opportunities to settle this matter and he chose to ignore those opportunities.

It was unfortunate that this matter ended up in a contested disciplinary hearing, rather than being settled by negotiation during the pre-hearing process. As an example, it seemed to the panel that this case might have easily been resolved with an agreement from the member to receive some remedial training in both surgery and record keeping, along with a nominal costs award and some period of licence restriction. Instead, the member chose to take the matter to a contested hearing, as was his right. However, it seemed to the panel that the refusal of the member to accept any responsibility for his actions probably played a large part in the failure to achieve a negotiated settlement, and this attitude continued throughout the hearing, adding greatly to the length and significantly to the cost of the process. In addition, the member's choice to be self-represented (through his daughter) also added considerable time and expense to the hearing by frequently causing the normal flow of the procedure to be diverted and delayed.