NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Wagdy Abdalla Botros, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Botros, 2015 ONCPSD 31

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. WAGDY ABDALLA BOTROS

PANEL MEMBERS:

DR. P. TADROS (CHAIR)
DR. E. ATTIA (Ph.D.)
DR. C. CLAPPERTON
DR. J. WATTS

Hearing Dates:	**2013:** July 15 to 18 and August 26 to 27 and 30 **2014:** January 20, 22 to 24 and June 10
Decision Date:	July 31, 2015
Release of Written Reasons:	July 31, 2015

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on July 15 to 18, August 26 to 27, 30, 2013, and January 20, 22 to 24 and June 10, 2014. At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATIONS

The Notice of Hearing alleged that Dr. Botros committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

2. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

It is also alleged that Dr. Botros is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, ("the Code").

RESPONSE TO ALLEGATIONS

Dr. Botros denied the allegations in the Notice of Hearing.

SLEEP MEDICINE - DEFINITION OF TERMS

Dr. Botros is a psychiatrist who practises sleep medicine full-time.

Due to the technical nature of certain aspects of this area of practice, some general definitions are helpful to understand the practice of sleep medicine.

Apnea: Cessation of breath or airflow at the mouth and/or nose for ten seconds or longer.

Three Types of Apnea:

1. Obstructive – when the upper airway (throat) closes completely. The patient is asleep and struggles to breathe.
2. Central – the breathing stops for ten seconds or longer, but no obstruction.
3. Mixed – a component of central apnea followed by obstruction.

Hypopnea: Obstruction is not complete but there is reduced breathing of 10 seconds or longer.

Apnea-Hypopnea Index: The number of times a patient stopped breathing completely or partially in an hour.

Diagnostic Sleep Study or Polysomnogram: The patient is wired for measurement of an electroencephalogram (brain waves), heart rate, oxygen, eye movement (to detect rapid eye movement sleep or dreaming), chin muscle activity, movement of the legs and thermistors that detect changes in temperature of air going through the nose, as well as belts for movement of the chest and abdomen to detect whether the apnea is central, obstructive or both. A central computer at a station analyzes all the data relayed by the transducers.

Continuous Positive Airway Pressure (CPAP): A compressor that generates air pressure through a tube into an airtight mask. The pressure keeps the throat open so the patient has a reduction in apnea, hypopnea, lack of oxygen or snoring.

Bi-level Positive Airway Pressure (BiPAP): A more sophisticated machine delivering a higher pressure breathing in and a lower pressure breathing out. Depending on the pressure differences, it may act as a ventilator.

Titration Sleep Study: Generates numerical values of apneas, hypopneas and oxygen saturations (along with other data) at different CPAP pressures so a decision can be made about what the correct pressure is for the patient.

Oxygen Saturation: The hemoglobin in the red blood cells carry oxygen and when it is saturated or full of oxygen, the saturation is typically 97 to 98%. When there is apnea, or reduced breathing, the saturation drops. Reduced oxygen saturation for lengthy periods has serious long-term consequences for health.

FACTS AND EVIDENCE

Overview of the Issues

The issues in this case are as follows:

1. Did Dr. Botros fail to maintain the standard of practice in his care patients from the Kitchener and London Sleep Clinics between 2007 and 2010?
2. Is Dr. Botros incompetent?
3. Did Dr. Botros engage in conduct relevant to the practice of medicine that, having regard to all the circumstances would reasonably be regarded as disgraceful, dishonourable or unprofessional,
    a) in his treatment of the College investigators; and,
    b) in the delay in the provision of requested material for the expert witnesses.

Regarding the allegation of failing to maintain the standard of practice, there were three issues that related to 23 patients:

a) whether Dr. Botros failed to provide an adequate standard sleep study interpretation;
b) whether Dr. Botros failed to triage patient referrals; and,
c) whether Dr. Botros failed to conduct physical examinations of patients and / or failed to document his physical findings.

d) Beyond these three issues, there were specific issues as follows:

i) whether Dr. Botros prescribed inappropriate CPAP pressure following CPAP titration studies (Patients 1, 2, 3, 4);

ii) whether Dr. Botros failed to take appropriate steps to treat patients with severe obstructive sleep apnea within a reasonable period of time (Patients 3, 5, 6);

iii) whether Dr. Botros allowed patients to be prescribed CPAP without first being seen by a sleep physician (Patients 7 and 8);

iv) whether Dr. Botros failed to document prescribed pressures (Patients 7, 1, 2, 4, 8);

v) whether Dr. Botros incorrectly or incompletely diagnosed patients (Patients 9, 10, 11, 12, 13, 14, 15, 16);

vi) whether Dr. Botros failed to appropriately notify or follow up with the Ministry of Transportation (Patients 17, 2 and 6)

vii) whether Dr. Botros failed to appropriately prescribe supplemental oxygen for a patient on CPAP therapy (Patient 18)

viii) whether Dr. Botros demonstrated poor knowledge and understanding regarding CPAP treatment.

Regarding the allegation of incompetence, the Committee considered this allegation in relation to Dr. Botros' care of patients generally and specifically, in relation to his care of five patients - Patients 5, 6, 3, 14 and 18.

Finally, the Committee considered whether Dr. Botros' treatment of the College investigators and conduct regarding the provision of requested documents for the expert witnesses, would be considered disgraceful, dishonourable or unprofessional.

Applicable Legislation and Legal Principles

Burden and Standard of Proof

The College has the burden of proving the allegations of professional misconduct and incompetence against Dr. Botros. The Committee recognizes that it must make its findings based on a balance of probabilities with evidence that is clear, cogent and convincing.

Failure to Maintain the Standard of Practice

A failure to maintain the standard of practice of the profession is an act of professional misconduct under section 1(1) 2 of Ontario Regulation 856/93, made under the *Medicine Act, 1991*. The standard of practice is defined as the standard that is reasonably expected of the ordinary, competent practitioner in the member's field of practice. It is not necessary to find that there has been harm in order to find that there has been a failure to maintain the standard of practice.

The Committee recognizes that the standard of practice may be established on the basis of evidence from experts, policy publications from the College, guidelines published in particular areas of practice, teaching and residency programs, current practice patterns, as well as other sources.

Incompetence

To make a finding of incompetence under s. 52(1) of the Code, the Committee must be satisfied that the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to practise, or that his or her practice should be restricted.

Incompetence differs from professional misconduct in that a finding of professional misconduct will be based on events that occurred in the past. An assessment of incompetence is based on the member's care of patients in the past, but the Committee

must be satisfied that the member is currently incompetent in order to make a finding of incompetence.

Summary of the Evidence

The Committee heard evidence from two expert witnesses, Dr. X and Dr. Y. Dr. X provided opinion evidence regarding Dr. Botros' care of 25 patients from the Kitchener Sleep Clinic whose charts he had reviewed as part of a section 75(1)(b) investigation. Thirteen of the 25 patient charts were submitted in evidence. Dr. Y gave opinion evidence regarding 10 patients whose charts were identified during an Independent Health Facilities (IHF) review of the London and Kitchener Clinics and submitted in evidence. Of the 23 charts submitted in evidence, one patient (Patient 19) was seen by another consultant at Dr. Botros' clinic and therefore, the Committee made no finding in respect of that patient and considered 22 patient charts in its review.

In addition to the two experts, the Committee heard evidence from two College investigators, Ms A and Ms B, in support of the College's position on the unprofessional conduct allegations.

Dr. Botros testified himself but did not call any expert witnesses.

In addition to witnesses, the Committee was presented with documentary evidence, including: a joint book of documents that included the relevant patient charts, the IHF Clinical Practice Parameters and Facility Standards for Sleep Medicine from 2005 and the revised standards from 2011, and correspondence from the investigators to Dr. Botros. The Committee also had the experts' written reports, a memo to file from Ms B, excerpts from a textbook on sleep medicine, as well as other documentary material.

The Expert Witnesses - Reliability and Credibility

Dr. X

Dr. X is a respirologist with lengthy experience in that field. He is currently an Assistant Professor in the Department of Medicine at the University of Toronto, which involves teaching residents and giving presentations to family practice residents and others.

Dr. X became involved in the opening of the first sleep clinic at his hospital in 1995 and was fully involved until two years ago. He has also worked at other sleep clinics for several years. He continues to teach and give presentations in the sleep medicine field.

The Committee accepted Dr. X as qualified to give evidence as an expert in the area of sleep medicine.

The Committee found Dr. X credible and reliable in his testimony, and accepted his opinions on the care of patients by Dr. Botros, as specified in this decision.

Dr. Y

Dr. Y is an otolaryngologist (ear, nose and throat specialist) with many years of experience in that field. He has been practising sleep medicine since 1992, when he opened a sleep lab with a partner. He has also been an owner of various sleep clinics over the years.

Dr. Y was the co-chair of the Committee developing the second edition of the Clinical Practice Parameters and Facility Standards for Independent Health Facilities, a document developed with the College of Physicians and Surgeons of Ontario. The document is a set of rules, regulations and recommended procedures for sleep medicine facilities. Dr. Y was an Independent Health Facilities Assessor for Sleep Laboratories from 2005 to 2009. He has also acted as a sleep preceptor for the College. That entails supervising another physician who has been having problems with his practice of sleep medicine.

The Committee accepted Dr. Y to give evidence as an expert in the area of sleep medicine. The Committee found Dr. Y credible and his evidence reliable and accepted his opinions on the care of patients by Dr. Botros, as specified in this decision.

Dr. Botros – Reliability and Credibility

Dr. Botros is a psychiatrist who became a fellow of the Royal College of Physicians and Surgeons in Psychiatry in 1990. He has been involved in the sleep medicine field at various clinics since 1994. He completed a two-week course in sleep medicine in the United States and obtained his American Board Certification in 2002.

Dr. Botros frequently portrayed himself as a victim of the College during their investigations, with comments such as "But my thinking was always, what did I do wrong? Does that happen to every physician in this province? [Does] every physician get picked on?"

Dr. Botros' responses to questions were often discursive and off-topic. For example, he was asked many times whether or not the Standard Sleep Study Interpretation form was simply a computer generated template and he was evasive and rambling.

Even when not challenged and simply being referred to an issue of his management of a patient, Dr. Botros said, "So we didn't do anything wrong" and "There is nothing wrong with that" when speaking about an inadequate CPAP pressure that a patient had been receiving at home, for example.

He displayed arrogance at times. He was disparaging of the expert witnesses, for example, because they did not practise sleep medicine full-time and were not Board Certified in the United States. When commenting on Dr. Y's criticism of him for not fast-tracking a patient, Dr. Botros said, "So, this overreacting to an idea, it's a first-year resident behaviour, not an experienced physician." Dr. Botros was often disparaging of the questions asked by College counsel. For example, when asked about why he did not complete physical examinations prior to prescribing CPAP for patients and specifically contraindications in certain patients, he responded, "The contraindication that Dr. X

referred to is something out of science fiction. It's a hole in your nose that's going to your brain. That's what Dr. X is going by. How many patients have you seen with a hole in the nose going to their brain?" And later on the same topic, "If you know what that means, and how often it happens, you would---nobody would ask the question…" Dr. Botros would sometimes twist the question to deflect attention from his actions. In the above example, by focusing on a rare contraindication, he deflected attention from the point, i.e., that he was not examining and speaking to patients prior to their beginning CPAP treatment.

When questioned by College counsel about the patient questionnaire and the questions about daytime sleepiness and whether or not the patient was reported to the Ministry of Transportation, Dr. Botros gave a lengthy reply about daytime sleepiness being circumstance specific. In the course of that response, he said, "That's why people with a science degree would not have asked that question." His derogatory comment was not an isolated one.

Later, when he was asked about why the titration table was misleading, Dr. Botros went on to say, "If you understand how math works…", and proceeded to testify regarding the pitfalls of choosing a small raw sample and that if only a narrow band is chosen, it would be misleading. When he was asked if the standards with regard to the titration table support the expert opinion, Dr. Botros replied (referring to himself), "…if the physician's experience, knowledge and expertise is ahead of the standard, then that's what it is."

Dr. Botros' manner of testimony detracted from the task at hand in the Committee's quest for the truth. The Committee, in its analysis of the evidence and testimony, was aware of and took into account Dr. Botros' response style. His credibility and the reliability of his evidence suffered. He appeared unable to admit to even the smallest omission or error that would normally be expected in any practice dealing with huge amounts of material and data.

1. Did Dr. Botros fail to maintain the standard of practice of the profession?

a) Did Dr. Botros fail to maintain the standard of practice with respect to his sleep study interpretation?

The second edition of standards for sleep medicine titled, *Independent Health Facilities, Clinical Practice Parameters and Facility Standards, Sleep Medicine* (the Standards) was in effect at the time of the investigation into Dr. Botros' practice. The Committee finds on the expert testimony that the Standards reflected the standard of practice of the profession at all relevant times.

The Standards state that a qualified sleep physician must review the data, interpret the polysomnogram and issue a final report within four weeks of the study date. The report sent to the referring doctor should contain a summary of the data, indices of sleep architecture, sleep disorders, breathing and saturations, abnormal movements, arousals and behaviour, and a histogram correlating these events along with the sleep physician's final interpretation.

The Standards also state that a short narrative summary will assist the referring physician in understanding the basis of the findings. Finally, the Standards indicate that it may be desirable to include further recommendations and an indication of who is to be responsible for implementing further action.

The Standard Sleep Study Interpretation form utilized by Dr. Botros to report the sleep study was common to all 22 patients. The experts, Drs. X and Y, were critical of Dr. Botros' form as it was a computer generated quantitative summation of the data with comments defining normal and abnormal values and ranges; it contained no evidence of the physician's conclusion(s) in the form of diagnoses, differential diagnoses, interpretation or analysis, or patient-specific recommendations as required by the Standards. Both experts testified that the sleep study is a test which has to be interpreted and reported independent of seeing the patient in consultation. The study is done, interpreted and a report of the study is provided via a form. Then, the patient is seen in

consultation and a consultation report, which usually repeats the sleep study interpretation, follows.

Dr. X testified that some of the information on Dr. Botros' form did contain the elements of sleep architecture, the physical diagnosis of the presentation and the course of the study done overnight.

Dr. Y in his report noted that Dr. Botros' form had a single standard for normal; a "one-fits-all" range for the entire adult population, which he said is inaccurate and inappropriate. He testified that many of the parameters have different normal ranges that vary according to the individual's age. In cross examination, Dr. Y indicated how the normative values in Dr. Botros' form were close to the values that Dr. Y considered ideal and those noted in the Standards.

Dr. Y testified that the lower half of the second page of Dr. Botros' form was "useless". For example, he said the comments "Obstructive sleep apnea is diagnosed based on respiratory disturbance index (RDI), mild, moderate or severe," but with no numbers given, although they appear several lines above this line. The next sentence "Insomnia syndrome…" lists some of the criteria for diagnosis, but many other reasons are not listed. Further along on that page, the sentence, "Comorbidity of Sleep Disordered Condition…", lists some of the possible differential diagnoses and reports that further clinical information is completed by a sleep medicine specialist after clinical assessment, sleep history, and examination of the patient. Dr. Y thought that this report would not provide a clinical interpretation or differential diagnosis. Dr. Y called this document a "do-it-yourself" interpretation. According to Dr. X, Dr. Botros did not intervene in the Sleep Study Interpretation, in that he did not add his own analysis or opinion.

Dr. Y noted that Dr. Botros' signature on the Standard Sleep Study Interpretation form was electronic and a disclaimer line stating "dictated but not read" was at the bottom of the form. Dr. Y was confused about why the Sleep Study Interpretation would be stamped "dictated but not read" when it was a standard template and clearly had not been dictated. Under the electronic signature was another disclaimer line stating "For sleep

study purposes only". Each form also included a standard recommendation that the patient see a sleep medicine specialist as scheduled at the clinic.

Dr. Y testified that the second edition of the Standards did not provide a prescribed form for reporting sleep study information to referring physicians. In looking at the information in the chart of Patient 21, Dr. Y acknowledged that the package of information provided to the referring physician, which included the Sleep Study Interpretation form and the Summary Document, along with the history form, three pages of study information, two pages of a history and a medication form filled out by the patient, and another form filled out by the sleep technician outlining data from the diagnostic sleep study at different periods through the night, would be in compliance with the Standards and meet the required standard of practice of the profession.

Dr. Botros' Standard Sleep Study Interpretation form was virtually the same for every patient, although some were not stamped with the doctor's signature stamp, including those related to Patients 4, 19, 9, 10, 11, 7, 17, 1, 12, 13, 18, 2, and 20. The foregoing had no signature either. Other than Patient 4 from the London Sleep Clinic, the rest of the patients were seen at Dr. Botros' Kitchener Clinic.

Dr. Botros testified that some Standard Sleep Study Interpretation forms do not have a stamp with his name because "probably, there is another signature on another document that is going out."

Dr. X testified that the most important part of the sleep study is the narrative summary of the abnormalities, including a firm diagnosis and recommendation, so that the referring doctor will understand what the results mean. It is not essential for the sleep physician to have seen the patient before completing an interpretation or report, as its chief purpose is to interpret the data provided by the sleep study. While it is appropriate to provide an interpretation of the sleep study in the consultation report, it does not meet the requirements of the *Independent Health Facilities Act* for providing the interpretation with the sleep study report, according to Dr. Y. He went on to explain that when the sleep study is done, the physician must review all the data, make an interpretation, and send a report to the referring physician. When the subsequent consultation is done, the sleep

medicine physician would probably repeat the interpretation in the consultation report and then it forms part of the consultation note.

Dr. Botros testified that almost 100% percent of the patients referred to him receive a consultation, and that the consultation appointment with the patient is important to come to a diagnosis and to determine patient treatment.

College counsel asked Dr. Botros several times whether or not his Sleep Study Interpretation form was in fact a computer-generated template. Dr. Botros repeatedly sidestepped the question and testified about “quality control”. Dr. Botros testified that the information was only transferred onto the Standard Sleep Study Interpretation form once he ascertained that the raw data reflected what actually happened through the night. Once the Standard Sleep Study Interpretation form is “authenticated” in this way, the explanation in conjunction with his dictation goes in the Summary and Management form. Once he has satisfied himself that the file and scoring match each other and are “legitimate”, he arranges for a staff member to stamp the form before they put it back in the patient’s file and enter it into a “Quality Control” book or lab book, which he said was similar to his log book or referral book. Dr. Botros testified that when an entry has been done, it signifies that the patient has been seen or the “quality control” has been done. However, he also testified that he wrote the words “quality control” or QC to signify that he has looked at the raw data. When Dr. Botros was asked if there was an exercise of patient-specific skill and judgment in connection with any of the information found on the Standard Sleep Study Interpretation form, Dr. Botros answered that it was generated by a computer along with the table and the document was “legitimate” and could be sent out only once “quality control” had been documented. Dr. Botros explained that a nurse and the chief technician sat with him for every patient, to show the patient the raw data for all the files. He said the patient is shown the display of the brain wave activity, their breathing and oxygen levels and their electrocardiogram (ECG). Dr. Botros said that once he is satisfied that quality control had been documented, he dictates that section of the Summary and Management letter, to reflect the patient’s study.

Dr. Botros provided two examples of the Standard Sleep Study Interpretation form after the proceedings started that reflect his current practice. Both of these contain a succinct diagnosis in the summary section (Exhibits 34 and 35).

Finding regarding Standard Sleep Study Interpretation

The experts and the Standards were clear that the sleep medicine physician through the Standard Sleep Study Interpretation form needed to provide a report of the sleep medicine physician's interpretation of the sleep study data so that the referring physician would know what the diagnosis was and if there was a problem, the recommendation. Dr. Botros' Standard Sleep Study Interpretation form documented neither of these in the cases reviewed. The Committee was persuaded that Dr. Botros failed to maintain the standard of practice of the profession regarding sleep study interpretation based on the deficient content of the Standard Sleep Study Interpretation form that he included in the information package.

Notwithstanding Dr. Botros' testimony about quality control, there was no evidence of Dr. Botros' interpretation and explanation in plain language for the referring physician in the Standard Sleep Study Interpretation form as required. Dr. Y's comment that this was a "do-it-yourself" document was accurate in the Committee's view. It would be very difficult, if not impossible, for any referring physician to read Dr. Botros' Standard Sleep Study Interpretation form and make sense of it or find it helpful in the treatment of the patient.

The Committee concluded that Dr. Botros did not have input into the completion of the Standard Sleep Study Interpretation form. Dr. Botros failed to maintain the standard of practice of the profession with regard to his lack of sleep study interpretation. This failure is common to all 22 charts reviewed. This general finding will not be repeated with every patient's care reviewed in the subsequent analysis of the evidence and findings.

b) Did Dr. Botros fail to maintain the standard of practice with regard to triage of all patient referrals?

The Standards clearly state that signed requisitions are required for all sleep studies and they must include information relevant to the referral. The requisition must be clear that the referring physician may request a sleep assessment only, or a consultation only, or both. The Standards also require that the sleep medicine physician review and triage all patient referrals by deciding the appropriateness of the request.

Dr. X testified that when the referring doctor has indicated, “snoring, un-refreshing sleep, daytime sleepiness” the patient needs a sleep study first as it saves the taxpayer money to do the assessment after the sleep study. If the requisition reads, “insomnia, anxiety, poor sleep quality,” the patient needs to be seen first. Dr. X testified that a sleep study should not take place first in those cases. Nor should a sleep study take place first in the case of a CPAP reassessment.

Dr. Y points out in his report that there are two unusual stamps on the requisitions from the referring physicians in Dr. Botros’ patient files. One contains an unusual addendum, “For sleep study purposes only” and the other stamp notes, “Confirmed physician requested sleep study and consult.” Dr. Y pointed out that there was no indication which staff received confirmation about what, and from whom the confirmation was obtained. A review of the patient charts revealed that another stamp appears on the requisition in most of the charts, “Please book” followed by circles to tick stating, “sleep study, CPAP study or consultation.” Most of the requisitions had a box to tick at the top, reading “Triage by Medical Director” and some had “Triage by Medical Director” in handwriting that did not appear to belong to Dr. Botros. Three charts had no requisition and one, Patient 5, had a note saying the referral was phoned in. The fact that there was no indication that Dr. Botros applied the stamp and triaged the patients led Dr. Y to doubt whether Dr. Botros was compliant with the Standards. Dr. X, in his evidence, accepted that Dr. Botros triaged the sleep study referrals, although the basis for this is unclear.

Dr. Botros testified that he triaged the patient referrals. He testified that the use of the three stamps was in response to previous inspections and investigations and the stamp application is done by the staff under his direction. In his examination-in-chief, he testified that the staff put all the referrals in a referral book and he looks through them and notes nothing unusual about them. He said they are all going to be booked for a study. He testified that he then picks up the referrals and looks through them and asks the staff to book them and the staff applies the stamp.

Later, when Dr. Botros was asked why he did not initial the requisitions to indicate he had seen them, he answered that it would mean initialing 300 forms a month because every day, he receives reports from hospitals that are dictated but not signed.

Finding related to Triage of Patient Referrals

The Standards are clear that the sleep medicine specialist must review and triage patient referrals for sleep studies.

Dr. Y was skeptical about Dr. Botros' involvement in the triage process as the use of a stamp does not make any sense when all Dr. Botros needed to do was initial the form indicating that he had seen it and triaged it. Counsel for Dr. Botros submitted that Dr. Y's criticism of the use of stamps amounted to only speculation that Dr. Botros did not actually triage patient referrals. She submitted that Dr. X confirmed that the triage process was acceptable. However, the Committee could not discern the basis in the evidence for Dr. X's view and therefore did not give it weight. Dr. Botros' own evidence leads the Committee to conclude that he did not.

In addition, there were three boxes – Sleep Study, CPAP study or consult - that could be ticked after the stamp was applied. If Dr. Botros simply looked at the forms and handed them over to the staff to stamp, it is not clear how he would have denoted whether to book all of the appointments. A review of the patient charts suggests that all of the patients had a sleep study and follow up appointments booked at the same time (with the exception of Patient 5). None of the patients had a consult before the sleep study and none were booked for a consultation appointment after the sleep study. It appears that Dr.

Botros did not do any triage at all. He simply booked all the patients for a sleep study irrespective of what their problem was. Two of the patients (7 and 18) were fast tracked, but it is not clear that Dr. Botros actually had any input into that decision. Dr. Botros never answered adequately the repeated question put to him, i.e., why did he not simply initial the requisition to indicate his involvement during triage.

Dr. Botros had another version of how triage occurred - that he and his staff triaged the referrals systematically together in a line. This is a different method than the one he described where the staff put all the referrals in a book that he looked at a couple of times a week and then handed over to them to stamp and book.

The Committee concludes that triage cannot be done unless the medical information on the referral form is reviewed for appropriateness, as well as for the type of testing required. Stamps or writing in a referral book do not accomplish that goal. The simplest method to triage would be to review the forms and initial them. Dr. Botros said that he did not do that.

Dr. Botros testified that he gets roughly 300 reports and referral forms a month, intimating that it would be difficult for him to initial them. There was no reason for a box to be ticked saying Triage by Medical Director or to indicate the same thing in someone else's handwriting. If Dr. Botros' testimony is to be believed, he made the process more complicated and time consuming, which strains credulity. The simplest way to deal with triage was to review and initial the forms. If he did not have the time to initial the forms, this suggests to the Committee that he did not take the time to read them. The Committee finds that Dr. Botros did not initial the form, or sign it, because he did not do the triage himself in all cases.

In fact, the Committee questions whether Dr. Botros was in fact doing triage at all, versus simply booking all patients for a sleep study, irrespective of whether they would have benefitted from an initial consult to determine whether the sleep study was necessary. All indications are that every patient was simply booked for a sleep study and a follow up appointment, with the exceptions of Patient 5 and there are no bookings indicated for Patient 21, although he had appointments. If Dr. Botros had triaged Patient 6 for an initial

consult, it would have been determined that he had already had a sleep study and he would not have waited for such a lengthy time for his CPAP titration study.

The Committee finds that Dr. Botros failed to maintain the standard of practice in that he failed to review and triage the patient referrals. This finding regarding failure to triage is common to all 22 cases and will not be repeated for each of them.

c) Did Dr. Botros fail to maintain the standard of practice in failing to complete or document physical examinations of patients?

Dr. X testified that 94% of sleep apnea patients snore. In the section pertaining to assessment of a snoring patient in the second edition of the Standards, there is reference to a physical examination. The examination is largely limited to the head and neck and a long list of potential observations and abnormalities are listed. In addition to the head and neck examination, measurement of blood pressure and thyroid should be undertaken and an assessment for cyanosis and cardiac failure should be done according to the Standards. Except for the section related to snoring, the second edition of the Standards does not provide a guideline regarding physical examination.

In his testimony, Dr. X was critical that there was no notation of a physical examination by Dr. Botros in 7 of the 25 patient charts he reviewed. Dr. X testified that it was inconceivable to not conduct an examination on a patient who has apnea, and he does not believe it is necessary to have a manual to recommend a physical examination. In other cases, the examination was incomplete with no detail provided. Dr. X testified that the lack of physical examination failed to meet the standard of practice.

The Committee examined the handwritten clinical notes and summaries of the charts reviewed by Dr. X, along with Dr. Botros' testimony. Dr. Botros' handwriting is very difficult to read. The Committee's review indicates that there was no physical examination recorded for 3 of the 7 patients identified by Dr. X, Patients 1, 11, 18, and also, on the Committee's review, Patient 22. The remaining charts indicate an examination of the airway. Dr. Botros charted a brief line denoting a normal opening, or pharynx normal, for Patients 10, 7, 20, 13.

Dr. Y testified that a very basic examination of a patient with significant sleep apnea must include an examination of the upper airway, in particular the oro-pharynx, the throat, and the mouth. However, Dr. Y did not note in his report deficiencies with Dr. Botros' physical examination, although he testified that Patient 3 lacked a physical examination.

The Committee examined the charts that Dr. Y reviewed. Patients 15, 6, 23, 4 and 8 had at least a cursory examination of the throat as noted in the typed "Summary, Management and Conclusion" page of the consultation letter. Whether or not the other patients Dr. Y reviewed had a physical examination is not clear from the clinical notes.

Dr. Botros testified that he examined the pharynx in every case and noted any abnormalities or findings that were relevant to rule out physical obstruction.

Findings in relation to Failing to Complete or Document Physical Examinations

The requirement to do a physical examination in the sleep medicine context is not onerous. The Committee is of the view that despite the lack of a general guideline related to physical examination in the second edition of the Standards, a physician practising in sleep medicine or for that matter in any area of medicine is required to examine the system of interest and to document his or her findings.

Dr. X testified that it was inconceivable to not conduct a physical examination on a patient with apnea and that it need not be spelled out given it is a basic requirement in medicine to conduct a physical examination.

The Committee finds that the allegation that Dr. Botros failed to complete physical examinations is proved for Patient 1. With respect to Patients 11, 18 and 22, the Committee finds that Dr. Botros either failed to complete a physical examination, or failed to document it. Dr. Botros' testimony that he examined the patient's pharynx in every case was clearly not so, as he admitted in his testimony that he did not conduct a physical examination of Patient 1. It is not clear from the clinical notes whether all of the patients reviewed by Dr. Y were examined. Five of the patients reviewed by Dr. Y had a

clinical exam documented; the Committee could not ascertain whether or not the remaining five had a physical as Dr. Botros' note is so hard to read.

d) Specific Allegations Related to Clinical Care

The Committee considered specific allegations related to 17 of the 22 patients. In some cases, there was one and in other cases, there were multiple specific allegations and an allegation of incompetence related to the patient's care.

i) Allegation that Dr. Botros prescribed inappropriate CPAP pressure following CPAP Titration Studies (Patients 1, 2, 3 and 4)

Patient 1

Dr. X summarized this patient as having obstructive sleep apnea with the additional problem of depression. The patient had been receiving nasal CPAP for about a year and was evaluated with a repeat sleep study and nasal CPAP titration at Dr. Botros' clinic. However, the pressures were not moved up quickly enough, according to Dr. X, and the titration was unsatisfactory. The patient had an apnea-hypopnea index (AHI) of 24.6 indicating that a moderate sleep apnea persists. Dr. X testified that the condition has a risk similar to hypertension, diabetes and high cholesterol and the AHI index should be below 5 per hour. He said that the AHI of 24.6 per hour is unacceptable and the patient required further intervention. The options included requesting permission for a repeat nasal CPAP titration from the Ministry of Health, or asking one of the CPAP companies to provide the patient with an automatic CPAP system and provide the CPAP supplier with a pressure range.

In his interpretation of this case, Dr. X testified that the key piece of information was the best or ideal CPAP (pressure) and a description of the AHI and oxygen saturation at different CPAP pressure levels. There was no ideal pressure indicated on the Standard Sleep Study Interpretation form for this patient. Dr. X testified that Dr. Botros mentioned in his consultation note that the patient acknowledged benefit with the CPAP device with improved daytime energy, but it was not clear to Dr. X whether the patient was using the CPAP regularly or correctly, or whether the pressure was different at that time.

Dr. Botros' consultation note also said that the pressure was adjusted upwards to 8 to 9 cm of water but he did not note the patient's previous CPAP pressure. Dr. X thought that should have been clearly stated. If the pressure is 8 and the patient had 24.6 apneas or partial apneas per hour, the patient would have very significant underlying obstructive sleep apnea and be exposed to the risks associated with it, even if he is feeling less tired. Dr. X was critical because Dr. Botros did not comment about what the AHI was to the referring doctor. Dr. Botros' only comment was that "We will keep you informed of the patient's progress." There is no indication that other options were considered by Dr. Botros and if they were, they should have been detailed in the consultation note.

Dr. X said that the results of the CPAP titration, the interpretation, the consultation note and the recommendations did not meet the standard of practice. He said that Dr. Botros had not put any thought into this matter. He also commented that in his consultation note, Dr. Botros refers to the AHI of 15, which is the average AHI over the course of the titration, and this is meaningless information in the context of a CPAP titration study where the purpose is to determine the recommended pressure for CPAP. As mentioned above, the important index is the number of apnea/hypopnea events at different pressures so that the ideal pressure can be determined, along with other considerations. This patient had not been helped according to Dr. X.

Dr. Botros testified that his clinic did not know what pressure the patient was on previously and there was no note that the clinic attempted to find out. Dr. Botros agreed that this was not a good titration for this patient as the patient slept only 50% of the time. He also testified that there were twelve central apneic episodes through the night and they can be exacerbated by a higher pressure. Dr. Botros said this patient was under his care for two years and he could come at any time if he did not achieve success with the intervention they completed. He also admitted that he did not do a physical examination on this patient.

Finding regarding Patient 1

This patient came to see Dr. Botros because his daytime energy was low. At the end of titration, Patient 1 had significant episodes of apnea and hypopnea. The inadequate

titration was not Dr. Botros' fault; it was in large part because the patient slept only 50% of the time. Dr. Botros did not arrange for follow-up of this patient even though he continued to have moderate sleep apnea. Reporting the average AHI over the course of the night was misleading and made the titration sound better than it was.

The Committee finds that Dr. Botros in his care of this patient failed to maintain the standard of practice, in that the pressure prescribed was inadequate. In the Committee's view, Dr. Botros' approach was lackadaisical. Dr. Botros did not arrange for a follow-up appointment to deal with the problem. The patient was at risk and Dr. Botros was content to allow the patient to return to his clinic if he felt it was necessary in the following two years. There was no indication that the patient was informed that he still had moderate sleep apnea. Nor was this fact spelled out to the referring doctor. There was little analysis of this case by Dr. Botros and he showed a lack of concern for the patient's welfare.

Patient 2

Patient 2 suffered from bipolar affective disorder and was referred to the clinic complaining of difficulty falling asleep and daytime fatigue. Her initial sleep study showed very severe obstructive sleep apnea with an AHI of 119.7 per hour. Dr. X testified that it cannot get much worse than that. Her oxygen saturation was below 90% for three hours, 52 minutes and 30 seconds. It was below 80% for one hour and 29 minutes. She had a CPAP titration study five days later. When the CPAP pressure was set at 11, the patient's AHI was 8.4, with normal or acceptable oxygen saturation. Dr. X noted that Dr. Botros ordered a CPAP pressure of 12/13 for this patient but the patient had 20.7 hypopneas or apneas at this pressure. The Standard Sleep Study Interpretation form for this patient did not record a recommended CPAP pressure, nor is there a final diagnosis or recommendations. Although there was a notation that the "CPAP treatment will be tried at home for one month to examine tolerance and benefit", there was no follow-up recorded on the chart.

Dr. X noted that Dr. Botros' initial paragraph on his Summary, Conclusion and Management section of the form is correct. He also opined that Dr. Botros correctly mentioned that the patient's significant oxygen desaturation may be due to

hypoventilation, which is defined as insufficient breathing, in this very obese patient. However, Dr. X was critical of the fact that Dr. Botros did not record a pressure for treatment, one that would control apneas, hypopneas and snoring. The expert testified that this patient would likely need to see a respirologist to eliminate other diagnoses, in order to diagnose obesity hypoventilation.

Dr. X opined that Dr. Botros did not deal with the patient's bipolar illness and medication appropriately and thus, did not meet the standard of practice. Dr. Botros wrote in his consultation note that "past medical and surgical history as well as demographic and clinical detail data are enclosed in my consultation notes". Dr. X did not think this was adequate and said that the patient's illness and medication should have been specifically mentioned in the consultation report. The form that was sent with the consultation note did not contain the diagnosis of bipolar illness either, although the medications were listed. There is a lack of thoroughness in Dr. Botros' care of this patient, Dr. X testified.

Given the patient was referred for a sleep study and consult by a psychiatrist, Dr. Botros testified that it would be "inappropriate to teach a psychiatrist what his patient is suffering from".

Dr. X testified that reporting this patient to the Ministry of Transportation was appropriate because the patient rated at the maximum in all possible sleepiness scales. Given the numerous psychotropic medications that this patient was on, and pending the results of the nasal CPAP test, Dr. X testified that he would have told the patient not to drive. He would have pulled her driver's licence and reinstated it when she was better. However, Dr. Botros told the Ministry of Transportation that the patient's problem would be resolved in three to four weeks and if not, the Ministry would be informed. However, he made no arrangements to follow the patient to determine if resolution had occurred.

Dr. Botros testified that he was caught between the legal obligation to report because she is impaired and the awareness that there will be a recovery. He testified, in his mind, he fulfilled his obligation.

Dr. X opined that Dr. Botros failed to maintain the standard of care in his treatment of this patient, because of the lack of recorded CPAP pressures on the material that was sent to the referring doctor and because the final pressure still left this patient with significant apnea/ hypopnea events. She should have been seen for follow-up and Dr. Botros did not record the recommendation on her chart that she should be seen for follow-up.

Findings regarding Patient 2

The Committee finds that Dr. Botros' failed to maintain the standard of practice of the profession in his care of this patient. Although the Committee acknowledges that there is an art mixed with the science in sleep medicine and that the best pressure is sometimes determined by taking into account various factors, the fact is, this patient had a significant number of apnea-hypopnea episodes at the pressure recommended by Dr. Botros. Although the Committee accepts his rationale, the patient nonetheless needed further follow-up as she had significant apnea/hypopnea events at the pressure he chose.

Follow-up was not arranged. It was left open to the patient to return but there is no clear documentation that he told the patient she still had significant apnea/hypopnea events, nor was it clear in the disorganized consultation note he sent to the referring psychiatrist.

Also, Dr. Botros did not institute follow-up with regard to the driving issue and the Ministry of Transportation. Although Dr. Botros testified that he had done his duty with regard to reporting, he was in fact the consultant and should have ensured that the driving issue was dealt with adequately. Similar to other cases, there is a lack of analysis or a pulling together of all of the facts of the case. It is as if Dr. Botros did as little as possible to complete his consult. The patient was left with significant apnea-hypopnea episodes, a possible hypoventilation problem due to her severe obesity, no referral to a respirologist, a report to the Ministry of Transportation and little else in the way of help. Leaving follow-up in the patient's hands was not satisfactory in this case.

The Committee finds that Dr. Botros did not maintain the standard of practice with regard to the follow up of the inadequate CPAP pressure. In addition, the Committee finds that there was a lack of analysis of all the factors affecting this patient's sleep problems and

lack of thoroughness in dealing with the driving issue and the report to the Ministry of Transportation and the referring doctor, which are relevant to other allegations, including the allegations of incompetence.

Patient 3

This middle aged female patient with a BMI of 56.6 was referred to the Kitchener Sleep Clinic with possible obstructive sleep apnea. Dr. Y noted that her first diagnostic sleep study was done in August 2007, and the standard one page history checklist was sent to her referring doctor. The last paragraph of the letter states, "Patient sleep study results and recommendations for management are attached." However, the recommendations in the Standard Sleep Study Interpretation form for this patient sent to the referring doctor were the same as in most other cases, that is, "We recommend the patient to see a sleep medicine specialist as scheduled in the clinic." Dr. Y considered it extremely unlikely that the referring doctor would have any idea of the significance of the Standard Sleep Study Interpretation form that was mailed to him in August 2007. The patient had extremely severe mixed sleep apnea with apnea/hypopnea index of 87 events per hour [severe obstructive sleep apnea begins at 40 events per hour according to Dr. Y] and she also had extremely severe oxygen desaturation.

Dr. Botros saw the patient in consultation in September 2007, and a diagnosis of severe obstructive sleep apnea was made. Her CPAP titration study was performed two days later. A review by Dr. Y leads to the conclusion that the pressure Dr. Botros recommended of 15 to 16 cm/H20 was inappropriate. Although Dr. Botros said in his letter that clinical progress will be monitored, Dr. Y testified it was difficult to determine how that was to be done. Dr. Botros did note in his charting that it was considered that this patient may need a BiPAP device, yet, it does not appear that the approval was requested from the Ministry of Health's Assistive Devices Program until March 2008, six months later. The BiPAP titration study to establish proper pressures to control the patient's respiratory events was not carried out until January 2009.

Dr. Y opined that Dr. Botros did not meet the standard of practice with this patient because his Standard Sleep Study Interpretation form contained no interpretation or

diagnosis. The patient was placed on CPAP at a suboptimal pressure and he waited for many months before placing the patient on BiPAP. He did not titrate the BiPAP for almost a year. Dr. Y opined that Dr. Botros displayed a lack of knowledge, skill and judgment and exposed the patient to harm or injury.

Dr. Botros testified that even though the patient was able to tolerate the pressure of 18 to 19, he decided to prescribe a lower pressure of 15 to 16 because he did not want to "disrupt" the patient further, even though she was able to tolerate the higher pressure. She had woken up at the pressure of 15 and he wanted to achieve "solid success". He testified that at that pressure, her AHI was 27.8. When he saw her in October 2007, Dr. Botros charted that she may need BiPAP. When Dr. Botros was asked about his response to the criticism of Dr. Y that he did not titrate the BiPAP until February 2009, he responded that the patient was already on BiPAP. When it was pointed out to him that there was no charting in the patient's file about who put her on BiPAP or what pressure was prescribed, Dr. Botros testified that he must have put the patient on BiPAP and that the pressure she was put on was "probably in the file somewhere." He later admitted that there must be a missing document, which is the communication with the home care company for the prescription of BiPAP and the pressure for this patient.

Findings regarding Patient 3

The Committee finds that Dr. Botros failed to maintain the standard of practice of the profession in that he failed to prescribe an adequate CPAP pressure. With respect to other allegations, including the allegation of incompetence, Dr. Botros did not interpret the patient's results or give a diagnosis on the Standard Sleep Study Interpretation form. While the Committee understood Dr. Botros' reference to several of the considerations when deciding on CPAP pressure, Dr. Botros' pressure setting left this patient with significant apnea/hypopnea incidents. More importantly, he did not follow-up with this patient after the initial titration for CPAP, when he knew she would likely need BiPAP as he charted. Nor did he chart her conversion to a BiPAP device. He did not arrange for the patient to return for titration of the BiPAP in a timely manner. There was a lack of an

overall plan for follow-up. The Committee accepts the opinion of Dr. Y that Dr. Botros failed to maintain the standard of practice regarding this patient's care.

Incompetence in the case of Patient 3

Dr. Y opined that Dr. Botros displayed a lack of knowledge, skill and judgment and exposed Patient 3 to harm or injury. The Committee accepts the opinion. Dr. Botros' failure to follow up in a timely manner in a patient for whom the titration had been inadequate, and who reported significant daytime sleepiness such that he reported to the Ministry of Transportation, indicates his judgment is deficient. Dr. Botros' skill is also lacking in putting together all the variables in this patient's case, such as the significant obesity as noted in the patient chart.

Patient 4

This patient had an initial sleep study in May 2009 which showed moderate sleep apnea with an AHI of 22 and significant oxygen desaturation. An initial CPAP titration was incomplete, according to Dr. Y and at the highest pressure tried, there was still moderate obstructive sleep apnea. The patient was prescribed a CPAP pressure of 9 to 10, below the maximum that was tried during the CPAP titration study, and that would leave the patient with almost severe apnea of 29 events per hour if the pressure of 9 was used or mild apnea if 10 was the pressure used. Dr. Y testified that this recommendation did not meet the standard of practice.

According to the chart, following the initial titration study, the patient returned for a consultation at the sleep clinic with another physician and reported that he was doing well with CPAP and was complying with treatment and reported increased energy and alertness. The CPAP pressure was maintained at the same level. No further titration was done at that time, or any other measure taken to ensure the patient's problem was dealt with.

When the patient returned a year later for another CPAP titration, he had a successful titration and Dr. Y testified that the pressure recommended was appropriate. According to

Dr. Y, the patient's success at this pressure was the fact that he had lost sufficient weight so that the initial pressure prescribed was appropriate.

Dr. Botros testified that Patient 4 had some central apnea which limited the ability to achieve a very good titration. In addition, the patient could not tolerate a higher pressure so he chose a lower pressure after the initial CPAP titration.

Findings regarding Patient 4

The Committee finds that Dr. Botros failed to maintain the standard of practice in that he did not initially prescribe an appropriate pressure for this patient. The titration study was incomplete and Dr. Botros prescribed pressure ranges of 9 to 10. A pressure setting of 9 would leave the patient with apnea of 29 events per hour, in the almost severe range, while a pressure of 10 would leave the patient with mild apnea. Although the patient was seen in another month for a consultation to see how he was doing, there was no further titration study done to confirm the patient's self-report. The patient waited a year to have confirmation that the pressure setting was ultimately appropriate for him, in part because of his own weight loss.

The issue of Dr. Botros prescribing inappropriate CPAP pressure following titration studies is also found in the Committee's review of one other patient, Patient 18, below.

ii) Allegation that Dr. Botros failed to take appropriate steps to treat patients with severe obstructive sleep apnea within a reasonable time frame (Patients 3, 5, and 6)

Patient 3

The Committee finds that this allegation is proved in relation to Patient 3 as stated above under Findings regarding Patient 3 on pages 27 to 28.

Patient 5

This patient was a man in his thirties who was on methadone.

According to Dr. Y, Patient 5 had extreme obstructive sleep apnea with breathing stopping about 122 times an hour. Dr. Y testified that sleep apnea is associated with certain health risks, including increased sleepiness, increased blood pressure, and an increase in the incidence of heart attack and stroke. The higher the number of apnea events per hour, the greater the risk. In addition, in those with excessive daytime sleepiness, there is a tendency to have an increased risk of work injuries, single vehicle accidents, and incidents that would happen if the person was inebriated or distracted. Dr. Y was also concerned because the patient also had central apnea where the brain does not send a signal to the thoracic muscles to breathe. Usually CPAP or BiPAP will correct the problem and if it does not, he testified that these patients need to be on a ventilator.

This patient had an initial sleep study in December 2008, and the Standard Sleep Study Interpretation form for this patient along with the standard one page symptom and history check-list was sent to the referring doctor. However, Dr. Y was very critical of the package sent by Dr. Botros to the doctor as there was no interpretation or diagnosis provided. Dr. Y testified that the referring doctor would have no idea about the significance of the standard sleep study, and the fact that the patient had extremely severe mixed sleep apnea with an AHI of 132 events per hour and extremely severe oxygen desaturation with the majority of the apneas of central origin. Patient 5 was not seen by Dr. Botros in consultation until February 2009. Dr. Y said that given the severity of the apnea, the two-month time period was excessive between his initial sleep study and the consultation. The results of the sleep study were sent to his family doctor six days later and this fell below the standard of practice as the Standards state that they need to be communicated within four weeks of the initial sleep study. Dr. Y opined that Dr. Botros did not have a “red flag” system in place to arrange for early and timely consultation with Patient 5.

Patient 5 subsequently had a BiPAP study in April 2009, five months after his initial sleep study. Dr. Y testified that the interval between the initial sleep study and consultation was not acceptable due to the severity of the apnea in this case. The patient had started BiPAP with a pressure setting of 12/8 prior to the April titration study which was reasonable. Dr. Y testified that there was a troubling oxygen desaturation at that

pressure setting, although there was a reduction of the apneas, hypopneas and mixed apneas. Dr. Y agreed that the ultimate pressure setting met the standard of care but he did not concede that the time delay in the titration study being completed was appropriate. He opined that the standard was not met in that case.

Dr. Botros testified that the Christmas holidays accounted for some of the delay. Dr. Botros testified he deals differently with patients who have substance abuse issues than other patients. Dr. Botros said he does not like to exercise authority. He testified that in February "… seemed to have been the day that he was willing to come." He said it was "probably his personal background", as well as Christmas and New Year's that contributed to the patient not coming earlier.

Findings regarding Patient 5

The Committee finds Dr. Botros' explanation of why the patient was not seen sooner to be contrived and disingenuous. There was no note to this effect in the patient's chart or any indication he had told the patient the significance of his problem. Dr. Botros blamed the patient for the delay.

Dr. Y's assessment that the standard of practice for this patient was not met is accurate in the Committee's view. Dr. Botros should have seen the patient sooner. There were 23 more days before the Christmas and New Year's holidays, which should have allowed for follow-up. Other patients were seen within five days. The Committee also accepts Dr. Y's opinion that Dr. Botros' judgment is questionable. The Committee finds that Dr. Botros failed to maintain the standard of practice in that he failed to take appropriate steps in a timely manner regarding the care of this patient.

The Committee was not concerned that Dr. Botros did not have the central apnea investigated by a neurologist. The central apnea was likely due to the Methadone that the patient was taking. Dr. Y testified that there was not much that a neurologist could do.

Incompetence regarding Patient 5

The College alleges that Dr. Botros' was incompetent in the care of this patient. Dr. Y's report outlines his view that Dr. Botros' care of this patient reveals a lack of judgment because he sent out a useless sleep study interpretation report with no interpretation and no diagnostic information. There was no "red flag" system to identify patients with severe or life threatening sleep apnea. There was an unacceptable delay in seeing this patient after the initial diagnostic sleep study was performed and an unacceptable delay in performing a titration study. There was a disregard for the patient's welfare and Patient 5 was exposed, or likely exposed, to harm or injury due to the delay in diagnosis. The patient had extremely severe mixed, central and obstructive sleep apnea. Some of the apneic episodes were of central origin, likely due to the methadone the patient was receiving. He could have stopped breathing anytime.

The Committee accepts the assessment of the expert. Dr. Botros did not communicate with the family physician effectively and take into account the variables with this patient that made his case more urgent. The Committee finds that Dr. Botros' deficiencies involve not only a lack of judgment but also a lack of skill and knowledge.

Patient 6

Patient 6 was referred to the London Sleep Clinic to have snoring investigated. Following his diagnostic sleep study in June 2009, Dr. Botros sent the standard one page symptom and history check-list and a two page Standard Sleep Study Interpretation form to the referring doctor. The one page symptom and history check-list states in the last paragraph of the letter "patient sleep study results and recommendations for management are attached." Dr. Y is critical in his report that the Standard Sleep Study Interpretation form is not an interpretation and does not provide a diagnosis. Dr. Y thought that it was extremely unlikely that the referring doctor would have any idea of the significance of the sleep study reports mailed to him. The lack of diagnostic information in the report is significant in its absence because according to the diagnostic sleep study, Patient 6 had

severe obstructive sleep apnea with an apnea/hypopnea index of 64 events per hour associated with severe sleep fragmentation and severe oxygen desaturation.

The patient had a previous sleep study at Hospital 1 in October 2008. Dr. Y in his report and testimony considered that not requesting a copy of the previous sleep study fell below the standard. In July 2009, about two weeks after the diagnostic sleep study, Dr. Botros initiated CPAP at home for this patient, setting the pressure at 10 to 11 cm of water. No CPAP titration was done. Since the patient had a previous sleep study at Hospital 1 in October 2008, the titration was not to be carried out until December 2009, when the CPAP titration study would be eligible for reimbursement by OHIP. Dr. Y was critical of the care of this patient. As he said in his report, “Placing a patient with severe obstructive sleep apnea on a home trial of CPAP at a pressure of 11 cm without any monitoring and without having the CPAP titration done to show that this pressure was in fact even sufficient to control his apnea, is a significant and serious deviation from generally accepted standards of care.”

Dr. Botros’ consultation note dated July 2009, reads “depending on outcome, future management will be decided” and also “information on the disorder has been provided.”

There is a note that a December 2009 appointment was made for the patient to come for CPAP titration and he did not show up. A note by a staff member indicates that the patient was called to reschedule. Dr. Y was critical of the fact that Dr. Botros made no note in the chart that this patient was contacted and encouraged to come in to the clinic for a titration of his CPAP pressure. Dr. Y noted that the chart did not contain any Assistive Devices Program form for CPAP authorization and consequently, there was no evidence to confirm that Patient 6 did obtain a CPAP machine. Dr. Y opined that Dr. Botros’ care fell below the standard because there is no evidence that the “guesstimated” CPAP pressure was working or if the patient was using the CPAP. An Assistive Devices Program form provided following Dr. Y’s report indicates the patient did acquire a CPAP machine.

Dr. Y was also critical that there was no report made to the Ministry of Transportation and no follow up report sent to the family doctor about the fact that the patient did not show up for a titration study.

Dr. Botros explained that after seeing thousands of patients he has a sense of what is the right CPAP pressure for a patient. He prescribed a pressure of 10/11 for this patient to try at home. It is a judgment call, he said, based on multiple factors. Dr. Botros responded to Dr. Y's criticism that the titration study did not take place until five months later by saying that the patient has been treated and the titration study was just to satisfy ourselves that "things have cleaned up" and that the patient did not have any complaint during the time on treatment. Because of the government rules about CPAP tests, the patient was not eligible for another sleep study until twelve months had passed. Dr. Botros testified that the delay would have no clinical impact on the management of the patient at all.

Findings regarding Patient 6

The Committee finds that Dr. Botros failed to maintain the standard of practice in that he failed to take steps to treat this patient within a reasonable period of time. Dr. Botros failed to obtain the previous sleep study records. The risks for someone with the severe sleep apnea this patient had are significant, as noted above in this decision. The Committee also heard evidence of other options for management when the billing system does not allow for an additional sleep study. None of those options were considered based on the chart. However, Dr. Botros chose to allow the patient to be at risk of stroke, heart attack or other events for five months with a pressure on the CPAP that he had not verified was adequate.

In relation to other allegations, the Committee finds that there was no report to the Ministry of Transportation when there should have been. The Committee also notes that when the patient did not show up for the titration, there was no note by Dr. Botros or report to the patient's family doctor.

Incompetence regarding Patient 6

Dr. Y opined that Dr. Botros' care of Patient 6 displayed a lack of knowledge, skill and judgment. He opined that Dr. Botros' clinical care exposed or was likely to expose this patient to harm or injury.

The Committee accepts the opinion of the expert. Dr. Botros' failed to follow-up adequately, demonstrating a lack of judgment. That he did not use other methods, as previously noted to ensure the "guesstimated" pressure was appropriate, indicates that Dr. Botros did not see himself as having any responsibility for this patient's well-being. A lack of knowledge is also demonstrated. The Committee finds that Dr. Botros did not understand the risk that the inattention to follow-up posed.

iii) Allegation that Dr. Botros allowed patients to be prescribed CPAP without first being seen by a sleep physician (Patients 7 and 8)

Patient 7

This patient suffered from severe sleep apnea and had a diagnostic sleep study in September 2008, followed by a titration study eight days later. Dr. Botros saw the patient in consultation at the end of September 2008.

Dr. X noted in his report that the diagnostic sleep study showed an average AHI of 120.4 over the duration of the sleep study and the patient had significant oxygen desaturation. The patient had significant oxygen desaturation with one hour and 25 minutes and 35 seconds below 90%. Dr. Botros did not see the patient before the titration study was done despite the Standards clearly stating on page 23, that "The accepted standard of practice is to carry out a clinical examination of the patient prior to prescribing CPAP." Dr. X noted that there were contraindications for CPAP therapy as discussed on page 68 of the Standards.

Dr. Botros testified that this patient was fast tracked. Although Dr. Botros agreed with his counsel that the patient had a titration two days after the diagnostic sleep study, the chart reveals that the titration study actually took place eight days after the diagnostic sleep

study. Dr. Botros explained that in some circumstances, the patient needs to be treated urgently and it is acceptable to prescribe CPAP prior to the physician seeing the patient. The Standards allow for and “encourage” a split night study and the same principle applies, he said. He also explained that the night make-up of sleep was different from the beginning to the end of the night when there is more REM sleep.

The Standards state that in certain circumstances if it is apparent that the patient has moderate to severe obstructive sleep apnea syndrome, the study may be a split. Dr. Botros testified that the CPAP may be applied in the last half of the night prior to seeing the physician, even though the stages of sleep vary from the beginning to the end of the night. However, the Standards also say that the rationale for initiating the CPAP prior to seeing the physician needs to be documented in each case and a follow-up appointment with the patient should be arranged.

Besides the issue above of Dr. Botros not seeing the patient prior to being started on CPAP, Dr. X opined that Dr. Botros fell below the standard with regard to not recording the pressure setting in the material he sent to the referring doctor. Dr. Botros claimed that it was in his consultation note.

Dr. X was also critical of Dr. Botros’ consultation note that referred to the average AHI for the titration CPAP study, rather than the AHI at particular pressure levels. Dr. Botros did not refer to the AHI at particular pressure levels. Dr. Botros stated that the AHI improved significantly, reduced to 42 events per hour. Dr. X testified that was true, but it has no clinical significance when dealing with a titration study. This patient still has very severe obstructive sleep apnea. Dr. Botros also did not mention in his consultation note that there were quite a few central apneas in addition to the apneas and hypopneas. Dr. X was critical of the notation in the consult note that the patient was “likely” to need BiPAP in the future. He said that it would have been better to use the word “may”, as often patients are quite comfortable with the 14 cm of water pressure that Dr. Botros ordered.

Findings regarding Patient 7

The Committee finds that Dr. Botros failed to maintain the standard of practice in not seeing the patient prior to the titration CPAP study. There were eight days between the studies. The Committee was not persuaded that the Standards "encourage" split studies. The Committee did not interpret the Standards that way and heard no evidence from the experts to support that split studies were encouraged. In fact, the Standards were very clear that the doctor was to see the patient before the CPAP titration. While the Committee understands that there may be extenuating circumstances occasionally, this was not the case here, as the patient waited eight days for the titration study.

Patient 8

This patient had an initial sleep study in May 2009, and was followed up with a titration study twelve days later. Dr. Y testified that it was not appropriate for a patient to have a CPAP titration without being seen by the sleep physician. Dr. Y opined that the doctor should complete a physical examination of the airway, explain the condition to the patient and outline the benefits and risks of treatment.

This patient had 79 apnea/hypopnea episodes on average per hour with severe oxygen desaturation at times. It dropped below 70% at one point. Dr. Y agreed that the titration being done within twelve days was appropriate. However, in looking at the results of the titration, he testified that it was hard to choose an appropriate pressure for the patient because when the pressure was increased, so did the AHI. Dr. Y testified that, ideally, a pressure would be chosen and the patient would be given a machine that has a recording chip in it to record whether the apnea persists or not. The patient could be evaluated in two weeks to see if the pressure was appropriate.

In cross-examination, Dr. Y was presented with the details of the case; the patient was seen in May, fast tracked for a titration study, which she had on twelve days later, then had a consultation with the physician in June; the prescription was made and the patient given assistance and support. Dr. Y was then asked if Dr. Botros met the standard of practice expected of him and Dr. Y responded yes.

Dr. Y testified that the pressure that Dr. Botros ultimately chose for this patient was appropriate. However, the patient was a “no show” for a subsequent follow-up appointment, five months later. Dr. Y testified that in a patient with these symptoms, it was important to contact the patient and let them know they need to come in.

Initially, Dr. Y opined in his report that he thought Dr. Botros’ clinical practice and behaviour, exposed the patient to harm or injury. However, in his testimony, Dr. Y revised that opinion. He testified that he thought that Dr. Botros’ pressure setting was reasonable and the follow up may well have been out of his control since the patient did not show up for her next appointment.

Findings regarding Patient 8

Dr. Y opined that the standard was not met with regard to the issue of Dr. Botros not seeing the patient prior to the titration. The Committee finds that Dr. Botros failed to maintain the standard of practice of the profession by not seeing the patient after her diagnostic sleep study. The same rationale applies in this case that applied in the Patient 7 case. The Standards are clear. She had a significant problem, and the Committee views the fact that there was a twelve day period between her diagnostic sleep study and the titration sleep study as sufficient to have been able to have a consultation with this patient. Although Dr. Botros downplayed the significance of the contraindications and relative contraindications to CPAP in his testimony, there are nonetheless standards in place for guidance and he chose to ignore them. There was no charting to indicate any reason to depart from the Standards.

In relation to the general allegation of incompetence, Dr. Botros reported to the referring physician a nightly average AHI for the titration study, which is meaningless in a titration study. He did not give the referring physician any indication of the AHI at different pressure levels, and more specifically at the pressure level he ultimately chose.

iv) Allegation that Dr. Botros failed to document prescribed pressures (Patients 7, 1, 2, 4, and 8)

The College alleged that Dr. Botros failed to document the prescribed pressures for the patients listed above and the Committee finds this to be the case in some of the post-titration study Standard Sleep Study Interpretation forms. However, if it was not on the aforementioned form, it was included in the Summary, Conclusion and Management letter, or the Consult letter. There was one exception, Patient 2, where there was no prescribed pressure recorded in the mailing to the referring doctor. Dr. Botros recorded Patient 2's pressure in his chart, however.

Finding

The Committee finds that the allegation that Dr. Botros failed to maintain the standard in that he did not document prescribed pressures not proved.

v) Allegation that Dr. Botros incorrectly or incompletely diagnosed numerous patients (Patients 9, 10, 11, 12, 13, 14, 15, and 16)

Patient 9

This patient saw Dr. Botros because of a complaint of fatigue with a history of depression. According to the diagnostic sleep study, she had no significant sleep disorder.

Dr. X's opinion was that in the absence of a description of Patient 9's sleep study interpretation, he thought that Dr. Botros' comments in the consultation note were too succinct. Dr. X was critical of Dr. Botros' comment in his consultation note which stated that: "Patient is presently on antidepressant regime which tends to modify sleep architect [sic] and sleep pathology that is may [sic] conceal any primary disorder." The patient did not have sleep apnea and Dr. X did not understand Dr. Botros' comment because the wording was unclear in the foregoing. The expert said that the issue of whether or not depression or medication was causing the fatigue was not addressed. His main concern was that Dr. Botros failed to mention that the depression itself could be the main reason for the patient's daytime fatigue. In cross–examination, Dr. X agreed that he and Dr.

Botros reached the same conclusion for this patient in substance. However, Dr. X testified that Dr. Botros should have simply said that this patient has depression and that alone could be the reason for the fatigue, and he should have noted that the medication could be responsible for the patient's main complaint.

Finding regarding Patient 9

The Committee agrees with Dr. X that the wording was unclear and also agrees that this is a small complaint in the context of the discipline hearing. The Committee finds the allegations that Dr. Botros failed to maintain the standard of practice in relation to this patient not proved.

Patient 10

This patient had an initial sleep study in August 2008, and was seen by Dr. Botros in consultation in September 2008. In her patient questionnaire, the patient stated that she had been diagnosed with fibromyalgia, which is also checked in a box in Dr. Botros' summary checklist of medical history accompanying his note to the referring physician.

According to Dr. X, the chart for this patient tells us that the patient had un-refreshing sleep and significant pain, which was labeled as fibromyalgia. Her sleep study showed mild obstructive sleep apnea. Dr. X testified that fibromyalgia is a chronic condition that affects more females than males, is very disabling and poorly defined. It is frequently associated with depression and un-refreshing sleep. In cross-examination, he pointed out that a box ticked by a patient saying he or she has fibromyalgia does not amount to a diagnosis he would trust. Dr. X testified that asking about the symptoms and getting information would be helpful, and it is not up to the sleep physician to diagnose it. Fibromyalgia affects sleep quality significantly in many direct and indirect ways.

Dr. X testified that this patient had mild sleep apnea and the consultation note of Dr. Botros is adequate in the report of the sleep study results. However, Dr. Botros did not mention that fibromyalgia interferes with the quality of sleep and Dr. X was critical of that. The duty of the sleep physician is to improve the quality of the sleep. Instead of discussing fibromyalgia in a consultation note, it is simply selected in a form that the

technician likely completed. It does not meet the standard of practice because of a lack of evaluation and comments about fibromyalgia, a condition that affects sleep quality on a regular basis.

Dr. X did agree in cross-examination that Dr. Botros' consultation note indicated that he talked to the patient about pain and its role in sleep apnea.

Findings regarding Patient 10

The Committee accepts Dr. Botros' evidence that he discussed with the patient the connection between pain and sleep apnea and that he commented on the use of Amitriptyline and the potential for increasing the dose for this patient. The Committee finds the allegation of failing to maintain the standard of practice in that he failed to diagnose, or incorrectly diagnosed, this patient not proved.

Patient 11

Patient 11's complaints were insomnia, un-refreshing sleep, and daytime sleepiness. His diagnostic sleep study showed insignificant sleep apnea. Dr. X testified that the patient's psychotropic medications were important factors in this case. According to Dr. X's testimony, the three medications the patient was taking could have contributed to drowsiness.

Dr. X testified that Dr. Botros' consultation note was succinct but correct in the description of the sleep study. Dr. Botros did not comment on the medication, except to say, "The recent combination of psychotropic medication have helped sleep quality; however, has not resolved daytime sleepiness". Dr. X was critical of the fact that Dr. Botros did not comment on the medication as the possible reason for the daytime sleepiness.

Dr. X was also critical of the consultation note and said that one line in particular was unusual: "Possible differential diagnosis will be examined in follow up". Dr. X questioned, "Why in follow up? Why do I need a follow up to examine the differential diagnosis?" He did not understand Dr. Botros' rationale.

Dr. X was also critical of the organization of the consultation note and testified that the summary and conclusion should be towards the end. He testified that the consultation note did not meet the standard of practice.

Dr. Botros testified that alerting the referring psychiatrist to the possibility that the patient's daytime sleepiness was due to the psychiatric diagnosis or the psychiatric management (medication) would have been a "very, very inappropriate thing to do." He said the psychiatrist did not send the patient for a psychiatric diagnosis.

When Dr. X was asked about what the responsibility of the sleep physician was with regard to communicating with the referring psychiatrist about the psychiatric illness or the medication being the source of the fatigue, Dr. X testified that the sleep physician has a duty to remind the psychiatrist of the possibility. It was not the sleep physician's role to make assumptions.

Findings regarding Patient 11

The Committee accepts the opinion of Dr. X with regard to the duty of the sleep medicine physician. His role does not vary depending on who is referring the patient, whether it is another sleep physician, a psychiatrist or a family doctor. His role is to diagnose the patient's sleep problems, and in the case of Patient 11, Dr. Botros did not adequately address the issues. Dr. Botros conducted the sleep study and in his role, he is the one who can tie all the factors affecting sleep together. Although Dr. Botros testified that it would be inappropriate for him to diagnose the psychiatric patient, it was far from inappropriate for him to report that the psychiatric diagnoses and psychiatric medication may be contributing to this patient's problem. The patient's chart contributes to continuity of care and may be used in the future by another doctor who may want to evaluate the results of the sleep study. Dr. Botros' diagnosis and conclusions in Patient 11's case would be deficient in that instance. The Committee finds that the allegation of failure to maintain the standard of practice as it relates to an incomplete diagnosis in this case is proved.

Patient 12

This patient had moderate obstructive sleep apnea and vocal cord paralysis diagnosed ten years previously. He had a diagnostic sleep study in November 2008, and saw Dr. Botros again in late November 2008.

Dr. X testified that it appeared that Dr. Botros' recommended BiPAP titration with this patient to avoid continuous, intense pressure in the pharyngeal structure. The expert said that there was no indication whatsoever to recommend BiPAP for this patient as the initial treatment. He opined that the patient should be treated with CPAP first with a low pressure and humidification and then booked for a CPAP titration.

Finding regarding Patient 12

The Committee accepts the opinion of Dr. X. In addition to the expert testimony, common sense dictates that it is appropriate to try the least expensive and simplest system to solve the problem of obstructive sleep apnea in any patient. The Committee finds that Dr. Botros failed to maintain the standard of practice not properly diagnosing this patient's condition as demonstrated by recommending his BiPAP rather than suggesting a CPAP trial first.

Patient 13

This patient was referred to Dr. Botros because she had un-refreshing sleep and snoring. She was taking a tranquilizer and antidepressant medication for psychiatric illness of a general anxiety disorder.

Dr. X was critical of Dr. Botros' comment in the consultation note which read: "I have explained to the patient that most hypersomnolence/narcolepsy syndrome is often related to physical or emotional trauma." Dr. X testified that this is an inaccurate statement. Dr. X said the most common cause of hypersomnolence, or excess daytime sleepiness is not physical or emotional trauma. Someone suffering from significant emotional or physical trauma could develop post-traumatic stress disorder, chronic anxiety disorder, and that may lead to daytime tiredness. He explained that obstructive sleep apnea is by far the

most common cause of excessive daytime sleepiness or hypersomnolence. He indicated that other issues contribute to the problem as well, such as insomnia, depression, and sleep restriction due to work commitments and pain at night.

Narcolepsy is different altogether, Dr. X said. It is not common but the patient has daytime sleepiness, sleep attacks, and attacks of muscle weakness called cataplexy. The patient with narcolepsy also has vivid dreams, which is a mixture of reality, dreams and sleep paralysis, and is very rarely related to trauma according to Dr. X. Dr. X went on to add that Dr. Botros made appropriate suggestions about medication for this patient and that he correctly assessed that part of the problem.

In cross-examination, Dr. X reviewed an article called Narcolepsy. Following the review, Dr. X affirmed his testimony that Dr. Botros was inaccurate in his consultation note.

In his examination-in-chief, Dr. Botros was discursive on this issue. He testified how there was a biologic basis for narcolepsy that gets “triggered”. He did not think that other diagnoses, such as insomnia, psychiatric illness, etc., should be included under hypersomnolence. At no time did he back away specifically from using the word “most” and in his testimony, never conceded that the word “most” exaggerated or was inaccurate.

Dr. X opined that Dr. Botros’ consultation note did not meet the standard of practice.

Findings regarding Patient 13

The Committee accepts the opinion of Dr. X and finds the allegation that Dr. Botros failed to maintain the standard of practice in that he did not properly diagnose this patient as demonstrated by the comments in his consultation note and find this allegation is proved. Dr. Botros was imprecise in his language, organization and diagnoses in the consultation letter. The mention of narcolepsy along with hypersomnolence was very imprecise as there was no evidence that this patient had narcolepsy. Attributing most excessive daytime sleepiness as due to physical or emotional trauma was not accurate either.

Patient 14

This patient was a teenager who was referred to Dr. Botros because of fatigue and depression. When the patient had her initial sleep study, she had difficulty getting to sleep and a decrease in the amount of REM sleep. There was mild obstructive sleep apnea but it did not require treatment according to Dr. Y. Following Patient 14's diagnostic sleep study, she was seen by Dr. Botros. His conclusion in the consultation letter was that her history was "highly suggestive of idiopathic hypersomnolence" and he recommended Modafinil 100mg twice daily. Dr. Y explained that idiopathic hypersomnolence is a term that is used to describe a group of patients who suffer from severe daytime sleepiness for no identifiable reason. It is considered to be a permanent condition.

Dr. Y opined that there was no reason to come to that conclusion in this patient. In deciding whether someone has hypersomnolence, whether idiopathic or narcolepsy, a multiple sleep latency test is required to quantify and identify the sleepiness and see if there are any other pre-existing conditions. Dr. Y testified that this patient was a teenager who had delayed sleep phase syndrome and he was critical of Dr. Botros' decision to put her on Modafinil for what was essentially poor sleep hygiene. Modafinil is a drug that does not have the side effects of the original medication such as Dexedrine, which gives patients the shakes, twitches and high blood pressure. Modafanil does not negatively affect the body and it takes care of daytime sleepiness. However, Dr. Y was critical that it was used for a teenager with a poor sleep schedule. Dr. Y was also critical of the fact that Dr. Botros later prescribed Amitriptyline to this patient.

The patient kept a sleep diary and Dr. Y testified that her sleep schedule was "out of whack" as she was going to bed between 2 a.m. to 4 a.m. and sleeping ten or eleven hours. She is a "night owl", according to Dr. Y.

The patient underwent an overnight sleep study followed by a multiple sleep latency study. Dr. Y testified that the tests showed that Patient 14 did not fall asleep until 2 a.m. the night of the sleep study. On the next day when she came in for the multiple sleep latency test, she fell asleep on average between seven and eight minutes each time she

was given the opportunity to nap. The lack of REM sleep indicated that there was no dream sleep and that ruled out narcolepsy. Dr. Y found no interpretation by Dr. Botros of the daytime sleep study.

However, Dr. Botros sent a consultation letter and in it he wrote, “Testing confirmed significant daytime sleepiness and idiopathic hypersomnolence.” Dr. Y did not agree with Dr. Botros. The average time to fall asleep on the multiple sleep latency test was 7.1 and this was at best “mildly sleepy”. He said there was no evidence of idiopathic hypersomnolence. The patient’s sleep diary showed a “slightly worse than average teenager”, whose sleep schedule was “out of control” and is sleepy during the daytime and not sleepy during the evening hours and the early part of the morning.

Dr. Y testified that idiopathic hypersomnolence is considered a permanent condition and depending upon who made the diagnosis, it could interfere with the patient’s ability to get a licence to operate a motor vehicle, or to operate heavy machinery. Someone could report her to the Ministry of Transportation and her driving licence would be gone, he said.

Dr. Y was critical because the patient was labeled with a chronic condition and treated with medication that affects the central nervous system when her problem is a condition that could be managed with a proper sleep schedule change. She does not need medication to get her sleep schedule back, and he outlined different methods to solve the patient’s problem.

Dr. Y testified that the patient was exposed to harm or injury with the label of a chronic condition. Dr. Y testified with respect to Dr. Botros’ explanatory note that there was no basis to conclude that this patient had narcolepsy.

In cross-examination, Dr. Botros was defensive and discursive in his testimony and did not agree with simple questions about the nature of idiopathic hypersomnolence. Sometimes he did not answer the questions at all and controlled the cross-examination by rambling on. Even after agreeing to answer the questions, he persisted in speaking on unrelated topics. He also gave discursive answers about biology and genetics when

discussing patient sleeping problems. Dr. Botros agreed that he made a diagnosis of idiopathic hypersomnolence and put her on medication when he had not yet booked the patient for the multiple sleep latency tests.

Dr. Y opined that Dr. Botros' care of this patient did not meet the standard of practice.

Findings regarding Patient 14

The Committee finds the opinion of Dr. Y compelling and accepts it. The Committee accepts the evidence of Dr. Y that this teenage patient should be considered as a "night owl" who needed to have her sleep regulated. The Committee finds that Dr. Botros incorrectly diagnosed her with a chronic condition and inappropriately treated her with medication to keep her awake during the day. Dr. Botros jumped to this diagnosis even before he did the appropriate testing.

The Committee finds that following testing, Dr. Botros did not accurately diagnose the problem. Dr. Y's evidence was persuasive. The Committee concluded that this patient did not get the help she needed and instead was medicated, and finds Dr. Botros' failed to maintain the standard of practice of the profession in his care of Patient 14.

Incompetence regarding Patient 14

Dr. Y opined that Dr. Botros' care of this patient displayed a lack of knowledge, skill and judgment. He also was of the opinion that Dr. Botros' clinical care exposed or was likely to expose this patient to harm or injury.

The Committee accepts the opinion of Dr. Y and finds that Dr. Botros displayed a lack of knowledge. The evidence shows that Dr. Botros formed a conclusion about this patient prior to testing being completed and his judgment is therefore lacking. His lack of skill in inappropriately medicating this patient for whom there were other options is also of concern. The Committee finds that Dr. Botros was incompetent in the care of this patient. Dr. Botros' rigid refusal to admit to an alternative diagnosis and to persistently justify his stance leads the Committee to conclude that Dr. Botros' impaired judgment is current. His lack of ability to self-monitor and self-reflect is evident and poses concerns about

whether he is teachable and remediable. Dr. Botros confirmed twice in cross-examination that his patient's diagnosis was idiopathic hypersomnolence when clearly the evidence was contrary to that and the expert had an opposing opinion.

Patient 15

This patient was seen by Dr. Botros prior to weight loss surgery scheduled in the United States. The sleep study was required by the American clinic doing the surgery and the results were to be faxed there. Her diagnostic sleep study revealed that her sleep apnea was mild, but when she was in the REM, or dreaming stage of sleep, her apnea was severe.

In his written report, Dr. Y was critical of Dr. Botros' care of this patient because he did not think the patient required CPAP. Dr. Y thought the patient's obstructive sleep apnea was mild and would be resolved after the bariatric surgery which would result in significant weight loss that would cure her apnea.

However, in Dr. Y's testimony, his opinion was that CPAP treatment was appropriate. Dr. Y testified that CPAP was not unreasonable, at least temporarily in this case, and the device would give the patient some comfort before surgery. No follow up plan was recorded in the chart, nor was there any indication of whether or not the patient purchased a CPAP machine or returned for a titration study.

Findings regarding Patient 15

The Committee finds the allegation that Dr. Botros failed to maintain the standard of practice regarding this patient not proved. Dr. Y essentially agreed with the treatment by Dr. Botros. What was in question was the follow-up and a notation about whether or not the treatment was temporary. There were several variables in this case, including the possibility that the patient would lose weight quickly and perhaps not require the CPAP. There is no indication she had a follow-up appointment and the Committee heard from the witnesses that follow-up with patients in Sleep Clinics is sometimes difficult for several reasons, mostly related to the patient's compliance and difficulty adjusting to the CPAP machine.

Patient 16

This patient was referred to the Sleep Clinic because of snoring and the referring doctor suspected sleep apnea. The patient had an initial sleep study in March 2009 and it showed severe insomnia but no sleep apnea.

Dr. Botros' consultation letter indicated that the patient had insomnia and recommended Amitriptyline 20 to 30 mg orally at night. Dr. Y testified that the patient did not have insomnia. She had worked the night shift for a few years in Canada and for years prior to that, in Europe as a midwife. Her hours of sleep corresponded to someone's schedule on the night shift, he said. Amitriptyline is an antidepressant and although it has a slight sedative effect, Dr. Y did not consider it a primary treatment for insomnia. In cross-examination when taken to the product monograph for Amitriptyline, he agreed that the medication has a sedative effect, but he remained critical of its use. It is not a good hypnotic and it has a lot of side effects, he said. Although he agreed that Dr. Botros noted that the patient may well be suffering from an element of post-traumatic stress disorder as a result of the move to Canada, he did not agree that prescribing an antidepressant was a reasonable course to take because he could find no evidence of depression in this patient.

Dr. Botros also stated in the consultation letter that, "medication will have multiple benefits including being beneficial for mild sleep apnea." Dr. Y testified that the patient did not have sleep apnea at all. He said Dr. Botros' care did not meet the standard of practice because he prescribed an antidepressant to someone who was not depressed; she did not need that medication as her major complaint was not insomnia; and she did not have sleep apnea as Dr. Botros intimated she did.

Dr. Botros testified that he used his experience in psychiatry and sleep medicine in using Amitriptyline. He testified that it was an effective treatment for a patient who has a history of post-traumatic stress disorder and anxiety and who is suffering from insomnia.

Findings regarding Patient 16

Although the patient questionnaire was suggestive of sleep apnea, this patient did not have that problem according to the diagnostic sleep study, and the fact that Dr. Botros said that she did in that circumstance amounted to a failure to maintain the standard in the Committee's view. In addition, diagnosing this night shift worker with insomnia without a rationale contributed to Dr. Botros' failure to maintain the standard of practice. The Committee accepted the opinion of Dr. Y with regard to this issue.

Regarding the use of Amitriptyline, the Committee notes that Dr. Botros is the one who saw the patient. He had extensive experience with Amitriptyline and notwithstanding the fact that his consultation letter was brief, he did appear to have a discussion with the patient about anxiety and post-traumatic stress.

vi) Allegation that Dr. Botros failed to appropriately notify or follow up with the Ministry of Transportation

Patient 17

This patient had mild obstructive sleep apnea. He reported that he felt sleepy and had a moderate chance of falling asleep while driving. Dr. Botros testified that he had no choice but to report the patient to the Ministry of Transportation. When given the option of CPAP or lifestyle measures such as weight management, avoiding alcohol, avoiding late meals and regular exercise, the patient preferred to try healthy lifestyle measures. Dr. Botros testified that he reported to the Ministry of Transportation to alert them about this patient, as was his legal obligation. Dr. Botros testified that he told the Ministry that he expected the patient's condition would resolve in the next three to four weeks and if not, then he would inform them otherwise. However, he noted to the referring physician that the patient's progress will be monitored in one year. Dr. Botros testified that he reconciled the discrepancy in his reports by surmising that patients can achieve some success in a month with lifestyle changes and he was not planning to monitor this patient for the Ministry of Transportation. His legal obligation was to report the patient's

impaired condition, and it is up to the Ministry of Transportation to decide to suspend his licence or not.

Dr. Botros stated that the patient had the option to return to him at any time. The patient did return and likely because the Ministry of Transportation suspended his licence. Dr. Botros testified that the patient reported some clinical improvement and significant recovery from many symptoms of sleep apnea and Dr. Botros therefore supported him getting his licence back with the Ministry of Transportation.

Dr. X was critical of Dr. Botros' lack of follow up with the patient. Since the patient had mild obstructive sleep apnea and reported sleepiness while driving, a follow-up needed to be arranged. Dr. Botros' follow-up was arranged in one year and Dr. X did not agree that was appropriate.

Findings regarding Patient 17

The Committee finds that Dr. Botros failed to maintain the standard of practice of the profession in not arranging for follow up of Patient 17 who opted to follow lifestyle changes to manage his mild obstructive sleep apnea. In reporting to the Ministry of Transportation in an ambiguous way, Dr. Botros gave the impression he would be following the patient in a month, and informing the Ministry if the patient did not make lifestyle changes. Dr. Botros failed to maintain the standard of practice of the profession by a report to the Ministry which suggests that he would be following up with the patient, which the Committee found was not his intention.

Patient 2

The issue related to the Ministry of Transportation report for this patient is dealt with in the section related to the allegations of Dr. Botros prescribing inappropriate CPAP pressures under Findings regarding Patient 2 at pages 25 and 26.

Patient 6

The evidence and findings related to this patient have been previously summarized in the section dealing with allegation of failing to take appropriate steps to treat patients with

severe obstructive sleep apnea within a reasonable time period under Findings regarding Patient 6 at page 34 and 35.

vii) Allegation that Dr. Botros failed to appropriately prescribe supplemental oxygen for a patient on CPAP therapy

Patient 18

This patient was in his fifties and had numerous problems according to his medical records. Besides the requisition for a sleep study, a two page summary of the patient issues, likely from the hospital physician following a recent stay, indicate that the patient had an atrial flutter and primary pulmonary hypertension. Dr. X, who is himself a respirologist, explained that in pulmonary hypertension, the pressure in the pulmonary artery coming out of the right side of the heart is elevated with serious consequences. Dr. X testified that the patient had multiple complaints related to sleep, including difficulty falling asleep, awakenings, un-refreshing sleep, daytime sleepiness with a provisional diagnosis of insomnia and sleep apnea. The patient also had coronary artery disease and low oxygen saturation and required oxygen at night for a total of sixteen hours during the day. All of this information is critical for the sleep medicine physician who is dealing with a patient in respiratory failure and probably some degree of heart failure too, according to Dr. X.

Dr. X pointed out the questions in the footnote of the referring letter: “Given his guarded prognosis, is CPAP reasonable? What best medication would help him with insomnia, which has only been one month duration?”

The patient slept only 42 minutes the night of his diagnostic sleep study. Although Dr. X testified that it is impossible to diagnose sleep apnea in that short time, he went on to say that if the condition is severe, it is possible to do so. He testified that in that short time period, the patient’s AHI was 67.8 per hour, which is severe obstructive sleep apnea. The patient’s oxygen saturation was below 90% for most of that time. The study was performed without oxygen.

Dr. X testified about the results of the CPAP titration trial the following night when the patient slept only 31 minutes and four pressures were tried. The oxygen saturation was still below 90%. The titration was totally inadequate, according to Dr. X, because the patient did not sleep enough. There was no information on the patient file about whether or not the patient was on oxygen or not, but information supplied by Dr. Botros sent after Dr. X's chart review, indicated that the patient was not on oxygen.

Dr. Botros saw the patient in consultation right after the CPAP titration study and his consultation notes describe the results of the titration study. Dr. Botros included in his note that the oxygen saturation was below 90% for over 40 minutes. Dr. X opined that if the patient had been put on four litres of oxygen per minute, the results of the test would have been different, and oxygen saturation may have been normal. Dr. X testified that it was very important to mention that oxygen was not used as it has enormous consequences. The patient was seeing a respirologist in consult, and whether the patient was on oxygen, or not, would have given guidance to him. The respirologist would be helped to decide how much oxygen to give the patient overnight. Dr. X testified that it was a significant deficiency that Dr. Botros did not mention that the patient was not on oxygen.

Dr. X said that it was insufficient for Dr. Botros to say that "past medical and surgical history as well as demographic and clinical data are enclosed in my consultation notes". The patient had significant pulmonary hypertension. Treatment of the patient's sleep apnea might improve the pulmonary hypertension and prevent the decompensation of the coronary artery disease, as well as prevent the triggering of cardiac arrhythmias. The diagnoses are ticked off on a questionnaire and not mentioned in the consultation letter, which is not what the referring physician needs to see, Dr. X said. Dr. X testified that the referring doctor needs an explanation and a plan of action.

Dr. Botros testified that he did not need to "recopy" what was in the patient's file. He went on to say, "Do I really want to compound and complicate, and just to revisit stuff that has been revisited by specialists, by family physicians, to tell him again, oh, by the way, he has heart failure." He testified that he focused on "what was relevant to me".

Dr. Botros made an extraordinary statement in his consultation note according to Dr. X. He said: "Patient acknowledged clinical benefit the following day after treatment manifested by some improvement in sleep quality, and a sense of feeling more rested the following day." The patient slept 31 minutes and Dr. X was puzzled about how Dr. Botros could draw that conclusion. Dr. X testified that although there were fewer apneic events, it is not satisfactory to draw any conclusion when the patient was not tested during REM sleep or slow wave sleep. Dr. Botros' explanation that there was improvement was inaccurate.

Dr. Botros testified that he did not tell the referring physician that Patient 18 only slept 42 and 31 minutes during the diagnostic and the titration studies respectively, because if he did, and then told him that the patient stated that he felt fantastic, the family physician would question whether the sleep specialist was joking. It would need a lot of explanation and would create confusion, he testified. Dr. Botros testified the referring doctor would think, "These people don't know what they are doing". Dr. Botros said academic scientific knowledge is needed to understand why that was happening. Dr. Botros went on to say that the patient had micro sleep, which is when the patient sleeps more than the EEG records in the sleep study indicate, and the patient experienced sleep as satisfying.

Dr. Botros testified that it was shocking to him when Dr. X testified that when a patient sleeps only 30 minutes in a sleep study it is of no clinical value. He intimated that he practises full-time while Dr. X practises only part-time and Dr. X does not understand sleep state misperception and micro sleep. Although the EEG is not recording sleep, Dr. Botros testified that according to the patient's experience, he is sleeping.

The pressure that Dr. Botros ultimately used for this patient may not have been ideal as there was insufficient time to determine the pressure. Other options should have been tried rather than a one-month home trial at a pressure setting that is uncertain to assist this patient, Dr. X said.

Dr. X in his report stated that patients with severe cardiopulmonary disease and low oxygen saturations must receive home oxygen therapy to ensure the oxygen saturation is above 88-90% at all times. Dr. X also commented in his report that it is equally important

that the oxygen administration through a CPAP system requires a flow rate higher than usual due to the dilution of oxygen by the high airflow generated by the CPAP system. Dr. X reported that the flow of oxygen in litres per minute that the patient used should have been mentioned in the consultation note. He said it was also Dr. Botros' responsibility to give advice to the referring physician and the CPAP supplier during the CPAP trial period about how many litres of oxygen will be necessary. Dr. X commented in his report that an overnight oxygen saturation study at home is advisable in these patients to ensure that the patient is not deprived of oxygen throughout the night at the ideal CPAP level. Dr. Botros provided no comment or advice in this respect.

Dr. X testified that the determination of the appropriate oxygen level is not solely in the purview of a respirologist. The Standards are very clear:

"Prescribing and administering nasal CPAP, spontaneous bi-level positive pressure and/or supplemental oxygen during sleep is routine practice for qualified sleep physicians."

Dr. X pointed out that Dr. Botros could have consulted a local respirologist about the initial therapy with oxygen through the CPAP system. Dr. Botros did not recommend any rate for the oxygen therapy that the patient was already using.

Dr. X testified that Dr. Botros' recommendations do not meet the standard of practice and any advice is non-existent. Dr. Botros did not give advice about the oxygen use with the CPAP and he did not respond to the specific request of the referring doctor regarding medication for insomnia.

Dr. Botros explained that he did not provide any recommendations to the family physician on the issue of oxygen and CPAP because "he didn't think he needed my direction on this point." He testified that, "…we'll just sort of continue the two (CPAP and oxygen) together, until I see him next time. And then gradually take him off oxygen." Dr. Botros testified that it was not his job to interfere. He testified that "But just to sort of be impulsive and say, well, you stop the oxygen, or continue with the oxygen, or---what's that got to do with me?"(Later, he testified that it was not his field of expertise).

When he was asked about whether the Standards clearly state that the prescribing and administering of supplemental oxygen during sleep is routine practice for qualified sleep physicians, Dr. Botros did not agree, and testified that was for a qualified respirologist in sleep medicine. When taken to the exact quote from the Standards, Dr. Botros testified that what the Standards were referring to was that oxygen could be used if the patient was still having desaturation of oxygen when they were in the sleep lab.

Dr. Botros testified that the patient was on sleeping medication. Once the patient follows up with his family physician again and mentions sleeping better, the family physician would likely discontinue the sleep medication. The question could not really be answered at that point in time. He testified that when he saw the patient in a month he would deal with the oxygen and the sleeping medication. Dr. Botros testified that what he did was appropriate as he wanted to keep the patient stable because his oxygen saturation had improved during the titration study.

Findings regarding Patient 18

The Standards are clear and Dr. X's testimony was unequivocal as well. The use of oxygen is within the scope of practice of sleep medicine specialists and not isolated to only respirologists, as Dr. Botros asserted. The Committee finds that Dr. Botros failed to maintain the standard in his use of oxygen in his clinic in relation to this patient and in not referring to its lack of use in his consultation letter.

The Committee finds Dr. Botros' explanation of why he did not refer to oxygen in his letter to be confusing and contradictory. On the one hand, he said that it was out of his area of expertise and at another time, he testified that he did not want to interfere. Later he said he planned to address the issue in follow-up. The Committee considers it more likely that Dr. Botros did not have the expertise to deal with the use of oxygen with CPAP or understand the use of oxygen for primary lung diseases and these were the main reason for his failure to mention or use it in the first place when the patient came to the clinic without his own oxygen source.

In relation to other allegations, including the allegation of incompetence, with regard to failing to mention to the referring physician that the patient only slept 31 minutes during the titration study and instead reporting that the patient felt as if he slept well, the Committee finds Dr. Botros was engaging in impression management. Dr. Botros testified that he did not want to explain the discrepancy between the time actually slept and the patient's experience because the family doctor would think he was joking or assume the sleep medicine specialist did not know what he was doing. It was Dr. Botros' role as a sleep medicine physician to analyze the findings and present them to the referring doctor but he failed to do that. Instead he selectively reported that the patient said he slept well.

The Committee finds that Dr. Botros failed to maintain the standard of practice is that he failed to prescribe proper CPAP pressure. Dr. Botros was unable to prescribe an appropriate level of CPAP in part because of the short period of sleep, but also because the study was not done with the patient receiving oxygen.

The Committee also finds that Dr. Botros' failed to address the issue of the sleep medication. Although Dr. Botros said that he would address the oxygen issue and the medication for insomnia at the follow-up visit, the Committee did not consider this response truthful. Dr. Botros had already told the Committee that the patient's family doctor could alter the sleeping medication and that oxygen was outside his area of expertise. If he truly believed that the family doctor could alter the medication when the patient reported sleeping better with the CPAP, he could have mentioned it in his letter. The Committee considers it more likely that he did not mention the sleeping medication because he did not turn his mind to it.

In summary, the Committee finds that Dr. Botros failed to maintain the standard of practice of the profession in his care of Patient 18 with regard to failing to appropriately prescribe supplemental oxygen for a patient on CPAP and failing for prescribing an inappropriate CPAP pressure that did not take into account the use of oxygen therapy. Dr. Botros considers that the questionnaire style form with the diagnoses ticked off, likely by the technician, to be adequate as he does not need to reiterate to the referring doctor what

he already knows. He said he focused on “what was relevant to me.” However, the Committee considers that Dr. Botros’ inability to analyze the patient’s sleep study results to what is going on with the patient medically to be a major problem. His comment that, “But to sort of be impulsive and say, well, you stop the oxygen, or continue with the oxygen, or - what’s that got to do with me?” illuminates the thinking of Dr. Botros on this case and others. Dr. Botros is able to report technically on the patient’s sleep study, although not always truthfully, as this case demonstrates. Furthermore, he is of the view that it is not his role to tie the sleep study results to what is going on with the patient medically as evidenced by his testimony, ‘what’s that got to do with me?” When referring physicians are asking specific questions and for help in managing patient’s care, Dr. Botros’ assistance as a sleep physician is limited when he cannot write a consultation letter that ties the medical history and the sleep study results together in a meaningful way.

Incompetence regarding Patient 18

Dr. Botros exposed the patient to the risk of harm or injury in Dr. X’s opinion. He failed to identify the important information in the patient’s history and link it with the study results and the implications. He failed to document whether the patient was on or off oxygen during the diagnostic and titration CPAP study and failed to mention it in his consultation report. Dr. X opined that the final pressure was likely not accurate due to the limited time that Patient 18 spent asleep. There is no evidence that Dr. Botros advised the CPAP supplier as to how many liters of oxygen per minute through the CPAP system were required and follow up with regard to oxygen saturation at night while at home was advisable to ensure the patient was not deprived of oxygen through the night at the ideal CPAP level. No advice was provided in this respect. This was important information to the referring doctor and could have been communicated to the respirologist subsequently to help in the care of this ill patient. Dr. Botros did not document that the patient only slept 42 and 31 minutes, respectively, on the nights of the diagnostic and titration CPAP study. All of these deficiencies serve to persuade the Committee that Dr. Botros’ care of Patient 18 exposed the patient to the risk of harm or injury. The Committee finds Dr. Botros is incompetent.

viii) Allegation that Dr. Botros demonstrated poor knowledge and understanding regarding CPAP treatment

As discussed in the reasons above regarding specific patients and in the reasons regarding the finding of incompetence below, the Committee finds that Dr. Botros demonstrated poor knowledge and understanding regarding CPAP treatment in patients who were prescribed CPAP.

2. Is Dr. Botros incompetent?

The Committee finds Dr. Botros incompetent in the practice of sleep medicine. He displayed a lack of knowledge, skill and judgment of a nature and to an extent that demonstrates that he is unfit to continue to practise, or that his practice should be restricted. Despite the fact that Dr. Botros has improved his practice with respect to the completion of the Sleep Study Interpretation form, the Committee finds that he has many areas of deficiency that are current. The Committee bases its finding in that respect on the evidence of the expert witnesses and his own testimony at the hearing. The reasons for finding Dr. Botros incompetent follow.

Non-Patient Specific Factors

Dr. Botros' testimony regarding the significance of the average AHI over the course of the CPAP titration study demonstrates a profound lack of knowledge, skill and judgment regarding sleep medicine. Rather than report the pressure at which the apnea/hypopnea were reduced the most, Dr. Botros regularly reported the average AHI over the course of the titration study. This number is meaningless in terms of treatment. The effect of using the average number, in his reports and treatment, was that Dr. Botros then sometimes used a pressure that was less than optimum for that individual patient. In general, Dr. Botros did not have to put as much thought into considering what the best pressure was for the patient. The allegation that Dr. Botros prescribed inappropriate CPAP pressure following titration studies was proved with Patients 1, 2, 3 and 4.

Dr. Botros' evidence related to Patient 18 in which he said that the patient slept in micro bursts accounting for the patient's report of sleeping well indicates a lack of knowledge

and skill. Dr. Botros impaired judgment is revealed in justifying his erroneous report to the family doctor by saying it would reflect badly on him if he reported the truth. His judgment is lacking.

Dr. Botros used the patient's unsuccessful CPAP titration to justify his therapeutic treatment of the patient's sleep apnea. While this may be helpful in the short term, it is concerning that he had no plan for follow-up to better address the difficulty with titration. In this case as well, it is as if Dr. Botros is satisfied to put as little analysis and care into ensuring the patient is well looked after and suggests that he did not have any understanding of this patient's problem in the first place.

Dr. Botros repeatedly stated words to the effect of understanding scientific principles, but despite having the results of the CPAP titration study, he often arbitrarily chose a CPAP pressure. Evidence for the best pressure existed in the recordings of the CPAP study. In some cases, Dr. Botros testified that he chose a sub-optimal pressure because he thought the patient would tolerate it better. The Committee understands that rationale. However, when no follow-up is recommended, and the patient has not been informed that they have significant apnea/hypopnea episodes at their current pressure, and need to have the pressure increased after they have a period of adjustment to the CPAP mask and machine, the Committee concludes that Dr. Botros' care is not conscientious and thoughtful. His judgment is lacking as well since he is apparently satisfied to let the patient have less than optimal treatment. Leaving it up to the patient, by saying they can return anytime, is not acceptable. Dr. Botros is incompetent. Dr. Botros does not recognize the responsibilities to patients in his role as a consultant.

Dr. Botros did not tie the patient's medical history, the information he gathered and the original questions from the referring doctor together for a comprehensive evaluation of the patient's sleep problem. He acted as a technician in reading the diagnostic and titration studies, and he seemed to be able to do this function. However, the deficits he showed were in his ability to tie the information all together in assessing the patient's problem with sleep. The Committee considers that certainly in many of the cases, the deficits were due to a lack of knowledge, skill and judgment, but in other cases, it was

just as likely that Dr. Botros was not motivated to do so. He was satisfied with cursory consideration of the case. He did not seem to understand his role in managing the patient's care.

Patient Specific Factors

Patient 18

This patient was very ill and Dr. Botros care exposed the patient to harm or injury. The referring physician had specific questions that Dr. Botros failed to answer. Dr. Botros failed to identify the important information from the patient's medical history. The Committee considers it just as likely that the genesis of the problem begins with the fact that Dr. Botros was not involved in the triage in the first place. The next stage of the process required a patient to fill out a medical history by way of a check list. The Committee was not reassured that Dr. Botros even considered his history in any meaningful way. Dr. Botros said he saw no reason to reiterate the history that the referring doctor already knew. While that may be true, it also gives the medical team that he is reporting to the assurance that the patient's history has been evaluated in the context of the sleep study results. This is an important function for a sleep medicine physician. The information sleep medicine physicians garner needs to be incorporated into a plan that takes into account the medical history. Dr. Botros did not seem to consider that in his care of Patient 18.

Dr. Botros also did not take into account the patient's needs in terms of the oxygen therapy he was on when he prescribed the CPAP pressure. In fact, Dr. Botros did not mention the patient's oxygen needs at all in his consult letter and he did not seem to see the patient's oxygen needs as under his purview at all. The Standards and the expert evidence stated otherwise. Dr. Botros' knowledge skill and judgment were lacking in several areas in this patient's care, and given his testimony, continue to be lacking.

Patient 5

This patient had extremely severe mixed sleep apnea with central and obstructive apnea, along with severe oxygen desaturation. Despite these difficulties, Dr. Botros did not see

this patient until two months after the diagnostic sleep study. A study to determine the CPAP pressure that should be used was not completed until five months later. The patient was at risk in the intervening period. Dr. Botros' knowledge, skill and judgment was demonstrated to be deficient in his care of this patient.

Patient 6

Dr. Botros "guesstimated" the pressure for this patient who had severe obstructive sleep apnea. A titration study was not completed until six months after diagnosis. Ministry of Health guidelines were in play this case because the patient had a previous study conducted at another clinic. Dr. Botros had other options for managing this patient. Given the patient's severe obstructive sleep apnea, his best interests were not taken into account. Dr. Botros took the most expeditious course for his own interests.

Patient 14

This teenager with delayed sleep disorder was wrongly diagnosed as suffering from idiopathic hypersomnolence (a life-long condition) and prescribed inappropriate medication. The expert was very critical because the patient was labeled with a chronic condition and treated with medication that she did not need. Her problem could have been managed with a sleep schedule change. Dr. Botros' knowledge, skill and judgment is lacking in this case.

Patient 3

This patient had severe obstructive sleep apnea requiring a BiPAP machine. The patient was ordered a CPAP machine with a pressure that was too low for her problem, following an unsuccessful CPAP titration. While the Committee understands why a low pressure may be used to help the patient adapt, there is no evidence of timely follow-up and she did not receive a BiPAP study until sixteen months after the initial consultation. She was put at risk in the interim. Dr. Botros' judgment, skill and knowledge are demonstrated to be lacking and deficient. There is a lack of conscientiousness that is concerning.

In summary, the Committee finds that although knowledge and skill constituted some of the deficiencies of Dr. Botros, his judgment was the premier issue. He did not seem to have the ability to self-monitor or assess his own competency. There was no evidence of self-reflection, insight or the ability to admit that he may have been in error in any way.

For example, it appears Dr. Botros knew he needed to triage patients. Yet he justified having the complicated system he had when in fact, he could have done it by simply looking at the referrals himself and initialing them. He did not do that. The Committee finds that he did not because he was involved personally as little as possible.

Despite the expert's very cogent evidence about the diagnostic error in respect to Patient 14, the "night owl" teenager, Dr. Botros dogmatically maintained his initial diagnosis. He expressed no doubt, with an arrogance and rigidity that does not bode well for future remediation.

Although the Committee was of the view that Dr. Botros has some skill in interpreting a sleep study, he did not incorporate his findings into a management plan that takes into account the patient's complaint and medical history, with a suitable follow up plan. His largely incomprehensible consult letters were consistent with his lack of comprehensiveness.

3. Did Dr. Botros engage in behaviour that was disgraceful, dishonourable or unprofessional in his treatment of the College investigators?

The Committee heard evidence from two College investigators on this issue, both of whom were found to be credible. Their stories were unembellished and straight-forward and the Committee is of the view that they had no reason to be less than truthful. Documentary evidence corroborated much of their testimony as well.

Ms A was a College investigator who was appointed as one of the investigators in this matter, along with her colleague, Ms B. Ms A testified that she was in charge of the investigation in the early stages and sent a letter to Dr. Botros on May 13, 2008, informing the doctor of the Appointment of Investigators under section 75(b) of the *Health Professions Procedural Code.* She asked to arrange for a meeting in order to pull

some patient charts for review. As a follow up to that letter, Ms A telephoned Dr. Botros on November 6 and referred to that call in a letter dated November 10, 2008 asking for information about how his records were stored. Ms A made a note to her file after the call. In that call, Dr. Botros told her that his clinical patient records were stored in paper files and the sleep studies were electronic records. She called him again on November 10 in order to arrange the date for the chart pull. In her testimony, Ms A referred to a note she made at the time of the call and had filed. She reported that Dr. Botros told her that she was not qualified to conduct the investigation; she had broken a standard and he told her about a colleague of his, suing a colleague of hers. Ms A testified that she thought that it seemed as if Dr. Botros was threatening her with that comment. Dr. Botros also told her that she could not break in and open files "willy-nilly", she said. In addition, Ms A testified that Dr. Botros told her that he would not be replying to her letter of November 10 and would be writing to the President of the College and the Premier of Ontario. He ended the call, she said.

Ms A testified that they were able to schedule a date for attendance on January 23, 2009. When they attended, Dr. Botros met both herself and her colleague Ms B with 100 charts that he had pulled himself. Ms A testified that she had asked for access to the electronic appointment records and that their preference was to work from those, not the charts Dr. Botros pulled.

Although Ms A said she told Dr. Botros it would be helpful if he could provide the OHIP billing records in order to assist with the chart pull, he did not provide them.

When they were unable to access the electronic records, Ms A testified that she and her colleague took paper charts that Dr. Botros did not want removed from the office. He initially refused to allow them to remove the charts and they began to photocopy them in the office. He did not agree to that either. However, they did copy charts of eight patients as Dr. Botros said this group could return at any time. Photocopying the charts was impractical so Dr. Botros was informed that the charts would be removed and photocopied at the College.

Ms A testified that during the time they were at his office, Dr. Botros did not speak to them directly but would communicate with them with what seemed like prepared statements on pieces of paper he gave to his counsel to answer on his behalf.

Dr. Botros went through each of the charts they pulled and drew a line through a page in two or three charts while saying something about a dictated note, according to Ms A. She also testified that Dr. Botros continued to say to her that she was not qualified to carry out the investigation and that she did not know about sleep medicine and that she was being sloppy.

Ms A testified that she subsequently wrote to Dr. Botros' counsel indicating that an appointment was booked for Dr. Botros to meet with the medical inspector in the matter on April 27, 2009. Several letters were in evidence attesting to the difficulties that Ms A had in scheduling an appointment for Dr. Botros to meet with the medical investigator. The meeting eventually took place in August of 2009.

Ms A also confirmed that Dr. Botros requested a list of the questions that the medical inspector would ask him. Ms A responded to the doctor that they would not provide a list of questions, as there would then be little point to the interview and the interview was more of a back and forth process with the chart as a reference point.

Ms B testified, and documents confirmed, that she wrote a letter to Dr. Botros on September 29, 2009, requesting that the material previously requested in Ms A's letter of August 26 be sent to the College by October 2, 2009. On November 18, 2009, Ms B informed Dr. Botros that since he had not cooperated with the request for follow-up information, the medical inspector would be completing his report without it. Subsequently, Ms B received a letter dated September 22, 2009, but received by the College on December 3, 2009 (according to a date stamp), with the response to the request for documentation.

Following some concerns from the IHF staff, Ms B testified that they obtained a further ten charts and subsequently gave them to another medical inspector. The medical inspector asked for a typed transcription of Dr. Botros handwritten notes for the ten

patients and according to Ms B this letter was written on September 2, 2010, and according to documents, some explanatory notes, but not transcriptions, were received on September 21, 2010. The medical inspector was not satisfied with the transcriptions because a follow-up letter was written following an interview between the inspector and Dr. Botros on September 24, 2010. According to documents, Dr. Botros was given two weeks to comply with the request. When he did not, another letter was sent by Ms B on October 13, 2010.

Ms B agreed in testimony that she used language in the second letter indicating that according to the *Code*, Dr. Botros had a duty to co-operate with an investigator. Ms B testified that she sent two more letters on November 4, 2010 and January 5, 2011, again requesting the information previously requested. The last letter contained a copy of the medical investigator's report. The College did not receive the material requested by the medical investigator at the time he wrote his report according to the letter of January 5, 2011 and the testimony of Ms B. Dr. Botros eventually did respond to both medical inspectors' reports on March 14, 2011, according to documentation and Ms B' testimony.

Dr. Botros did not challenge the evidence of the two College investigators. He did not dispute the chronology set out in the correspondence admitted into the record. Dr. Botros had no explanation for his behaviour in his testimony.

Findings with regard to allegation of disgraceful, dishonourable or unprofessional conduct

The Committee is persuaded that Dr. Botros' behaviour was not compliant and that he was uncooperative in dealing with the investigators when they came to his office. Although his counsel portrayed Dr. Botros as a doctor who had recently completed a peer assessment, an IHF assessment and a quality assurance assessment, and thus may have had reason to be wary of the College, his previous experiences do not obviate the need for him to cooperate fully. He was less than cooperative in the Committee's view. He was resistant to the investigators' need to do a random chart pull based on his appointment schedule. The Committee recognizes that Dr. Botros had a right to have counsel present. His comments were derogatory and demeaning to the professionalism of the College

investigators. He also was obtuse and obstructionist when he was insistent that some files not leave his office, when they could have been faxed back immediately if the patient made a follow-up appointment. The Committee finds that his behaviour was unprofessional in his dealings with the investigators.

With regard to the untimely response to the request for more information from both inspectors, the Committee finds that it was likewise, unprofessional. Dr. Botros' response to repeated requests on behalf of both inspectors took months to arrive at the College. Dr. Botros' failure to comply reasonably with the requests made of him indicates his lack of understanding of the requirements of the duty of the College. In fact, the behaviour described by the investigators is congruent with the demeanour of Dr. Botros during his testimony. He was often petulant, arrogant, and angry when it was suggested to him that anything was amiss with his care in the face of clear evidence that it was. The Committee finds that the allegation that Dr. Botros was unprofessional in his dealings with the College investigators is proved.

SUMMARY OF FINDINGS

The College proved on a balance of probabilities on the basis of clear, cogent and convincing evidence that Dr. Botros failed to maintain the standard of practice of the profession in several areas in relation to his care of 22 patients.

Dr. Botros failed to maintain the standard of practice with regard to sleep study interpretation in all of the patients reviewed. Similarly, his triage methods were deficient and failed to maintain the standard of practice. The allegation that he did not do a physical examination is proved with respect to one patient and the Committee finds that he either did not do a physical examination or did not chart a physical examination in respect of three others.

The allegation that Dr. Botros prescribed inappropriate CPAP pressure following CPAP titration is proved in relation to Patients 1, 2, 3, 18 and 4.

The allegation that Dr. Botros failed to take appropriate steps to treat patients within a reasonable time frame is proved in relation to Patients 3, 5 and 6.

The allegation that Dr. Botros allowed patients to be prescribed CPAP without first being seen by a sleep physician is proved in relation to Patients 7 and 8.

The allegation that Dr. Botros failed to document the prescribed pressures is not proved.

The allegation that Dr. Botros incorrectly or incompletely diagnosed several patients is proved in relation to Patients 11, 12, 13, 14,and 16. This allegation is not proved with respect to Patients 9, 10 and 15.

The allegation that Dr. Botros failed to appropriately notify or follow up with the Ministry of Transportation is proved with regard to Patients 17, 2, and 6.

The allegation that Dr. Botros failed to appropriately prescribe supplemental oxygen for a patient on CPAP therapy is proved with regard to Patient 18.

The allegation that Dr. Botros demonstrated poor knowledge and understanding of CPAP treatment is proved.

As noted in the decision above, the allegation of incompetence is proved. Dr. Botros' care showed a lack of knowledge, skill or judgment generally, and in the care of four patients who had severe conditions (Patients 5, 6, 3 and 18) - and one patient (Patient 14) who was inappropriately diagnosed and managed.

The allegation that Dr. Botros engaged in behaviour that was unprofessional in his treatment of the College investigators is proved.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made at the earliest opportunity.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Wagdy Abdalla Botros, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads, in relevant part:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

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THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. WAGDY ABDALLA BOTROS

PANEL MEMBERS:

DR. P. TADROS (CHAIR)
DR. E. ATTIA (Ph.D.)
DR. C. CLAPPERTON
DR. J. WATTS

Penalty Hearing Date:	November 18, 2015
Penalty Decision Date:	December 16, 2015
Release of Written Reasons:	December 16, 2015

PUBLICATION BAN

PENALTY AND REASONS FOR PENALTY

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario delivered its written decision and reasons on finding in this matter on July 31, 2015. The Committee found that Dr. Botros has committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession and he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Committee also found that Dr. Botros is incompetent.

The Committee heard evidence and submissions on penalty and costs on November 18, 2015, and reserved its decision.

EVIDENCE AND SUBMISSIONS ON PENALTY

A. The College's Position

The College is seeking a reprimand, and terms, conditions and limitations restricting Dr. Botros from practising in the sleep medicine field for an indefinite period, a six month suspension and an order that he pay the costs of the hearing. There is no request for a restriction on his ability to practise psychiatry, in which he is also qualified.

The College submits that the forgoing penalty is warranted because of Dr. Botros' repeated failures to maintain the standard of practice of the profession and because of the nature and breadth of the findings of professional misconduct and incompetence. Dr. Botros has demonstrated contempt for the College in its role as professional regulator and has shown no insight or ability to self-monitor and self-reflect, revealing a lack of remediability.

B. Dr. Botros' Position

Counsel for Dr. Botros argues that the College's submission on penalty is excessive. While Dr. Botros considers it appropriate that the Committee order costs and issue a

reprimand in order to express the profession's disapproval of the unprofessional behaviour demonstrated by his failure to cooperate with the College's investigators, his counsel submits that the other two terms of the Order are overly punitive.

Dr. Botros' counsel contends that a suspension of his certificate of registration for four months instead of six months would be more appropriate. Penalty principles should have regard for the potential of effective rehabilitation. Counsel for Dr. Botros submits that to impose a conditional restriction to practise sleep medicine on Dr. Botros' certificate of registration, which would be waived upon successfully completing a retraining programme approved by the College, would be more fitting for that objective.

The Committee considered Books of Authorities filed by both counsel. It also had a copy of Dr. Botros' application for renewal of his certificate of registration for the year 2015. On the application form, Dr. Botros stated that 35% of his clinical time was spent doing psychiatry and 65% sleep medicine.

DECISION AND REASONS ON PENALTY

Penalty Principles

The Committee considered carefully the submissions of the College and Dr. Botros, as well as his previous history with the College, and it reviewed the case law that was presented by both parties.

The Committee's determination on penalty is based, firstly, on the guiding principle of protection of the public. The Committee was also mindful that the penalty should serve as a general deterrent to the profession and a specific deterrent to the member, that it should express the profession's denunciation of the misconduct, that it be proportionate to the misconduct, that it uphold the honour and reputation of the profession and maintain the public's confidence in its ability to regulate itself in the public interest, and to the extent possible, it should rehabilitate the member.

The Findings

The nature and extent of the Committee's findings are relevant to the matter of penalty. The Committee found that the allegations of professional misconduct against Dr. Botros were proved in that he:

- failed to maintain the standard of practice of the profession regarding sleep study interpretation based on the deficient content of the Standard Sleep Study Interpretation form with respect to 22 patients;
- failed to maintain the standard of practice of the profession in failing to review and triage referrals with respect to 22 patients;
- failed to complete a physical examination of one patient, and failed to complete an examination or document it with respect to three others;
- prescribed inappropriate CPAP pressure following CPAP titration studies for patients 1, 2, 3, 4 and 18;
- failed to take appropriate steps to treat patients 5, 6, and 3, who suffered from severe sleep apnea, within a reasonable time frame;
- failed to maintain the standard of practice of the profession in not seeing patients 7 and 8 prior to the CPAP titration study;
- incorrectly or incompletely diagnosed patients 11, 12, 13, 14 and 16;
- failed to properly notify or follow up with Ministry of Transportation with respect to patients 17, 2 and 6;
- failed to appropriately prescribe supplemental oxygen for patient 18; and
- demonstrated poor knowledge and understanding regarding CPAP treatment in patients who were prescribed CPAP.

The Committee also found that Dr. Botros was incompetent in his practice of sleep medicine in that he displayed a lack of knowledge, skill and judgment of a nature and to an extent that demonstrated that he is unfit to continue to practise or that his practice should be restricted. The factors contributing to the finding of incompetence included, choosing arbitrary CPAP pressures, averaging the AHI over the course of the titration study, poor judgment and deficiencies in the area of follow-up, and an inability to provide a comprehensive analysis of the clinical information in a way that would be of assistance to the referring physician.

Furthermore, the Committee found that Dr. Botros engaged in unprofessional conduct during the College investigations, by making demeaning and derogatory comments to the investigators, being uncooperative, and failing to comply with repeated requests of the investigators. Dr. Botros did not seem to understand his professional obligations to the College.

Dr. Botros' Past History

Dr. Botros has a prior history with the College and the Committee looked at that history to appraise the doctor's amenability to rehabilitation, not to punish him further. The Discipline Committee rendered a decision in a separate matter on April 21, 2015, in which it found that Dr. Botros failed to comply with an Order of the Inquiries, Complaints and Reports Committee (ICRC) by not attending a communication skills course. The Committee found that he engaged in disgraceful, dishonourable, or unprofessional conduct.

On March 16, 2011, the ICRC ordered Dr. Botros to take the communications skills course. The Health Professions Appeal and Review Board (HPARB) confirmed the ICRC decision on April 20, 2012. Despite repeated communications with Dr. Botros and attempts by the Compliance Monitor to assist the doctor with scheduling, Dr. Botros still did not comply with the order to take the course. On May 15, 2013, Dr. Botros' lack of compliance resulted in a referral to the Discipline Committee. The penalty decision has not yet been rendered in that case. Although this decision was rendered after the hearing in the current case concluded, the Committee is entitled to consider it *as it relates to Dr.*

Botros amenability to remediation. The Committee is not considering that case in order to punish Dr. Botros further.

In November of 2011, in response to a patient complaint regarding care in Dr. Botros' London clinic in 2006 and 2007, the ICRC required Dr. Botros to attend a caution in person in relation to his failure to comply with College requests, such as providing records in a timely manner. Dr. Botros delayed responding and ultimately, the College had to resort to special investigative powers to obtain a response and records from Dr. Botros. The ICRC noted that Dr. Botros' response was troubling in that it did not reflect the professional and measured communication the Committee expects of College members.

Dr. Botros requested a review of the ICRC decision by HPARB. In its decision, HPARB noted that, "given the College's mandate to regulate and govern the profession in the public interest and in light of the information contained in the Record, the Board finds the Committee's decision is reasonable."

In another case in November 2011, in response to a patient complaint, the ICRC required Dr. Botros to attend a caution in person regarding his failure to meet his obligation to comply with College requests such as providing records in a timely manner. It issued a caution that it is advisable in most circumstances to discuss with and advise a patient when planning to report the patient to the Ministry of Transportation. Following a request by Dr. Botros for review of the decision by HPARB, the decision of the ICRC was confirmed.

In June 2002, in response to a patient complaint, the Complaints Committee required Dr. Botros to attend an in person caution regarding his failure to provide the patient's electronic sleep study data to a subsequent treating physician. He was also referred to the Quality Assurance Committee. The decision was subsequently upheld on a review of it by HPARB. In July 2007, the Divisional Court dismissed Dr. Botros' application for judicial review of the HPARB decision.

In considering the current findings along with the decisions of the Complaints, ICRC and Discipline Committee, it is apparent that Dr. Botros is not only incompetent and fails to

maintain the standard of practice of the profession in his care of sleep study patients, but his lack of compliance with the College processes that are in place to protect the public and fulfill its role as a self-governing regulator reveal a contempt that is of great concern to the Discipline Committee.

The decision of the Discipline Committee of April 21, 2015 characterizes Dr. Botros' conduct:

> "… a blatant disregard for College processes, but also an attempt to control the process, thus resulting in an unnecessary delay on his part in complying with the Order. In addition, it demonstrated a lack of cooperation with his governing body and a lack of *bona fide* intention to comply with an Order of the ICRC."
>
> "The absence of a response to these letters, combined with the absence of any explanation as to why he failed to comply, demonstrated contempt for his governing body."

In the instant case, Dr. Botros repeatedly did not respond to the investigators requests for appointments and for information. Dr. Botros was reminded of his duty to co-operate with the investigator. Dr. Botros was non-compliant and uncooperative in dealing with the College investigators. He was derogatory and demeaning to the College investigators as well.

Dr. Botros' behaviour in his response to the College investigators was considered by the Committee as an aggravating factor. His counsel points out that he cannot be faulted for appealing the Complaints Committee and ICRC's decisions to HPARB and this Committee agrees. Dr. Botros' right to seek a review of a decision is acknowledged, but his obtuse, obstructionist, rude and delaying tactics are not condoned in any way. Further reference to these aggravating factors will follow later.

Counsel for Dr. Botros submits that Dr. Botros has shown initiative in the past to learn and obtain advanced qualifications in Sleep Medicine. It was submitted that he demonstrated at the hearing that he has attempted to make improvements to his documentation practices by revising his Standard Sleep Study Interpretation Form.

Although Dr. Botros did revise his form, there was no evidence presented to show that the form allowed him to be more comprehensive in his consultation reports to referring doctors and to present an analysis of the sleep study that was cogent and meaningful. The Committee was not presented with any other evidence of efforts the doctor has made to address deficiencies in his medical knowledge. In fact, the Committee found there was no acknowledgement on the part of Dr. Botros that he may need any continuing medical education or remediation at all.

No evidence was presented that Dr. Botros had finally completed the communications course that was ordered in 2011 and the focus of the Discipline Committee decision of 2015. Although this Committee is not penalizing Dr. Botros for his conduct in the past that have led to cautions, and a subsequent further Discipline Committee hearing following the current one, this Committee would be remiss if it did not consider Dr. Botros' past patterns of behaviour when considering his rehabilitation prospects. The Committee agrees with the adage that the best predictor of future behaviour is past behaviour.

Prior Cases

In considering the cases filed, the Committee noted the broad nature of the penalty orders in like cases, spanning revocation, to lengthy suspensions, to restrictive terms, conditions and limitations. The nature of the deficiencies and the members' ability to comply or even recognize their deficiencies were factors in the Committee's determination of penalty in previous cases. The same attention to those factors informs this Committee as well.

The Penalty Submission

A reprimand is appropriate as it expresses the profession's abhorrence for the actions of the doctor. Both parties agree that it is appropriate and the Committee concurs. However, the Committee does not agree with Dr. Botros' counsel who argues that the reprimand will sufficiently address the issue of Dr. Botros' lack of cooperation with College processes.

Counsel also disagreed on the length of a suspension for Dr. Botros. The College submitted that a suspension of six months is more appropriate than four months. Dr. Botros' counsel presented the *Kooner* case as a guide to the Committee. Dr. Kooner was found to have failed to maintain the standard of practice and had committed an act of professional misconduct. He was also found to be incompetent and received a three month suspension. Counsel for Dr. Kooner suggested that he had already been effectively suspended for six months. Counsel for Dr. Botros argued that a suspension of four months instead of the proposed six month suspension would be more reasonable for Dr. Botros. The Committee disagrees.

The Committee had before it other cases such as *Yazdanfar, Liberman* and *Depass*. The context of these cases is quite different and the Committee did not find them particularly useful in determining the appropriate length of suspension to be imposed on Dr. Botros.

The Committee concluded that a four month suspension would not be sufficient in this case. When looking at the context, there were multiple areas in which Dr. Botros failed to maintain the standard of practice of the profession. He was also found to be incompetent in his care of several patients. Furthermore, his derogatory comments to College staff, and his demeaning their professionalism requires a significant sanction. His lack of compliance and delays in responding to College requests had the effect of impairing the investigation in this case. The Committee concluded on the basis of the findings made that a six month suspension is appropriate in the circumstances of this case. It will serve as a specific deterrent to Dr. Botros and a general deterrent to the profession.

College counsel submitted that as part of an appropriate penalty order that the Registrar should place terms, conditions and limitations on Dr. Botros' certificate of registration for an indefinite period that would restrict him from practising sleep medicine. Under the proposed order he would be restricted from ordering, supervising, and interpreting any sleep studies, diagnostic or therapeutic, and he would be restricted from assessing, managing, treating or prescribing to any patients for any sleep related problem. The College submitted that Dr. Botros should not be prevented from practising psychiatry as there have been no complaints about this area of his practice.

Dr. Botros' counsel argued that Dr. Botros should not be restricted from practising sleep medicine but instead should have a conditional restriction on his practice to allow him to complete remedial training in the area of sleep medicine. She also argued that the terms and conditions proposed by the College would limit Dr. Botros in his treatment of sleep problems in psychiatric patients.

The Committee carefully considered the submissions in this regard. In *Adams v. Law Society of Alberta,* [2000] 11 W.W. R. para. 6, the role of the College as regulator is defined clearly:

> *"…it may be helpful to consider the context of a professional discipline hearing. Professional bodies are those to whom the government has seen fit to grant monopoly status. With this monopolistic right comes certain responsibilities and obligations. Chief amongst them is self-regulation. Self-regulation is based on the legitimate expectation of both the government and public that those members of a profession who are found guilty of conduct deserving of sanction will be regulated –and disciplined—on an administrative law basis by the profession's statutorily prescribed regulatory bodies…the public dimension is of critical significance in the mandate of professional discipline bodies."*

The College must be diligent and rigorous in fulfilling its covenant to protect the public. In order to maintain the privilege of membership in their professional regulatory body, physicians must also be cognizant of their role and obligations. They likewise have a duty to cooperate with the College as their regulatory body. The Committee does not accept that Dr. Botros understands his professional obligations, even though he has had previous cautions in that regard. His behaviour over a period of years has not changed in his response to College requests for information and cooperation that is required to protect the public.

In considering the dichotomy in the positions of each party on an appropriate penalty, the Committee considered Dr. Botros' actions. Not only did he fail to meet the standard in many areas of practice and was found to be incompetent in his care of many patients in his sleep practice, he also was contemptuous of the College's mandate to protect the public. Rather than recognizing that the privilege of membership in the College required him to respond professionally, in an accommodating and timely fashion, Dr. Botros did nothing of the sort. Not only did he delay and act in a way that was ultimately

obstructionist, but also, in the course of the investigation and even during the hearing, he made himself out to be the victim, as if somehow the College was persecuting him. The ICRC and Complaints Committee decisions, as well as the more recent Discipline Committee findings, all point to a physician who is not disposed to being cooperative with the College in its mandate to protect the public. The Committee is basing its view not on the fact that Dr. Botros used legal processes that he was entitled to use, but that he was not cooperative or compliant with requests by the College, which is charged with the obligation of investigating complaints from the public in the first place. Dr. Botros' membership in the College requires his full cooperation, and even though he has been warned of this in past cautions, his behaviour did not change.

The Committee considers it would not be appropriately fulfilling its mandate to the public if it trusted a physician who has given no indication by his past conduct that he is willing to cooperate with the College. Accordingly, the Committee was not prepared to make an Order that allowed him to practise sleep medicine, conditional on his doing remedial work in sleep medicine.

Another question is whether the evidence demonstrates that Dr. Botros is even remediable. The Committee is of the view based on the evidence of his conduct, that he is not, and there are several reasons for arriving at this conclusion. At the outset, the Committee acknowledges that it was Dr. Botros' right to plead not guilty to the allegations in this case and defend himself vigorously, and does not factor that into its decision. Sleep medicine has many facets that are very technical. There are bound to be errors or grey areas and some parts of consolidating treatment where art is mixed with science. However, in the course of the hearing over multiple days and the review of many patient charts, Dr. Botros never once conceded that perhaps he could have done something differently, or was in error, where the evidence indicated he was. There was an absence of self-reflection or self-monitoring which is required of physicians to maintain their continuing medical education. Dr. Botros seems unable or unwilling to provide a comprehensive analysis of a patient's case to the referring doctor. He was argumentative, petulant, and spoke in a derogatory fashion to counsel and about the expert witnesses. He appeared to have no insight into his actions or to even see that his professional

obligations required him to be cooperative with the College. The Committee does not consider that it would be appropriate to impose the order submitted by his counsel that would enable Dr. Botros to practise sleep medicine after a period of remediation. It has been demonstrated to the Committee that Dr. Botros cannot be trusted to remediate in a way that would be commensurate with the College's requirements for public safety. Of course, it is open for Dr. Botros to undertake remediation on his own and apply to the Discipline Committee for a variation of the terms, conditions and limitations on his certificate of registration in the future. It would be the responsibility of the Discipline Committee on such a future application to vary to determine, on the evidence presented at that time, whether a variation should be made.

In fulfilling its mandate as a self-regulating body, the Discipline Committee decided at this time to impose, for an indefinite period, terms, conditions and limitations that will restrict Dr. Botros from practising sleep medicine. Thus, it will be his responsibility to prove to the Committee on a future application that he has changed and has undergone remediation that will justify returning him to the practice of sleep medicine.

Counsel for Dr. Botros expressed concern that such an order will not allow Dr. Botros to prescribe medication to his psychiatric patients for their sleep problems. The Committee does not intend that the restrictions it considers necessary would prevent Dr. Botros from prescribing appropriate medication for sleep if he is of the belief that a patient's psychiatric condition requires it. However, he would need to refer patients to a sleep medicine specialist, as other physicians do, if he considers their sleep problem is something other than those that accompany psychiatric disorders.

Costs

Both counsel agree that costs should be borne by Dr. Botros. However, Dr. Botros' counsel argues that the costs should be for only twelve hearing days since two days were shortened, one of them because the College's expert witness was not available. The Committee accepts this submission and costs are ordered against Dr. Botros in the amount of $53, 520.00, on the basis of twelve hearing days, at the tariff rate of $4,460.00 per day.

Summary

The Order as follows will address the need to protect the public and serve the purpose of specific and general deterrence. The suspension of six months is in keeping with the seriousness of the findings regarding Dr. Botros' disgraceful, dishonourable, and unprofessional conduct, his failure to maintain the standard of practice of the profession and his incompetence in sleep medicine. Maintaining the public trust and public safety are paramount and the penalty will serve that end. Members will be reminded that membership in the College is a privilege, not a right. Compliance with investigations is mandatory as the College fulfills its role in self-regulation. The indefinite terms, conditions and limitations on his certificate of registration protect the public and maintain the integrity of the profession. Dr. Botros may choose to undergo his own rehabilitation and remediation and apply to have the terms, conditions and limitations on his certificate of registration varied at some point in the future, if he can demonstrate a case for variance.

ORDER ON PENALTY AND COSTS

The Discipline Committee therefore orders and directs that:

1. Dr. Botros appear before the panel to be reprimanded.
2. the Registrar suspend Dr. Botros' certificate of registration for a period of six (6) months, commencing immediately.
3. the Registrar place the following terms, conditions and limitations on Dr. Botros' certificate of registration for an indefinite period:
    a) Dr. Botros is restricted from practising in sleep medicine, including but not limited to:
        i) Ordering, supervising and interpreting any sleep studies, diagnostic, or therapeutic; and
        ii) Assessing, managing, treating or prescribing to any patients in relation to any sleep disorder problems; except that this Order does not preclude Dr. Botros prescribing medication for sleep difficulties associated with a psychiatric disorder.

b) Dr. Botros shall co-operate with unannounced inspections of his practice and patient charts, conducted at his own expense, by a College representative(s), for the purpose of monitoring and enforcing his compliance with these terms, conditions and limitations.

4. Dr. Botros pay costs to the College in the amount of $53, 520.00, within 60 days of the date of this Order.