BRITISH COLUMBIA
DISABILITY
Indexed as: Kelly v. University of British Columbia (No. 3)
Cited: (2012), CHRR Doc. 12-0032, 2012 BCHRT 32

CHRR Doc. 12-0032 Paragraphs 1 – 570

Carl Kelly

Complainant

v.

University of British Columbia

Respondent

Date of Decision:
February 23, 2012

Before:
British Columbia Human Rights Tribunal, Enid Marion

File No.:
5777

Appearances by:
Marjorie Brown and Joni Warton, Counsel for the Complainant
Don Jordan and Rosyln Goldner, Counsel for the Respondent

DISABILITY — EDUCATION — PUBLIC SERVICES AND FACILITIES — REASONABLE ACCOMMODATION — DISCRIMINATION — BURDEN OF PROOF — EMPLOYMENT / Decision on a complaint of discrimination in services on the basis of disability. The Tribunal found that there is a clear, direct and substantive link between the complainant's disability and the adverse treatment he experienced in the respondent's family practice residency training program. The Tribunal found that the respondent did not discharge its duty to reasonably accommodate the complainant. The Tribunal ordered the respondent to cease the contravention and refrain from committing the same or similar contravention. There will be a hearing held on any other remedies to be ordered. Allowed: Feb. 23, 2012.

REASONS FOR DECISION

Complaint

[1] Dr. Carl Kelly has Attention Deficit Hyperactivity Disorder – Inattentive Type ("ADHD"). He also has a Non-Verbal Learning Disability ("NVLD") and has, at times, suffered from anxiety and depression.

[2] Throughout 2005 – 2007, Dr. Carl Kelly was enrolled in the Family Practice Residency Program (the "Program") administered by the Faculty of Medicine at the University of British Columbia ("UBC").

He spent part of his residency at St. Paul's Hospital ("SPH"), which is operated by the Providence Health Care Society ("Providence"). While he was a resident at SPH, Providence was Dr. Kelly's employer.

[3] The Professional Association of Residents of BC ("PARBC") is the trade union certified to bargain collectively on behalf of residents employed in teaching hospitals in BC. It represented Dr. Kelly in his dealings with the Program and Providence.

[4] On August 29, 2007, UBC terminated Dr. Kelly's enrolment in the Program for unsuitability. Providence then terminated his employment. Dr. Kelly filed both a grievance and human rights complaint against Providence, alleging discrimination in the provision of a service customarily available to the public and employment, based on mental disability, contrary to ss. 8 and 13 of the *Human Rights Code*. The human rights complaint against Providence was deferred pending the outcome of the grievance process.

[5] In *Kelly v. Providence Health Care and another (No. 2)*, 2010 BCHRT 126 [CHRR Doc. 10-0964], the Tribunal added UBC as a respondent to the human rights complaint in respect of both the ss. 8 and 13 allegations:

> Dr. Kelly alleges that UBC did not meet its obligation to accommodate him in the Residency Program, and that his termination from the Program resulted in Providence's termination of his employment as it could not continue to employ him as a resident once he was no longer in the Residency Program. Applying the analysis from *Mans,* I find that the words of s. 13 are broad enough to apply to a situation where UBC (allegedly) discriminated against Dr. Kelly in relation to Dr. Kelly's employment with Providence. (para. 35)

[6] Both the grievance and human rights complaint against Providence were dismissed. The grievance was dismissed because Providence could not employ Dr. Kelly once UBC had terminated him from the Program. In *Kelly (No. 2),* the human rights complaint was dismissed because it had been appropriately dealt with in the grievance procedure:

> The arbitrator thoroughly considered the facts and the applicable human rights principles. He determined that UBC terminated Dr. Kelly's participation in the Residency Program without any consultation with Providence, and that Providence could not employ Dr. Kelly (or anyone else) whom UBC had not assigned to it through the Residency Program. Hence, Dr. Kelly's termination from employment arose solely from his termination from the Residency Program. On these facts, the arbitrator concluded that there was no *prima facie* discrimination. In the event there was *prima facie* discrimination, the arbitrator concluded that the duty to accommodate had been met because the accommodations recommended in the consultants' reports related to aspects of the Residency Program. Therefore, they could only have been implemented by UBC.
>
> I am satisfied that the substance of Dr. Kelly's complaint was appropriately dealt with in the grievance proceedings. (paras. 42-43)

[7] The human rights complaint proceeded against UBC. It denied any discriminatory conduct.

[8] The parties agreed to bifurcate the hearing. As a result, this decision will only address whether or not Mr. Kelly's complaint is justified. If I determine that the complaint is justified, then the only remedy that will be ordered at this juncture is a mandatory cease and refrain order. A further hearing will be scheduled to hear evidence and argument on what, if any, other remedies should be ordered in all the circumstances.

Issues

[9] Has Dr. Kelly proven a *prima facie* case of discrimination under s. 8 of the *Code?*

[10] If so, has UBC proven a *bona fide* and reasonable justification ("BFRJ")?

[11] Is s. 13 of the *Code* applicable?

[12] If so, has Dr. Kelly proven a *prima facie* case of discrimination in employment?

[13] If so, has UBC proven a *bona fide* occupational requirement ("BFOR")?

[14] In all cases, the burden of proof is on a balance of probabilities.

Decision

[15] Section 13 of the *Code* is applicable.

[16] Dr. Kelly has proven a *prima facie* case of discrimination under both ss. 8 and 13 of the *Code.*

[17] UBC has not proven either a BFRJ or BFOR.

[18] The complaint is justified.

Credibility and Witnesses

[19] Dr. Kelly did not testify. He called Dr. Christopher Gibbins, who is a Registered Psychologist, and Dr. Michael Myers, who was his treating psychiatrist.

[20] UBC called Dr. Jill Kernahan, who was UBC's Director, Postgraduate Programs, Department of Family Practice, at the material time, and who recommended that Dr. Kelly be dismissed from the Program. She is currently the Co-Associate Post-Graduate Dean, Faculty of Medicine at UBC. She has extensive experience as a physician and educator in the area of family medicine.

[21] All witnesses gave their evidence in a straightforward, professional manner. At times, their memories were poor and needed to be refreshed, to the extent possible, through reference to contemporaneous documentation.

[22] Overall, there was little dispute on the facts. The focus of the dispute is the inferences to be drawn and the legal consequences of those facts.

[23] In the few instances where it has been necessary to assess credibility, I have had regard to the following factors summarized by Dillon J. in *Bradshaw v. Stenner,* 2010 BCSC 1398:

> Credibility involves an assessment of the trustworthiness of a witness' testimony based upon the veracity or sincerity of a witness and the accuracy of the evidence that the witness provides (*Raymond v. Bosanquet (Township)* (1919), 59 S.C.R. 452, 50 D.L.R. 560 (S.C.C.)). The art of assessment involves examination of various factors such as the ability and opportunity to observe events, the firmness of his memory, the ability to resist the influence of interest to modify his recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes his testimony during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally (*Wallace v. Davis*, [1926] 31 O.W.N. 202 (Ont.H.C.); *Farnya v. Chorny*, [1952] 2 D.L.R. 152 (B.C.C.A.) [*Farnya*]; *R. v. S.(R.D.),* [1997] 3 S.C.R. 484 at para.128 (S.C.C.)). Ultimately, the validity of the evidence depends on whether the evidence is consistent with the probabilities affecting the case as a whole and shown to be in existence at the time (*Farnya* at para. 356).
>
> It has been suggested that a methodology to adopt is to first consider the testimony of a witness on a 'stand alone' basis, followed by an analysis of whether the witness' story is inherently believable. Then, if the witness testimony has survived relatively intact, the testimony should be evaluated based upon the consistency with other witnesses and with documentary evidence. The testimony of non-party, disinterested witnesses may provide a reliable yardstick for comparison. Finally, the court should determine which version of events is the most consistent with the "preponderance of probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions" (*Overseas Investments (1986) Ltd. v. Cornwall Developments Ltd.* (1993), 12 Alta. L.R. (3d) 298 at para. 13 (Alta. Q.B.)). I have found this approach useful.
>
> Most helpful in this case has been the documents created at the time of events, particularly the statements of adjustments. These provide the most accurate reflection of what occurred, rather than memories that have aged with the passage of time, hardened through this litigation, or been reconstructed....(paras. 186-188)

[24] Finally, I have considered that I can accept some, all or none of the evidence of a witness.

Agreed Statement of Facts

[25] The parties provided the Tribunal with an Agreed Statement of Facts ("ASF") to facilitate the evidentiary portion of the hearing. In addition, the parties agreed to tender hundreds of documents for the truth of their contents. Where necessary, I have addressed, later in this decision, how I have resolved any conflicts in the evidence.

[26] The documents included an arbitration award issued by Arbitrator Colin Taylor, Q.C. on November 10, 2009 and an appeal decision issued by the Resident Staff Appeals Committee ("Appeals Committee") on September 6, 2010. The parties agreed that I am not bound by any findings in those decisions regarding the issues before this Tribunal. The parties emphasized that they specifically advised the Appeals Committee not to address issues arising under the *Code.*

[27] All excerpts from documents are as written.

[28] Finally, I note that while the ASF refers to a history of proceedings before the Tribunal, it is not a complete record of those proceedings.

Agreed Statement of Facts

Structure of Residency Program of UBC

1. The University of British Columbia (UBC) through a Faculty of Medicine ("FOM") operates a Family Medicine Residency Program ("FM PROGRAM") which is accredited by the College of Family Physicians of Canada ("CFPC") and is offered at ten primary distributed sites throughout the province. Residents who enter the FP Program are enrolled in one of the 10 training sites around the province. The CFPC sets Canada-wide standards by which residency programs offered by universities are assessed. A copy of the CFPC standards is attached as [Tab 190-Volume 4].

2. During their residency training, Residents are employed by the various health authorities that operate the teaching hospitals that are affiliated with UBC. The terms and conditions under which Residents are employed are set out in the collective agreement between the Professional Association of Residents – BC ("PAR-BC") and Health Employers of British Columbia ("HEABC") a copy of which is attached as [Tab 191].

3. There is an affiliation agreement between the University of British Columbia and Providence Health Care Society, a copy of which is attached as [Tab 192].

4. Dr. Jill Kernahan was the Program Director for the FM Program during the time Dr. Carl Kelly (the Complainant) was a resident. She reported to the Associate Dean Postgraduate Education and to the Department Head for Family Practice and was responsible for the administration of the FM Program. Each primary site for the program has a site director who is a UBC appointee and who reports to the Program Director. The Postgraduate Education Committee ("PGEC") is responsible for evaluation of Residents in the FM Program and is comprised of the Program Director, site directors, lead faculty, and resident representatives.

5. Dr. Carl Kelly entered the FM Program in November 2005 in the rural program. His start was delayed to accord with his graduation from the Undergraduate Medical Program at the University of Alberta ("U of A").

6. Residents are assigned to specific rotations within various teaching hospitals and community practices. Residents are evaluated during these rotations to ensure they meet [the standards] set by the CFPC (in the case of the family practice program) and by the UBC FM Program Postgraduate Medical Education in the FOM has developed a Resident Evaluation and Appeal Policy ("Policy"). The Policy applies to all Residents including those in the FM Program. A copy of the Policy is attached as [Tab 193].

7. Dr. Kelly was dismissed from the FM Program on the basis of unsuitability in August 2007 having only partially completed PGY 1 (Post Graduate Year 1).

Chronology of Dr. Kelly's Residency

November 1, 2005 – December 18, 2005: Kelowna General Hospital

8. Dr. Kelly's first rotation was a paediatrics rotation in Kelowna. This rotation usually consists of two blocks (each block being 4 weeks). Dr. Kelly was only scheduled for six and one half weeks of training in this rotation due to his late start in the program. His performance was rated "fail."

December 19, 2005 to April 30, 2006: Family Medicine at UBC Health Clinic

9. Dr. Kelly was then scheduled for two blocks of family medicine at the UBC clinic in Vancouver. This rotation was extended to almost five blocks.

10. In January 2006 Dr. Kelly's preceptors raised concerns about his performance which were discussed at a Site Directors meeting.

11. Around this time, Dr. Kelly's Director of his Residency Program, Dr. Carl Whiteside, advised Dr. Kelly that he had not passed his first rotation in paediatrics at Kelowna General Hospital. Dr. Whiteside discussed with Dr. Kelly undertaking his training in Vancouver so that he could access a more structured learning environment. Dr. Whiteside suggested Dr. Kelly see Dr. Mike Myers, a psychiatrist with a speciality treating physicians. Finally, Dr. Whiteside requested an assessment of any difficulties Dr. Kelly experienced during medical school so that accommodation of Dr. Kelly could be considered in the FM Program. Dr. Kelly gave his consent for Dr. Robert Drebit, from the U of A, to release this information to the FM Program.

12. By March 2006 the Site Directors had determined that Dr. Kelly was not suitable for continued training in the rural program. This decision was based on learning styles observed by the rural preceptors in Kelowna and by preceptors in the UBC Clinic. At a meeting of the urban Site Directors on March 15, 2006 the Site directors considered these observations. The Site Directors determined:

    a. that Dr. Kelly would remediate his paediatrics rotation;

    b. that Dr. Kelly's new site Director, Dr. Betty Calam would ask Dr. Garey Mazowita to act as a mentor for Dr. Kelly;

    c. that Dr. Kelly would be attached to the incoming PGY 1 group for St. Paul's Hospital as of July 1, 2006, if he successfully remediated his paediatric rotation;

    d. that Dr. Kelly could return to the UBC Health Clinic for his family medicine rotation in his PGY2 year; and

    e. that Dr. Kelly would follow a "vertical" structure for rotations, using both St. Paul's and the Greater Vancouver programs, rather than the horizontal model at St. Paul's.

13. Dr. Kernahan committed to meet with Dr. Kelly the following week to discuss the plan.

14. On April 5, 2006 Dr. Kernahan met with Dr. Kelly and Dr. Newton, Clinic Director at the UBC Health Clinic, to discuss certain issues that had arisen regarding his conduct during the rotation. These included a prescription he had signed and complaints from a member of the faculty, Dr. Donlevy, regarding Dr. Kelly's on call conduct. During that meeting Dr. Kernahan formed a concern regarding Dr. Kelly's behaviour when Dr. Kelly left the room saying he was "going to be sick". Dr. Kelly was advised that he had still not passed the UBC Health Clinic rotation and that his rotation at the UBC Health Clinic would be further extended before he would begin his remedial rotation. He was also advised that he could provide his response to the two incidents discussed.

15. On April 20, 2006 Dr. Kernahan again met with Dr. Kelly. Dr. Kelly advised Dr. Kernanhan that he was seeing Dr. Myers on a regular basis. Dr. Kernahan discussed the need for Dr. Kelly to be mentally healthy before undertaking his remedial paediatric rotation which was scheduled to begin on May 1, 2006. She advised that if he was not well enough to commence the rotation he could be granted a leave of absence for medical reasons. Dr. Kelly agreed to discuss the matter with Dr. Myers and to meet again with Dr. Kernahan on April 24th. Later that day, Dr. Kernahan also advised Dr. Kelly that a mentor had been arranged for him.

16. On April 23, 2006, Dr. Kelly provided Dr. Kernahan with a written explanation regarding the prescription incident and his conduct on call.

17. On April 27, 2006, Dr. Kernahan spoke with Dr. Simi Khangura regarding the structure of Dr. Kelly's remediation. She advised that Dr. Kelly had not been functioning at the level of PGY 1 Family Medicine Resident in his previous rotation. Drs. Kernahan and Khangura discussed an evaluation model of providing daily feedback forms to Dr. Kelly at the end of each shift so that Dr. Kelly would get immediate feedback from each of his supervisors daily.

18. Also on April 27, 2006, Dr. Kernahan advised Dr. Kelly of the goals and objectives for his remediation. She advised that the first part of the rotation was to be a one month block of paediatric emergency coordinated by Dr. Khangura. Dr. Kernahan advised Dr. Kelly that the emergency room physicians would fill out an evaluation of Dr. Kelly at the end of each shift and told him that he should make sure that he sees these feedback forms and ask for any clarification he requires.

19. Dr. Kelly was also provided with a remediation letter.

May - June 30, 2008: Paediatrics Remediation

20. Paediatrics is an eight week rotation consisting of four weeks in emergency, two weeks outpatients and 2 weeks of neonatal nursery.

21. On May 10, 2006 Dr. Kernahan and Dr. Newton met with Dr. Kelly to advise that he had failed his previous rotation in Family Medicine and that he would be restarting his training in the FM Program as a member of the St. Paul's Hospital cohort beginning with a rotation on the Family Practice in-patient ward.

22. Dr. Kelly passed each of the emergency, outpatient and neonatal surgery blocks of the paediatrics remediation rotation.

July 1-24, 2006: Family Practice Ward SPH

23. For Dr. Kelly's Family Practice Ward rotation, he was assigned Dr. Jason Kason as a preceptor. While Dr. Kelly's rotation was the Family Practice ward, he was also asked to attend the July Introductory Program with the incoming SPHR1s. The competing demands of the ward rotation with a patient load and the July introductory program contributed to absences by Dr. Kelly during the rotation.

24. On July 14, 2006, Dr. Calam spoke with Dr. Jason Kason about Dr. Kelly. Dr. Kason told Dr. Calam that he felt Dr. Kelly was not functioning at the expected level of an R1 and described some difficulties he thought Dr. Kelly had.

25. On July 16, 2006, Dr. Calam spoke with Dr. Myers regarding Dr. Kelly. By email of July 26, 2006, Dr. Calam wrote to Dr. Myers and asked whether Dr. Kelly required any restrictions based on health reasons for his next rotation in CTU. Dr. Calam also discussed the possibility of neuro-psychological assessment in follow up to the previous assessment done in 2002.

26. On July 17, 2006 Dr. Calam, the St. Paul's Hospital Site Director, met with Dr. Kelly to review his progress. During this meeting Dr. Kelly described his learning challenges as a "non-verbal" disability and "difficulty with auditory processing". He advised he was seeing Dr. Myers regularly. Dr. Kelly was advised that if he succeeded in his present rotation he would be placed on a Clinical Teaching Unit ("CTU") rotation. Otherwise he would be assigned to a further rotation on the Family Practice ward, or suitable alternative, to strengthen areas of identified weakness.

27. On July 20, 2006 Dr. Calam discussed Dr. Kelly's progress with Dr. Kason. Dr. Kason indicated that Dr. Kelly had shown some improvement, that he was more

organized around his schedule and more punctual. Dr. Kason also indicated that Dr. Kelly had managed patients with more attention to detail. Dr. Kason indicated he wanted to observe Dr. Kelly for another 4 or 5 days before providing Dr. Calam with a sense of whether Dr. Kelly had met expectations or whether there were still significant areas of concern.

28. On July 24, 2006 Dr. Calam again met with Dr. Kelly to discuss his progress. Dr. Calam suggested a follow up psycho-educational assessment. Dr. Kelly agreed this would be acceptable to him and Dr. Calam agreed to explore funding.

29. Also on July 24, 2006, Dr. Calam spoke to Dr. Kasan again about Dr. Kelly. Dr. Kason indicated that he did not think that Dr. Kelly was lacking in knowledge, but that he had some difficulties in appreciating the "big" picture in bringing together an assessment and management plan. Dr. Kason indicated that Dr. Kelly had followed his suggestions for improving areas of weakness closely and had shown steady improvement in his decision-making capacities and conduct. Dr. Kason committed to working closely with Dr. Kelly in the coming week to assess whether he met expectations for the rotation, keeping in mind that Dr. Kelly was to be assessed as if he was a new Resident and balancing the demands of the rotation with the July introductory course.

30. On July 25, 2006 Drs. Kernahan, Knell, Andrew and Calam met to discuss Dr. Kelly's progress. They determined to do the following:

    a. Obtain a neuro-psychological assessment;

    b. Talk to Dr. Myers regarding accommodations;

    c. Consider possible assignment to an out of province rotation; and

    d. Suggest career counselling to determine a more appropriate career path.

31. On July 26, 2006, Dr. Calam spoke with Dr. Myers regarding a consultant for neuro-psychological testing for Dr. Kelly. Dr. Calam indicated she would check with Dr. Kernahan for funding for same.

32. Also on July 26, 2006, Dr. Calam wrote to Dr. Myers and asked for an opinion outlining any restrictions for health reasons that Dr. Myers thought might be necessary for Dr. Kelly for his next rotation, scheduled at CTU at SPH for July 31, 2006, for four weeks. Dr. Myers provided same that day advising that, "Dr. Kelly is at risk for irritability, inner frustration and disorganization when he gets especially busy or tired." Dr. Myers recommended additional supervision or assistance. Dr. Myers noted that the first week or two of the rotation would be the most challenging because it was a new rotation. Dr. Myers concluded with the need for repeated and more detailed neuropsychological testing.

33. On July 27, 2006, Dr. Kason, provided Dr. Calam with further evaluation of Dr. Kelly's performance in the rotation. On July 28, 2006, Dr. Calam spoke further with Dr. Kason who advised that he felt he had not had enough time with Dr. Kelly during that rotation to decide on a pass or fail and recommended further evaluation. On July 28, 2006, Dr. Kernahan concluded that Dr. Kason's evaluation did not amount to a pass.

34. On July 28, 2006, Dr. Kelly met with Drs. Kernahan and Calam to discuss his performance in the rotation. They advised Dr. Kelly that he continued to need improvement. They also advised Dr. Kelly that he would now go to a CTU (Clinical Training Unit – Internal Medicine) rotation, starting the next week. Drs. Kernahan and Calam reviewed Dr. Myers' suggested restrictions and Dr. Kelly consented to the disclosure of those restrictions to the attending physicians in the CTU rotation.

July 31 – August 27, 2006: CTU Internal Medicine General

35. From July 31 to August 27, 2006, Dr. Kelly undertook a rotation in CTU – Internal Medicine (General). Dr. Kelly's performance was assessed as a "pass".

August 28, 2006 – September 24, 2006: Emergency

36. From August 28, 2006 to September 24, 2006 Dr. Kelly undertook a rotation in emergency medicine and was assessed as "pass".

37. In response to inquiries regarding setting up the neuro-psychological assessment Dr. Kelly advised he would try to do it after the CTU rotation ended on August 27th. On September 8, 2006 Dr. Kernahan asked for an update on the testing. Dr. Kelly advised that he had been in contact with a psychologist, Dr. Gibbins, and had provided him with a copy of the previous assessment. He advised he would set up an appointment with Dr. Gibbins.

38. On September 14, 2006 Dr. Calam received a complaint from some of the residents in Dr. Kelly's peer group about an e-mail he had circulated the previous month. Dr. Calam suggested that Dr. Kelly be relieved from his current rotation pending investigation. Drs. Calam and Kernahan decided that all the relevant information regarding Dr. Kelly's performance would be collected and then forwarded to the Associate Dean Postgraduate Education for consideration.

39. Dr. Kernahan recommended that the issue be forwarded to the Postgraduate Deans; that Dr. Kelly be suspended from any further clinical rotations until consideration of the matter by the Postgraduate Deans, but that Dr. Kelly should continue his St. Paul's Emergency shifts pending Dr. Calam's receipt of feedback from his supervisors regarding his performance in the rotation. Dr. Kernahan suggested that Dr. Kelly be allowed to continue in that rotation if his evaluations were acceptable.

40. On September 15, 2006, Drs. Kernahan and Calam met with Dr. Kris Sivertz, Associate Dean of Postgraduate Education. Dr. Calam advised that she would like to arrange neuropsychological testing as soon as possible to understand concretely the nature of Dr. Kelly's educational difficulties and their possible relationship with his style of communication with his educational colleagues.

41. On September 15, 2006, Dr. Calam spoke with Dr. Thompson who advised that he had no particular concerns regarding Dr. Kelly's performance in that rotation (emergency), based on his review of the end of shift evaluations.

42. On September 21, 2006 Dr. Kelly met with Drs. Kernahan, Calam and Sivertz to discuss the concerns about the e-mail. The following steps were suggested:

    a. that Dr. Kelly be granted an educational leave of absence to complete his psych testing;

    b. that he undergo an IME; and

    c. that the Postgraduate Dean's Office obtain his records related to his previous testing at U of A.

43. The leave would allow Dr. Kelly to study for an exam he had failed and to clear up the problems created by the e-mail he had sent to his peer group. This would also provide an opportunity to gather information to determine Dr. Kelly's educational challenges and to assess his suitability to continue in the FM Program.

44. On September 28, 2006 Dr. Calam met with the Complainant to follow up on concerns raised in the previous week's meeting.

45. In October, 2006 Dr. Kelly was placed on educational leave. During this time he underwent assessment by Dr. Gibbins. Dr. Kelly also provided his consent for the release to the Postgraduate Dean's Office of his undergraduate records.

46. In late December 2006 the FM Program received a copy of Dr. Gibbins' confidential psychological assessment report dated November 28, 2006.

47. The Postgraduate Deans, with the support of Dr. Myers, made arrangements for an independent medical examination ("IME") of Dr. Kelly by Dr. Stephen Kline. Dr. Kelly did not proceed with the IME.

48. On January 24, 2007 Ms. Zoe Towle, a representative of PAR-BC, wrote to Dr. Kernahan and the Associate Deans Postgraduate Education advising that Dr. Kelly had approached them for advice with respect to his "recent difficulties in the training program." In March 2007 Ms. Towle advised that on Dr. Kelly's behalf PAR-BC would seek a second opinion from Dr. Margaret Weiss, a psychiatrist specializing in adult ADHD, to obtain information regarding potential accommodation of his learning disabilities and of his suitability for residency training.

49. On March 29, 2007 Dr. Rungta, Associate Dean Postgraduate Education, wrote to Ms. Towle to advise that the Program did not require Dr. Weiss's opinion with respect to Dr. Kelly's ability to successfully complete the FM Program or any alternative Program. Dr. Rungta advised that the FM Program would welcome an opinion on Dr. Gibbins' report, specifically with respect to whether any of the deficits listed would be addressed by any therapeutic interventions and over what time frame.

50. On April 12, 2007 PAR-BC wrote to Dr. Gabrielle Weiss (not Dr. Margaret Weiss) seeking her opinion with respect to Dr. Kelly's "suitability for residency training." Dr. Weiss was provided with a copy of Dr. Gibbins' report. Dr. Gabrielle Weiss evaluated Dr. Kelly on May 23, 2007.

51. The Postgraduate Deans' Office ultimately received a copy of Dr. Weiss's written report dated June 4, 2007, on [date]. The Postgraduate Deans were provided a report by Dr. Weiss, dated May 23, 2007. Dr. Weiss concurred with Dr. Gibbins' recommendations. Neither of Dr. Weiss' reports were provided to the FM Program.

52. One month later, Dr. Weiss provided Dr. Myers with additional information regarding her assessment.

53. In August 2007 the Resident Performance Subcommittee ("RPS") of the PGEC met to consider Dr. Kelly's suitability for continued training in the FM Program. On or about August 23, 2007 the PGEC recommended that the Complainant be terminated from the FM Program on the basis of unsuitability.

54. On September 6, 2007 PAR-BC advised that Dr. Kelly intended to appeal the decision to terminate him for unsuitability pursuant to Article 10.01 of the Policy. Dr. Kelly sought, and was granted, an extension of time to file his appeal until the conclusion of the arbitration under the collective agreement regarding the termination of Dr. Kelly's employment as a resident with SPH.

55. On November 10, 2009, Arbitrator Colin Taylor, Q.C., issued his decision regarding the termination of Dr. Kelly's employment. A copy of that decision is attached as schedule "E". [Tab 194, Volume 4]

56. On August 30, September 1, and September 2, 2010 the Residency Staff Appeals Committee met to hear Dr. Kelly's appeal of the decision of the Associate Deans for Postgraduate Education to accept the recommendation of the UBC FM Program Committee of the Department of Family Practice to dismiss Dr. Kelly from

the FM Program. A decision was rendered on September 10, 2010 and a copy is attached as schedule "F". [Tab 195, Volume 4].

History of Proceedings Before the Human Rights Tribunal

57. Dr. Kelly initially filed a human rights complaint against Providence Health Care/HEABC, the Department of Family Practice at UBC, and the Faculty of Medicine, UBC on February 19, 2008. Dr. Kelly amended his complaint to amend the named respondents, respondents' address, add "services" as an area of discrimination, and added further particulars. Initially, the Tribunal made a preliminary decision to not proceed against UBC.
58. Providence Health Care and the Health Employers Association of British Columbia filed a response to the complaint dated June 10, 2008.
59. Dr. Kelly applied to add the University of British Columbia (operating as the Faculty of Medicine, Department of Family Practice (UBC) as a respondent to his complaint on June 12, 2008.
60. UBC responded to the application on July 14, 2008. The other Respondents responded to the application taking no position on July 14, 2008.
61. An application to defer the Application of the Complainant to add UBC as a respondent was made on July 18, 2008.
62. On December 10, 2009, Providence Health Care, and the Health Employers Association of BC applied to dismiss the complaint.
63. A decision dismissing the complaint against Providence Health Care and the Health Employers Association of BC, and allowing the application to add UBC as a respondent was made on April 15, 2010.
64. UBC filed its response to the complaint on May 19, 2010.

Medical Evidence

[29] As noted earlier, the parties tendered four binders of documents for the truth of their contents. Included in these documents were reports, medical records and evaluations from several doctors, including Dr. Gibbins, Dr. Myers, Dr. Gabrielle Weiss, who is a physician working at the ADHD Clinic at Children's and Women's Health Centre of British Columbia, and Dr. Drebit, who examined Dr. Kelly while he was a medical student at the University of Alberta. A 2002 assessment by Dr. Eda McClung, a psychologist at the University of Alberta, was also provided in the materials. Only Drs. Gibbins and Myers were called as witnesses. Nonetheless, I have accepted the contents of Dr. Weiss' evaluations, Dr. Drebit's note and Dr. McClung's assessment as reliable evidence. I also find the evidence of both Dr. Gibbins and Dr. Myers to be persuasive and reliable.

[30] Dr. Gibbins' evidence was most helpful in understanding ADHD, its manifestation in Dr. Kelly, and the various recommendations he made for accommodations that might assist Dr. Kelly in a working and learning environment.

[31] Dr. Myers commented primarily on his treatment and observations of Dr. Kelly, and his interactions with UBC. I will comment briefly on his treatment of Dr. Kelly and then review his interactions with UBC together with the evidence of Dr. Kernahan in a chronological fashion.

[32] Given the importance of the medical evidence, I will review it in some detail.

Dr. Christopher Gibbins

Background

[33] Dr. Gibbins is a psychologist who is currently working both at the B.C. Children's Hospital and in a private practice. The majority of his practice is focussed in the area of neuro-developmental disorders, which he described as conditions resulting from neuro-developmental abnormalities that appear primarily in childhood, though extend into adulthood. The most frequent disorders he works with are ADHD and autism. He also works with other learning disabilities. Dr. Gibbins does clinical research, and clinical and psychometric assessment in children and adults with ADHD. He has a particular interest and speciality in working with adults.

[34] I accepted Dr. Gibbins as an expert witness in psychology with particular expertise in neuro-developmental disorders, including ADHD.

ADHD Overview

[35] Dr. Gibbins explained that the core deficits in ADHD are in the brain's executive functions, in areas involving self-regulation, memory and attention. He described these deficits as present in "the parts of our functioning that enable us to organize and co-ordinate our abilities to achieve particulars tasks or goals." He also explained that in psychological literature, the term "executive functions" is used to refer to a range of functions related to attention, planning and memory and not to decision-making *per se*.

[36] Dr. Gibbins testified that in adults, the hyperactivity that is normally associated with ADHD is often reduced and not as noticeable. He said the most impairing symptoms in adulthood tend to be inattentiveness, keeping on track with uninteresting work, managing time, retaining or retrieving information as required to complete a task, and organizing information. Impulsive activities tend to be less than in childhood, and "in the moment" hyperactivity and restlessness are not as much as in childhood.

[37] Dr. Gibbins testified that adults with ADHD are broadly dispersed throughout the population and work in a variety of professions and occupations, including doctors, lawyers, and entrepreneurs. He stated that where a particular individual ends up working is largely a matter of their strengths, weaknesses and coping styles.

[38] When asked about a standard treatment for ADHD, Dr. Gibbins testified that the Canadian practice guidelines for ADHD recommend a combination of medical treatments, and noted that there are a number of medications currently available that reduce, but do not typically eliminate, symptoms

and that increase the manageability of the disorder. These medications do not work for every person, and it can be a "process" to find the right medication at the right dose.

[39] Dr. Gibbins also described the use of psycho-educational or behavioural management strategies to develop coping skills, help identify areas in which an individual may be having difficulty, and assist them in developing compensatory strategies to cope with these difficulties. This is often done through individual or group therapy.

[40] Dr. Gibbins stated that the inclusion of counselling as part of the treatment for adult ADHD would be clinically ideal, but that accessibility is imperfect. He typically recommends counselling and "universally" recommends consultation with a medical doctor for medication and, for people having practical difficulties in their day-to-day lives, retaining the services of a counsellor, coach or therapist to develop coping strategies.

[41] He noted that treatment for persons with ADHD is individualized since it is not a "generic impairment." The therapy that works best for a person with ADHD is specific and problem-focussed to assist them to deal with whatever issues they are having difficulty with.

[42] Dr. Gibbins testified that the clinical evidence in the last few years has been indicating that adults with ADHD are able to manage or learn coping skills more easily than children with ADHD, and that there is a growing body of evidence that once the brain matures, counselling and skill-building are more successful in symptom reduction.

[43] He explained that when a person with ADHD is presented with a new environment, there is a "learning curve" for them to deal with the new information and cope successfully within that environment. It takes them longer at the initial stages to become familiar with, and master, new information. They need to compensate for the fact that because they have difficulty focussing their attention in a new environment, the information they get from that environment is less reliable, and they need to learn what to pay attention to. He noted that while a person with ADHD can develop the same level of skill mastery as others in many environments, their earlier functioning is not as representative as their later functioning.

[44] Dr. Gibbins also explained that by "environment" he meant not just the physical environment, but also people and activities that were taking place in the environment. He stated that an environment might be "ADHD unfriendly" where there are constantly novel challenges, in the sense of being unlike things that the individual has done before. For example, he compared a situation where the individual would be performing a different process all the time, with a situation with there are different cases, but a familiar process.

[45] Dr. Gibbins further stated that there are "certainly" jobs or specialities within a diverse field like medicine which are "more or less" a good fit for persons with ADHD. He used the example that some

physicians with ADHD function well in an emergency room setting where there is a relatively high level of activity and an emphasis on dealing with immediate pressing problems.

[46] In making these comments, Dr. Gibbins was careful to state that he was not a medical doctor, and that he only had anecdotal information that some people with ADHD found emergency and paramedic work to work well for them. He also noted that he had no first-hand familiarity with the learning environment in a first-year family practice residency. I have considered this caveat when assessing his opinion.

[47] Dr. Gibbins went on to explain that part of the difficulty with new environments for a person with ADHD is the ability to respond quickly to new situations, and to adapt without having a prioritized strategy in place. Typically, because many tasks are less efficient for them, persons with ADHD will have to work harder to achieve the same goals as someone without ADHD. He has often seen adults with ADHD who were able to obtain a relatively high level of functioning, but says that this required a high degree of effort on their part.

[48] Dr. Gibbins agreed, in cross-examination, that persons with ADHD may not pick up on social cues. He testified that it would depend on the individual, and that some individuals are less impaired in that domain than others. He also agreed that, generally speaking, the more an environment required multi-tasking, the less it was "ADHD friendly."

[49] Dr. Gibbins testified that there are standardized treatment suggestions for adults with ADHD, as well as individualized strategies, including therapy. He noted that typically, after he completes an individual assessment and provides recommendations, there would be follow-up regarding the recommendations.

The Psychological Assessment

[50] On November 28, 2006, Dr. Gibbins provided a confidential psychological assessment report on Dr. Kelly to both UBC and Dr. Kelly. Dr. Kelly was referred to Dr. Gibbins through the Program. The Program paid Dr. Gibbins' fees and requested the assessment in order to get a "better handle" on diagnostic issues and the difficulties Mr. Kelly seemed to be having with the Program. Dr. Gibbins testified that UBC wanted to know whether Dr. Kelly had a learning disability, or some other neuro-developmental issue (such as ADHD).

[51] In his report, Dr. Gibbins described the reasons for the referral as follows:

> Carl is a 29-year-old man referred to gain insight into the difficulties he has had with his educational program. Psychological assessment was recommended to gain insight into Carl's functioning.

[52] UBC provided Dr. Gibbins with a description of Dr. Kelly's difficulties, information regarding an incident that had arisen regarding an inappropriate email Dr. Kelly had sent to other residents, and

copies of some of Dr. Kelly's educational information from his Program rotations. Dr. Gibbins also reviewed information about Dr. Kelly's educational program at the University of Alberta, and his secondary school records. As well, he interviewed Dr. Kelly "fairly extensively."

[53] Dr. Gibbins testified that Dr. Kelly's symptoms fit the DSM-IV diagnosis for ADHD – inattentive type. He also fit the psychological profile for a diagnosis of NVLD.

[54] Dr. Gibbins described the steps he took to assess Dr. Kelly, which included a standard clinical interview involving a review of developmental and family history, current functioning, presenting complaints, and functioning in important domains of daily life (such as work, education, household and social management), and a review of relevant medical history, including any past diagnosis or assessments related to mental or physical health. He also conducted certain tests to get a psychometric picture of Dr. Kelly's relative strengths and weaknesses.

[55] He summarized his findings at page 9 of his report as follows:

- Carl presented as a motivated, diligent man who was determined to do his best on the assessment and to participate fully. At times Carl could have difficulties with organization which could interfere with his efficiency, and he could become stuck and have difficulty disengaging from very challenging items. Carl was socially appropriate and had a typical range of affect.
- Carl shows significant discrepancies in his ability profile on the WAIS-III. He showed very strong cognitive abilities as his verbal abilities were in the Superior range while his visual-spatial abilities were in the Average range. Carl also showed significant weaknesses in his working memory, which was in the Average range, but significantly lower than anticipated from his strong verbal abilities. This profile of strengths and weaknesses is associated with difficulties with attention, concentration and working memory such as those found in Attention Deficit Hyperactivity Disorder, as well as a nonverbal learning disability.
- A screen of Carl's basic academic skills placed them in the High Average to Superior range overall. However, Carl could make errors related to difficulties with attention and working memory, such as losing track of aspects of instructions and making inattentive errors on multi-step problems. Thus, while his academic skills were in the range expected for his ability level, his performance was affected by his difficulties with attention and working memory.
- Tests of Carl's memory revealed strong short-term memory for both verbal and visual-spatial information. However, he did have some relative difficulties with his delayed memory for visual information as well as verbal information he had only been exposed to once. However, Carl's memory for verbal information he had heard several times was quite strong. Carl showed the greatest difficulties with tests related to attention and concentration, placing in the Low Average to Average range, while his working memory scores were in the Average range.
- ...
- On the D-KFES, Carl showed strengths in his fundamental cognitive abilities, but relative weaknesses in aspects of his attentional control and cognitive flexibility. He also showed difficulties with attention, memory and organization. Carl could have

difficulties with some complex novel tasks, showing initial difficulties followed by dramatically improved performance once he gained some experience with the task.

- Carl currently meets criteria for a DSM-IV diagnosis of an Attention Deficit Hyperactivity Disorder predominantly Inattentive type who also shows a cognitive profile consistent with a nonverbal learning disability. While Carl's cognitive strengths, strong motivation, and coping skills have allowed him to be quite successful in his educational endeavours, like many people with ADHD, Carl has a history of difficulties in academic and social environments, which have varied in severity depending on his circumstances, support structures and level of skill development.

In summation, at this time Carl is best characterized as a very bright man with an Attention Deficit Hyperactivity Disorder, predominantly Inattentive type who shows a comorbid nonverbal learning disability (NVLD). Both ADHD and NVLD are neurodevelopmental disorders which are lifelong and whose impact varies considerably in adulthood depending on the environment, coping strategies and personal resources and challenges of the individual concerned. Carl's very structured and academically supportive environment during childhood, his strong verbal abilities, and his determination had minimized the impact of his difficulties on his academic performance, enabling him to enter medical school and earn positive feedback on the majority of his rotations. Adults with ADHD and adequate coping skills and cognitive strengths can attain very high levels of academic and occupational success, though they often do so by spending the large majority of their time and energy in pursuit of their occupational goals. Thus, while people with ADHD are capable of performing at a high level in a range of occupations provided they have sufficient interest and determination, they can face barriers due to difficulties with inconsistent educational performance, organization and time management problems, and a risk of inadvertent social conflicts.

Carl shows, as do many adults with ADHD, periods in which his difficulties have overwhelmed his coping skills and caused him increased difficulty. These difficulties have been associated, as is often the case for adults with ADHD, with periods of anxiety and dysphoria. These difficulties are most likely to occur in new environments requiring novel skills, or when previous support mechanisms are withdrawn, as adults with ADHD can be slower to adapt to the demands and requirements of new environments due to their difficulties with attention, working memory, and juggling multiple challenging tasks. As mastered skills require less attentional resources, Carl, like other people with ADHD, generally shows much improved performance once he has had sufficient time and experience to learn the skills required in new settings, understand the expectations placed on them and develop new strategies and coping skills to adapt to these challenges. Stressful life events, including major transitions can both disrupt previously acquired coping skills and support systems and serve as a major source of internal distraction, triggering an increase in difficulties related to attentional functioning. The academic and occupational functioning of adults with ADHD can also be enhanced by strategies and accommodations to minimize the impact of attentional difficulties and coaching or other pragmatically focused therapies, in addition to medical treatment...

[56] Dr. Gibbins also stated in his report:

...It is important that Carl's areas of weakness not be viewed as roadblocks to his further progress towards his goals, as neurodevelopmental disorders such as ADHD and NVLD do not preclude attaining a high level of expertise and achievement in areas which individuals are strongly interested in, show a strong motivation towards, and which they demonstrate talents in. Carl's strong interest in and passion for medicine and his dedication to and care for his patients provide powerful incentives for him to

> exert the effort necessary to cope with his challenges, and help minimize the effects of his attentional weaknesses when he is working with patients, in some cases allowing his ADHD traits to become a strength due to the potential benefits of hyperfocusing. Carl and his future patients will thus be best served by an approach which seeks to work with Carl to improve his coping and organization skills, as well as provide him with assistance in working to maximize the effect he can obtain from his areas of strength and interest and minimize the impact of his attentional weaknesses. Indeed, one of the advantages of a broad field such as medicine is that many more modes of practice, types of specialization, and workplace structures are possible within the field of medicine than is the case for other more narrowly defined professions. As a result, with proper supports and his own continued drive, focus, enthusiasm and effort, Carl stands a strong chance of continuing to improve his adaptive functioning, reaching his educational and personal goals, and making an important contribution to his community. (page 12)

[57] Dr. Gibbins testified that Dr. Kelly presented the typical, textbook profile of an adult with ADHD. In a qualitative sense, Dr. Gibbins noted that while Dr. Kelly was able to perform well, the effects of ADHD were evident in the details of his performance. For example, if he had the opportunity to see the information more than once, he tended to be successful. It was remembering unstructured information that was problematic for him. Once he had experience with a task, his performance would increase significantly. Dr. Gibbins testified that this is consistent with a diagnosis of ADHD along with NVLD.

[58] Dr. Gibbins outlined a number of strategies that would be useful to help someone like Dr. Kelly cope and function better, including having a physical list or PDA to check to see what needs to be completed, reducing distractions, and building fluency and expertise in key tasks. He noted that when an adult with ADHD is first learning new skills, the more exposed the individual is to the new environment, the easier it becomes to function in that environment.

[59] Dr. Gibbins explained that, while some individuals appear to outgrow ADHD in the transition between childhood and adulthood, both ADHD and NVLD are generally life-long conditions. He also testified that while ADHD is not "curable" in the sense that it can be eliminated or removed, it is a treatable, chronic condition, analogous to diabetes.

[60] Dr. Gibbins concluded his report with nine recommendations, which will be reviewed in more detail throughout this decision. He testified that the recommendations would have to be "translated" into the learning pattern of a family practice residency and that this was best done by someone familiar with that environment. He noted that they were relatively high profile recommendations that he would make in any environment, with some specificity to the particular situation and informed by what he knows about the difficulties people with ADHD have and the particular pattern presenting in Dr. Kelly. He also noted that there is a level at which treatment recommendations are generic and that he did not customize his recommendations to Dr. Kelly's particular workplace environment.

[61] Dr. Gibbins testified that there was "no guarantee" that any of the recommendations would work in a family practice learning environment, but that if the recommendations were implemented, he would expect that they would reduce the effect of the disorder.

The Recommendations

[62] I will first set out Dr. Gibbins' recommendations and then his comments on each recommendation. I have numbered the recommendations for ease of reference, though they were not numbered in the original report.

[63] Recommendations

> [Number One] – In academic settings, it is important to note that when Carl is first learning a new area or acquiring new skills, his efficiency and accuracy may not initially be as high as other students of the same ability level, and this may not well represent his potential. As a result, Carl may at times need a longer familiarization period and may benefit from more time or repeated exposure to new material if he has difficulties initially. This is most likely to be the case with complex skills involving working memory, planning and organization, such as history taking.
>
> [Number Two] – As Carl's learning style and attentional difficulties can cause him to misprioritize or omit elements of tasks in a setting in which he is being evaluated, particularly if the task in question is relatively new to him, Carl would benefit from clear instructions, ideally in written form, stating what he is intended to accomplish and making clear the specific goals of an activity. It can often be beneficial to have a 'recipe' or template that Carl can follow to help supplement his working memory and help him to recall the key steps in the process. Generally, externalizing the steps in a process usually held in working memory into a physical form reduces the attentional demands on people with ADHD and aids them in being more successful.
>
> [Number Three] – Similarly, memory aides for detailed information such as PDAs, can be very useful for people with ADHD, particularly to assist them in time management, scheduling, and to provide quick access to detailed information that lacks conceptual hooks (e.g.: recommended medication dosages, differential diagnoses for less common conditions). These aides may become less important as Carl masters the content in a particular area, but may facilitate his performance and help solidify his learning prior to achieving mastery.
>
> [Number Four] – People with ADHD, though they may work quite quickly in areas where their skills are strong and fluent, often have more difficulty when under substantial time pressure, as they find it significantly more difficult than average to both work at a high rate of speed and to do the monitoring and error correction required to successfully and accurately complete all the steps they are expected to perform. As a result, people with ADHD tend to employ either fast but error-prone or slow, effortful and perfectionistic strategies when forced to choose between speed and accuracy, and an individual may alternate between these strategies in a different circumstances. As a result, it is often most effective for people with ADHD to first concentrate on thoroughly learning all the steps involved in a new task with minimal time constraints, and then work on improving speed and fluency once the basic skills themselves are mastered.
>
> [Number Five] – It is important to note that people with ADHD typically function better when pursuing their interests. Helping Carl to identify areas of specialization which are a particularly good fit for his interests and areas of strength will be important for his

future development. Carl may benefit from support in planning his program, ensuring he has met or will meet the required prerequisites to meet his goals, and doing the exploration and investigation necessary to help determine what areas of practice he will be more able and interested in.

[Number Six] – Carl may benefit from work with a counsellor or coach experienced in working with people with ADHD. Counselling will help develop effective organization and life skills and assist in providing perspective and aid in problem solving if interpersonal conflicts arise. Counselling would also be beneficial in helping Carl to develop a greater understanding of when others may understand his responses differently than he intends, and to work with him in developing communication skills that will allow him to avoid conflicts in complex social environments more effectively. Counselling appropriate for people with ADHD is generally goal-directed, focused on the here and now and aimed at developing pragmatic strategies for dealing with present sources of stress and difficulty. A typical consequence of counselling for adults with ADHD is improved insight into the nature of their difficulties, which though potentially upsetting does provide them with a more realistic understanding of their strengths and weaknesses and insight into the strategies they will need to compensate for their difficulties. As Carl's performance has been noted to deteriorate significantly when under stress, anxiety management training or similar techniques aimed at improving emotional regulation and control would be strongly recommended to reduce the impact of Carl's feeling of stress and anxiety on his performance.

[Number Seven] – A one to one resident – preceptor rotation has been recommended for Carl to help him improve his skills in the area of Family Practice. Such a rotation would provide Carl with the opportunity to receive coaching on the specific details of the skills he is expected to learn, as well as providing the opportunity to problem solve about strategies to improve Carl's performance in areas he finds particularly challenging. Carl would particularly benefit from working with a supervisor who could provide guidance around the planning and organizational skills which are most challenging for individual with ADHD, such as scheduling, prioritization, preparing for presentations and monitoring. It will be important for any such preceptor to develop a good working rapport with Carl, as he will be most receptive to feedback and better able to avoid defensiveness and examine his own performance in the context of a well established apprenticeship relationship. Carl is thus most likely to be successfully with a preceptor who takes an authoritative rather than an authoritarian approach.

[Number Eight] – A variety of books, websites and support associations (e.g., Children and Adults with Attention Deficit Disorder: CHADD) are available to provide further information, strategies and support for the management of ADHD. I have attached the information guide produced by the Provincial ADHD Program, which lists a number of these resources.

[64] In regard to the first recommendation, Dr. Gibbins testified that it would be his expectation that, in an academic setting, if Dr. Kelly was given a longer familiarization period, then his performance should improve up to the point at which he was able to become as fluent and proficient in a particular area as he was going to be. He also would expect to see a greater change with additional familiarization time than would be expected with other students.

[65] In regard to the second recommendation and the utilization of a written form or template, Dr. Gibbins explained that when an individual with ADHD is performing a task, if they have a series of instructions or steps that they need to go through that is provided in written form or a template that

they can refer to and ensure they have done all the components, they are more likely to be successful at the task. Rather than relying on being able to recall and organize newly learned information to complete a complex task, they can focus on becoming proficient on the necessary steps to complete the task.

[66] In Dr. Gibbins' opinion, Dr. Kelly would also benefit from more detailed and immediate feedback, preferably in writing, and particularly at the end of a shift. As well, it would be preferable if Dr. Kelly received feedback from one supervisor to ensure consistency.

[67] In regard to recommendation three, Dr. Gibbins provided specific examples of memory aides that could assist Dr. Kelly. For example, with the use of current technology, Dr. Kelly could have electronic access to information about common disorders, dosing and physician reference material to "double check" accuracy. This is information that could be memorized, but which could also be readily available in a convenient form for Dr. Kelly's reference.

[68] In regard to recommendation four, Dr. Gibbins reiterated that persons with ADHD should first master skills and then work on improving the speed and accuracy of those skills. He stated that people with ADHD often make a trade-off between working rapidly and maintaining quality control, particularly when learning a new task. If they focus on meeting a time limit, then they are more likely to overlook important details. If the individual is provided sufficient time to concentrate on doing their best work within a reasonable amount of time, then rather than focussing on the need to complete the task in a quick manner, they focus on gathering information and mastering skills. As they gain mastery over the skills, then their speed will increase.

[69] Dr. Gibbins also testified that there are treatments available to assist a person with ADHD when they are having difficulty dealing with time pressures. For example, he noted that medication may help focus attention and lead to better efficiency, as well as the utilization of time management skills.

[70] Dr. Gibbins stated that one of the difficulties for persons with ADHD is that when they run into difficulty performing a task, they may not recognize where it went wrong. If someone walked through the process with that individual, then they can often identify where the problem arises. By employing an iterative process, the individual can develop the necessary skill set to deal with problems as they arise, and to address new situations.

[71] In regard to recommendation six, Dr. Gibbins noted that since Dr. Kelly's performance deteriorated when he was under stress, anxiety management training would assist him to get his emotional state back to where he had a "sufficient but not excessive level" of anxiety and would be better able to focus on his work and studies.

[72] In regard to recommendation seven, Dr. Gibbins elaborated on how a one-to-one resident-preceptor rotation would benefit Dr. Kelly. He noted that it is beneficial for people with ADHD to have

support or a mentor relationship with someone who has detailed knowledge of the area they are working in, who can support them by doing such things as identifying critical parts of the skills set that the individual needs to learn, aid in problem solving and provide detailed feedback. He noted that one of the difficulties in restricting support to a counsellor is that a counsellor is unlikely to be an expert in an area of medicine unrelated to mental health, whereas a person with knowledge of a specialty area would be able to assist Dr. Kelly with problem solving and in developing strategies to deal with problem areas.

[73] In response to a question in cross-examination about the articulation of clear expectations in an environment where Dr. Kelly would be presented with different factual patterns on a routine basis, Dr. Gibbins stated that in an educational program like a residency, it would be most helpful to say "here are the metrics we usually use to evaluate performance, and here are the standards you are expected to meet in sufficient detail to ensure that it is workable." He noted that it is not sufficient to just say "do good work." He testified that what is most useful is detailed feedback from a supervisor who is closely aware of the individual's work. He stated that a general comment does not provide specific guidance as to how to improve. The more detail that is provided, the more helpful the evaluation is to the person with ADHD.

[74] Dr. Gibbins testified that his list of recommendations was not exhaustive, and could be enhanced or particularized with the assistance of a counsellor or therapist. He noted that all the recommendations may not need to be implemented, but that it would be necessary to figure out what combinations of strategies were sufficient and worked for Dr. Kelly.

[75] Dr. Gibbins stated that he would expect the early part of Dr. Kelly's residency to be the most challenging, and to see a gradual gain in fluency over time and improved performance toward the end.

[76] Dr. Gibbins concluded that Dr. Kelly had a strong chance of continuing to improve because, at the time that he saw Dr. Kelly, Dr. Kelly had a limited degree of support, and the treatment he began while at the University of Alberta ("UOA") was focussed more on anxiety and other issues. In this regard, I note that, while at the UOA, Dr. Kelly received medical treatment from Dr. R. Drebit. In 2002, Dr. Drebit referred Dr. Kelly to a psychologist, Dr. E. McClung, to assess whether he had a NVLD. Dr. McClung provided a written assessment in which she concluded that it was possible Dr. Kelly had a NVLD. She stated that additional neuropsychological evaluation could clarify the nature and extent.

[77] By October 13, 2005, the documents reveal that Dr. Drebit was treating Dr. Kelly with medication for ADHD and anxiety/dysthmia. There was no specific date provided as to when Dr. Kelly was first diagnosed and commenced treatment for ADHD.

[78] Having said this, Dr. Gibbins acknowledged in cross-examination that, at least from October 2005, Dr. Kelly had been receiving medication for ADHD and anxiety/dysthmia while at the UOA. He also

noted that there was a period where Dr. Kelly was treated primarily for anxiety (which he described as a common situation), and that Dr. Kelly had not received counselling or therapy for ADHD while at UOA. As well, he noted that between 2002, which was the date of Dr. McClung's report regarding a NVLD, and 2006, ADHD treatment had evolved in terms of available medication and a gradual increase in attention to psycho-social treatments.

[79] When asked, in cross-examination, whether he would have anticipated that someone in an educational context who had been diagnosed with ADHD, would also have been taught some of the coping mechanisms that he had earlier referred to, Dr. Gibbins testified that adult ADHD is a relatively new area and that accessibility to treatment is "spotty." He testified that the typical community treatment for ADHD is medication with a minimum of psycho-educational counselling support. He also said that epidemiological studies of community-based treatment have shown that medication is often not titrated adequately, and he was not aware whether Dr. Kelly's medication had been properly titrated. Therefore, he said he would not assume that if someone had been diagnosed with ADHD a number of years ago that they would have received optimal or recommended treatment, either in a medical or psycho-social sense.

[80] Dr. Gibbins stated that the "norm" is to be undiagnosed, and that, if diagnosed with ADHD, the typical treatment, broadly speaking, is primarily medication and an absence of appropriate psycho-social support. He testified that the type of testing and assessment he did for Dr. Kelly would not be the norm.

[81] Dr. Gibbins acknowledged that he was not aware whether Dr. Kelly had been taught any of the coping mechanisms he recommended by any of the psychologists who may have previously seen him. I note, however, that there was no evidence that Dr. Kelly had been provided this type of treatment or support by any psychologist.

[82] Dr. Gibbins also acknowledged that he did not recommend any different titration in his report. However, he explained that he is not a medical doctor, and cannot comment on the correct titration. He noted that his report was done before the publication of Canadian treatment guidelines, prepared by the Canadian ADHD Resource Alliance in 2008. If he was doing the assessment now, he stated that he would have likely referred to the Canadian treatment guidelines and suggested consulting with a medical doctor about this.

[83] Dr. Gibbins compared Dr. Kelly's situation to other people he has assessed where they have been attempting to cope with their difficulties without the support of many of the available resources. He stated that when those resources and strategies are available to assist them in functioning, they are commonly able to improve their functioning. In short, his experience is that when an individual with ADHD receives treatment and assistance, it is generally effective in improving their functioning.

[84] After sending the report to UBC, no one from the Program contacted Dr. Gibbins to discuss it.

Dr. Myers

[85] Dr. Myers was Dr. Kelly's treating psychiatrist during Dr. Kelly's UBC residency. He is a specialist in physician's mental health.

[86] Dr. Myers is currently a Professor of Clinical Psychiatry and Vice-Chair Education and Training at Suny-Downstate Medical Centre in New York. In that capacity, he oversees all of the education of medical students and the continuing education of mental health staff in the Department of Psychiatry. As well, as Training Director, he oversees the training of all psychiatry residents.

[87] Prior to this, he was a Clinical Professor in the Department of Psychiatry at UBC, which included teaching a clinic to residents in family medicine and psychiatry. He also maintained a private practice. He left UBC in May 2008 to assume his current position in New York.

[88] Dr. Myers explained that he became a specialist in physician mental health to accommodate the growing volume of symptomatic medical students and physicians, including residents. He testified that over the last ten years, ADHD has become an increasingly recognized or diagnosed problem in physicians.

[89] With the consent of the parties, Dr. Myers gave his evidence by telephone. All exhibits were available to him for review during his evidence, including his clinical notes, which are found at Ex. 10, Binder 1, Tab 4; Ex. 10, Binder 3, Tab 139 and Ex. 12. Each separate exhibit does not necessarily contain a complete set of the clinical notes. Dr. Myers confirmed that his clinical notes were intended to record matters of significance in dealing with his patient, and that he uses them, in part, as a resource to plan treatment. It is his habit to end his notes with a recommendations (Rx) section.

[90] Dr. Myers' notes are in point form and, at times, even he had difficulty discerning what he had meant by the note.

[91] Dr. Myers testified about his communications with UBC and his treatment of Dr. Kelly. Throughout his evidence, he consistently referred to Dr. Kelly's disorder as ADD, or Attention Deficit Disorder. When asked if there was a difference between ADD and ADHD, he indicated that he did not observe hyperactivity in Dr. Kelly, which is why he limited his diagnosis to ADD. He felt that the hyperactivity piece was minor or mild, did not remember "making a big deal of it," and said he would not say that his diagnosis of ADD was "different, worse or better" than ADHD. The parties did not place any significance on the reference to ADD as opposed to ADHD, and neither have I. I will refer to ADHD throughout this decision.

[92] In regard to Dr. Kelly's treatment, Dr. Myers regularly saw him from January 2006 until early 2008. During this period, his treatment plan for Dr. Kelly was based on a diagnosis of ADHD, NVLD, and varying degrees of anxiety and depression (mood disorder).

[93] Dr. Myers provided Dr. Kelly with support and psychotherapy, but testified that he did not provide him with the type of counselling or coaching recommended by Dr. Gibbins in his report. He adjusted Dr. Kelly's medication throughout this period.

[94] Throughout this period, Dr. Myers had the following communications with UBC:

i) a telephone call from Dr. Whitesite, Site Director, Rural Training Program, in January 2006;

ii) a conversation in early July 2006 with each of Drs. Knell and Andrews, who were covering for Drs. Kernahan and Calam, respectively, in their absence;

iii) a conversation and email exchange with Dr. Calam on July 26, 2006; and

iv) a telephone call from Dr. Sivertz in September 2006.

[95] Dr. Myers testified that, in his view, the UBC physicians were respectful of the boundaries in the doctor/patient relationship during their conversations with him. He noted, however, that Dr. Kelly had authorized him to speak to UBC for express purposes, such as when he communicated with Dr. Calam, until February 23, 2007 when the consent was withdrawn.

[96] As noted earlier, I will review Dr. Myers' interactions with UBC in some detail, as well as refer to relevant visits between Dr. Myers and Dr. Kelly, in the course of reviewing Dr. Kernahan's evidence, Dr. Kelly's residency and his dismissal from the Program.

The Residency and Dismissal of Dr. Kelly

The Standards

[97] Dr. Kernahan explained that there are two umbrella organizations that establish general standards for the evaluation and accreditation of residency programs (the "Standards"), which are the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. These include A and B standards. The A standards cover the administration of Postgraduate Medical Education as a whole, including all training programs and residents. The B standards cover the residency programs and address such things as structure, goals and objectives, resources, content of the program, and evaluation of resident performance.

[98] Every six years, there is a joint visit from both Colleges to assess whether or not the university meets the Standards set by these organizations and whether or not the university will receive accreditation. UBC could not run its residency program unless it was accredited, as its physicians could not get licensed. Dr. Kernahan testified that the Program's last accreditation visit was February 2007, and it was given full accreditation status at that time.

[99] Part of the accreditation process is to look at the standards that the Faculty Postgraduate Medical Education Committee has set for the selection, evaluation, promotion and dismissal of residents in all programs. In this regard, I note that Standard B.6, which addresses the evaluation of resident performance, requires, amongst other things, that:

> 3. There must be honest, helpful and timely feedback provided to each resident. Documented feedback sessions must occur regularly, at least at the end of every rotation. A mid-rotation evaluation is recommended. There should also be regular feedback to residents on an informal basis.
>
> 3.1 Feedback sessions to residents must include face-to-face meetings as an essential part of resident evaluation.
>
> 4. Residents must be informed when serious concerns exist and given opportunity to correct their performance.

[100] The Standards also require that the medical school establish and maintain an appeal mechanism for matters related to postgraduate medical education decisions. Pursuant to this, UBC has established a Resident Evaluations and Appeals Policy (the "Policy").

Remediation, Probation and Dismissal

[101] The Policy sets out rules that the Program must follow for remediation, probation and dismissal. Amongst others, it contains the following provisions:

> 3. **Evaluation**
>
> 3.1 Regular and timely evaluations and ongoing verbal feedback should occur throughout each Rotation.
>
> ...
>
> 5. **Dismissal of a Resident from a Training Program**
>
> 5.1 A Resident's position and progress in his or her academic program is dependent upon the maintenance of their standing as an employee, as a licensed physician, and as a Resident under this Policy. Residents may be dismissed from a University post-graduate medical training program in any of the following three ways:
>
> (a) Dismissal by the University
>
> Residents in either RCPSC or CFPC training programs are routinely evaluated, both formally and informally, according in RCPSC or CFPC guidelines. Failure of a Resident to meet the requirements of these accrediting organizations, or failure of a Resident to meet the requirements of the University will lead to dismissal pursuant to the procedures set out in this Policy.
>
> ...

6. **Identification of Weaknesses and Remediation**

6.1 In the first instance, it is the responsibility of the Program Director to bring any academic weakness or other problem to the attention of a Resident and to suggest and arrange remediation. Notice of such weakness, along with the suggested remediation and a specified time to effect such remediation, should be given by the Program Director to the Resident in writing and should be signed by the Resident who will be given a copy to retain.

6.2 Remediation is a defined period of time with training components structured to address an area or areas of weakness identified by the Program Director. It includes special evaluations, which may be of more than one kind, and may be performed by multiple internal or external evaluators. The evaluations will be discussed with the Resident, and signed by the Resident, the evaluator(s) and the Program Director.

6.3 After having received a notice of weakness and having been provided with remedial training, a Resident is expected to improve his or her performance in the identified area or areas of weakness. At the end of the specified remediation period the Program Director will either:

(a) notify the Resident that the weakness has been corrected within the specified time period and permit the Resident to continue in their postgraduate medical program; or

(b) notify the Resident that the weakness has not been corrected within the specified time period, that the Program Director intends to place the Resident on probation and the time and place of a meeting to be held with a Probation Committee to discuss the terms of the probation.

7. **Probation**

7.1 A Probation Committee will be convened by the Program Director to meet with a Resident in any case where the Program Director deems it necessary to place the Resident on probation. The circumstances in which a Probation Committee will be convened included, but are not limited to, those set out in sub-paragraph 6.3(b).

...

7.6 The probationary period is a defined period of time, structured to address identified areas of weakness. It includes special evaluations which may be of more than one kind, and may be performed by multiple internal or external evaluators. The Resident will have an opportunity to read and discuss each evaluation with the evaluator(s) before each evaluation is signed by the Resident, the evaluator(s) and the Program Director.

7.7 At the end of the probationary period the Probation Committee will meet again with the Resident to discuss his or her progress. The Probation Committee will then decide whether to reinstate or dismiss the Resident.

...

8. **Immediate Dismissal – "Unsuitability for the Program"**

8.1 Sections 6 and 7 of this Policy document the usual procedures for when a Resident's weakness is remedial. However, there will be instances in which Residents may be deemed by the Program Director to be unsuitable for the program for reasons that cannot be remediated. Such reasons may include, but are not limited to, the following:

(a) the lack of a basic skill (such as physical dexterity in the case of a surgical speciality);

(b) the presence of a personality problem related to the Resident's ability to practice medicine;

(d) conduct unbecoming a member of the medical profession; or

(e) other qualities of the Resident which make them unfit for the practice of medicine.

[102] Pursuant to this Policy, Dr. Kernahan recommended Dr. Kelly's dismissal from the Program for unsuitability. Her recommendation was accepted by the PostGraduate Deans ("PG Deans") and, as will be reviewed in detail later in this decision, the Appeals Committee denied Dr. Kelly's appeal of his dismissal from the Program.

[103] Dr. Kernahan agreed, in cross-examination, that under the remediation process, it was her responsibility to bring any weaknesses to the resident's attention in writing and to arrange remediation. She also agreed that a structured remediation could include special evaluations, with multiple internal or external evaluations. Dr. Kelly was provided a remediated rotation in paediatrics. After having had his weaknesses brought to his attention and being provided time to remediate, Dr. Kelly passed that rotation.

[104] Dr. Kernahan also explained the probation option. She testified that to place a resident on probation, there must first be a Probation Committee meeting where the resident has the opportunity to discuss the weakness that needs to be corrected. The duration of the probation is determined by the Probation Committee, as well as the training and evaluation that is to take place during the probation period. The probation may include special evaluations, and at the end of the probation, the Probation Committee will meet again to determine whether to reinstate the resident or dismiss them from residency. A decision to dismiss must identify the specific weaknesses that have not been addressed by the resident within the probationary period.

[105] While a probationary resident would have to meet all the same objectives as in a regular rotation, the rotation would be structured to take into account the requirements of the probationary period. Dr. Kernahan agreed in cross-examination that the Probationary Committee could decide to make a rotation longer than the standard number of weeks, could decide that the resident must have a course of daily feedback during probation, could decide that some form of daily instruction was necessary for the resident, and could make decisions about the preceptor assigned to the resident during the probationary period, including assigning one preceptor if that was what they determined necessary.

[106] Dr. Kernahan testified that the Probation Committee would determine the structure and duration of probation and that she, as Program Director, would implement the recommendations of the Probation Committee and find the appropriate resources. She noted, however, that it might not be possible to implement all recommendations. For example, when asked if she would resource or organize a process so that the resident could received clear goals each day, she said that she would be

limited by the structure of the rotation being remediated and it might not be possible. However, if the Probation Committee recommended this, she would be tasked with seeing if it was possible to implement.

[107] Dr. Kernahan also agreed in cross-examination that the Probation Committee could make recommendations that a resident needed a probationary period in order to work on planning and organizational skills, scheduling or prioritization. The recommendations could include whatever the Probation Committee thought was relevant to remediating the resident. At the end of the probationary period, the Probation Committee would decide whether or not the resident had made sufficient progress to return to a regular residency rotation.

[108] Dr. Kernahan confirmed that Dr. Kelly was never put on probation.

[109] The Policy also allows the Program, pursuant to s. 8, to dismiss a resident for unsuitability. Dr. Kernahan agreed in cross-examination that if a resident is going to be dismissed for unsuitability, the Program Director must first conclude the resident is unsuitable for reasons that cannot be remediated. She agreed that sections 6 and 7 (remediation and probation) of the Policy are the usual processes to assess if weaknesses are or are not remediable. She also stated, however, that if the Program determines that the weaknesses are not remediable, it may go directly to dismissal for unsuitability.

[110] Dr. Kernahan testified that it was her conclusion, for reasons set out in an August 23, 2007 letter that will be reviewed in detail later in this decision, that Dr. Kelly was unsuitable for the practice of family medicine. She confirmed that she was not alleging a personality problem or that Dr. Kelly had engaged in conduct unbecoming a member of the medical profession.

[111] She also agreed in cross-examination that, as set out in her letter, the reason for recommending that Dr. Kelly was unsuitable to practice family medicine was because his deficits were "life-long." She relied on that fact, in particular, as well as the rest of the Gibbins report. She testified that by life-long deficits, she meant the deficits associated with ADHD and NVLD.

[112] Dr. Kernahan then specifically disagreed in cross-examination that Dr. Kelly had been dismissed because the Program had determined that the life-long deficits of ADHD and NVLD <u>could not</u> be accommodated to produce Dr. Kelly as a practising family physician. Rather, she testified he was dismissed because he did not demonstrate the abilities needed to practice family medicine or to be successful in the completion of his residency. She would not agree that she determined that life-long deficits presented too great a barrier to his successful completion of his residency training. Rather, she testified that she "considered everything" and felt that he did not demonstrate the abilities that were necessary to complete family practice residency. As will become clear later in this decision, I find that Dr. Kernahan did, in fact, consider the life-long nature of Dr. Kelly's disabilities to be a factor in her determination that he was unsuitable to continue in the Program.

Site Match, Rotation Assignments and Resident Evaluations

[113] Residents originally match to sites (such as rural or urban), through what is referred to as the CARMS match (a computerized matching program). Dr. Kernahan testified that, through CARMS, UBC ranks the residents, the residents rank the sites, and CARMS matches. When UBC ranks the residents, it has the opportunity to give preference to which residents it takes, from 1-400. The allocation of resident slots is done through the Postgraduate Deans ("PG Deans") office and the number of actual slots they get per year is determined by the Ministry of Health.

[114] The Program does not rank all of the residents who apply. After it ranks the residents, and it has the number of slots determined by the Ministry, residents are matched to the specific sites.

[115] Once matched to a program site, the Program is responsible for deciding which rotations it requires for training its residents. The actual assignment is an administrative task done through various departments affiliated with UBC at the various teaching hospitals and in the community. For example, the SPH family medicine site would assign residents to wards at SPH.

[116] Dr. Kernahan testified that the sites each have a template as to how to structure the rotations. The administrative assistant to the Site Director then does the scheduling. Each site has a specific set of rotations within a specific institution and they schedule the residents in them.

[117] In order to graduate as a family physician, the resident must complete a specific set of rotations as determined by UBC. The resident can only work as a resident if they are part of the residency training program. An effect of dismissal for unsuitability is that a resident cannot continue to work as a resident in a hospital.

[118] Dr. Kernahan agreed that the decision to terminate Dr. Kelly for unsuitability was solely a decision of the UBC Program, and that after that decision, his employment was terminated through the PG Deans Office.

[119] When asked whether, in terms of the clinical work that a resident does during their rotation, the Program determines what the clinical work will be, Dr. Kernahan testified that the Program determines the objectives of the programs and what the residents need to learn about specific areas, such as paediatrics or internal medicine. The rotations and the academic program are then structured to deliver that curriculum. The sites implement the curriculum structured by the Program.

[120] The supervision of residents while they undertake the work required to meet the curriculum objectives is organized by the site and is done primarily by UBC clinical faculty. In addition, there are occasions when a resident may be supervised or taught by other health professionals.

[121] Dr. Kernahan testified that the assessment of a resident's work during rotations is done through an "in training evaluation report" or ITER, which is a summative evaluation at the end of a rotation. A

FITER is the final ITER. There are also formative evaluations that may be done during the course of a residency. She described these as "feedback." The ITER includes information from the formative evaluations.

[122] Both summative and formative evaluations are conducted by UBC clinical faculty. The formative evaluations, whether they take the form of observations of clinical work, chart reviews, comments from nursing staff, or other forms, serve as the basis for the ITER. Dr. Kernahan testified that her practice on each rotation is to have a designated UBC clinical faculty individual responsible for completing the ITER. It is that person's responsibility to collect information from supervisors, the chief resident or others and collate it into the ITER.

[123] Other than exams, the formative evaluations leading to the summative evaluation is the evaluation process for residents.

Family Medicine in General

[124] Dr. Kernahan explained that family medicine is a generalist field that requires knowledge and skills to deal with the scope of medical illness and preventative practice for patients "pre-birth to death". She testified that it is a field in which there is a lot of multi-tasking and time pressure, and where "every patient presentation is unique". She noted that most patients do not come in with one problem, and that a patient may not necessarily tell the physician about their problem. It is the role of physician to assess the situation.

[125] Dr. Kernahan described "full scope" family practice as involving such things as office management, hospital privileges, obstetric privileges, house calls, and admitting privileges. The scope of practice will vary depending on a variety of factors, including where the practice is located. For example, in a rural area all the noted skills would be required, as well as emergency skills. In an urban area, the physician may choose to focus only on parts of the practice.

[126] Dr. Kernahan noted that the Program is required to train a family physician to practice the full scope of family medicine. She stated that there is a "huge volume of information" and a resident needs to be good at processing information, organizing, time management, have good interpersonal skills, pick up on patient cues, look for hidden agendas when patients come in, be able to quickly analyze information, to generate treatment plans and incorporate patient education and preventative messages into the daily care of patients.

[127] The Program attempts to move a resident along quickly. While other residencies are five years, Family Practice is a two-year program where the students move quickly to becoming independent practitioners. Graduates of the Program work with family medicine preceptors in their offices or clinics so they are exposed to the whole model of family medicine.

Rotations

[128] The Program is broken down into blocks. A block is four weeks, and a year is divided into 13 blocks. A resident gets one block of vacation, so there are twelve blocks in a year.

[129] Each block has certain requirements that are to be met by the resident. Each resident is evaluated against the Program objectives for the particular block the resident is participating in.

[130] Residents are required to complete a series of core rotations over the course of the two years. The first year is made up of a number of rotations that are one or two blocks long, including two blocks of internal medicine ("CTU"), two blocks of paediatrics, two blocks of obstetrics gynaecology, and a block of emergency medicine. The resident is also required to complete two blocks of surgery and, at some point during the two years, a block of psychiatry and two blocks of family medicine.

[131] Residents are also required to take electives, and have the choice of which electives they wish to take. Dr. Kernahan explained that the first year is primarily comprised of core blocks.

[132] Each rotation has at least one preceptor who is responsible for evaluating the resident. In some rotations, there may be multiple preceptors, with one responsible for gathering information from the other preceptors to finalize the resident's evaluation for that rotation.

[133] Dr. Kernahan explained that the Program encourages the preceptor to sit down with the resident at or near the end of a rotation to discuss their evaluation, and advise whether or not the resident has passed the rotation. This might not occur until a week or two after the rotation has ended, particularly if there are multiple preceptors. In that case, the evaluation may occur later.

[134] Evaluation forms are available on-line. The preceptors file the evaluations electronically and residents can confidentially access their own evaluation.

Dr. Kelly's Entry into the Program

[135] Dr. Kelly graduated with a medical degree from the UOA. After graduation, he obtained a UBC family residency position at what was described as a "rural site" in Kelowna. At the time, UBC had only one rural site.

[136] Dr. Whiteside was the Site Director for the rural site. He was located in Vancouver. Dr. Tereposky was a Kelowna physician in the rural site program.

[137] Residents usually start their program on July 1. However, Dr. Kelly did not start at that time due to what Dr. Kernahan understood was a delay in the UOA granting his degree. His start was therefore delayed until November 1, 2005.

[138] Dr. Kelly's first rotation was in paediatrics. The rotation ended on December 18, 2005, which meant that it was a shorter than usual rotation.

[139] On December 13, 2005, one of the preceptors wrote the following observation about Dr. Kelly:

> ... as per our conversation yesterday I had a good chance to observe Carl Kelly today. My impression is that he is a hard worker who has a reasonable rapport with patients. His knowledge base is on the weak side but improving. His approach is more definite and less tentative than I had observed earlier. I continue to rate his performance as average for his stage of residency and therefore below that of his colleagues who started months earlier.
>
> It seems that many residents rotating through paediatrics are a little uncertain as to the expectations. Perhaps we (the paediatricians) need to meet with you to ensure that the expectations from the dept of family med and that of our department is in harmony. In addition the expectations need to be clearly laid out to the peds residents at the start of their rotation.

[140] Dr. Kelly did not pass this rotation. He was not advised of this until after the rotation had concluded.

[141] After Dr. Kelly completed his paediatric rotation, he was scheduled to do two blocks of family medicine at UBC. He started in the Mather clinic. However, the clinic was in the process of moving, and Dr. Kelly finished the block in the UBC clinic. When the clinic moved physical locations, it also changed its name.

[142] Dr. Kernahan explained that rural residents usually came to UBC at that time to complete their family medicine rotation, as UBC was in the process of transitioning the Program at that time. The first year is now done entirely in Kelowna, with the family medicine block completed in private family physician offices.

December 18, 2005 – Dr. Tereposky's communication to Dr. Kelly

[143] Prior to commencing his family medicine block in Vancouver, Dr. Kelly was advised by Dr. Tereposky that he may not pass his paediatrics rotation.

[144] On December 18, 2005, Dr. Tereposky sent the following email to Dr. Kelly entitled "message to Faculty":

> I hope your first week in Vancouver goes well.
>
> This is how I was thinking of wording the message...
>
> I just wanted you all to know that I met with Carl Kelly this past Friday. I wanted to discuss the probability that he will not yet be successful at passing his Paediatrics Rotation. It was 2 weeks short, and he had a slow start due to being off for 8 months and getting settled in Kelowna. He improved during the rotation, responding to feedback, but from speaking with [name] (Peds rotation coordinator), the Paediatricians may not be comfortable passing him as he is functioning at a 4th year level rather than as a Resident. Carl was disappointed by this, but willing to work and meet the challenge. If he does not pass, we will probably add 4 weeks of Paediatrics to the end of his first year. This will depend on how the rest of his year goes.
>
> Carl was very forthright with me about the time missed between medical school and starting his Residency. We had a long open talk (at his request) about his life and personal challenges and health issues. At some time he may be comfortable sharing

> this all with you. In the meantime, I am happy to see that he is enjoying his Residency and is attending to his health concerns.
>
> He seems to be a very earnest and pleasant young man. Although I see challenges ahead for him, I also see the makings of a fine Family Physician. I would like to give him as much support as we can to help him be successful. He has told me that he'll keep me informed of any concerns during upcoming rotations.
>
> ....let me know if you want something changed Carl.

[145] It is evident from this email that, at this point in time, his preceptor had formed the view that, despite challenges, Dr. Kelly had the potential, with appropriate support, to be a successful family physician. It is also evident that Dr. Kelly had disclosed his health issues to at least one faculty member within the Program.

January 8, 2006 – Dr. Tereposky's communication to Dr. Whiteside and others

[146] On December 28, 2006, Dr. Kelly emailed Dr. Tereposky inquiring about the email she was going to send to Faculty, and the outcome of his paediatrics rotation. Based on discussions with one of his evaluators and Dr. Whiteside, Dr. Kelly subsequently formed the opinion that he had passed the rotation, and sought email confirmation of this from an evaluator.

[147] On January 8, 2006, Dr. Tereposky wrote Dr. Whiteside and others the following email about Dr. Kelly's paediatrics rotation:

> [name] phoned me tonight regarding this email (see below) and to let me know that she just finished collecting information from the Paediatricians (delay because of holidays) and Carl Kelly's final evaluation will be put in this week – and he will not pass Paediatrics.
>
> She will be calling you directly Monday or Tuesday to discuss this with you – especially w.r.t how to notify and talk to Carl Kelly about this since he is in Vancouver now. I do not know how Carl Kelly's email came about – obviously some kind of misunderstanding somewhere along the way. As I told you before, not succeeding in Paediatrics should not come as a shock to Carl – we discussed the probability prior to his departure to Vancouver – and he was disappointed but seemed able to accept it. I told him that because he started late (and is therefore "out of sync" with other R1's), doing some Paediatrics again will not be noticed by his colleagues. We can add Paediatrics again at the end of his R1 year – you can discuss with him where it should be done – Kelowna again, or elsewhere. Let us know how it goes.

[148] Dr. Whiteside replied:

> Good day again,
>
> Clearly a bit of wishful thinking on young Carls part but understandable. I was aware of his mid term problems for sure but had no idea of the outcome at the end of the rotation. I tried to be somewhat optimistic about the situation thus may have given the impression he did ok. Certainly no statement that he passed for sure.
>
> Be that as it may, we need to talk about him on Tuesday and plan some interventions as I believe the underlying issues may interfere in all his rotations and may well relate to his past problems in Medical school?

> With this in Mind he has agreed to allow us to access his physicians assessments of his problems including the educational psychologists assessment. Clearly some of this info will have to remain confidential but he understands that by getting some of the past History we may be better able to help him with his learning needs.
>
> I have spent some time with Carl today and mentioned to him that he will not pass his Peds rotation. Clearly he was disappointed with this decision but seemed to accept it. His main concern was with the lack of feedback on how he was doing and what areas are causing concerns. So we need to keep this in mind as we progress with our interventions. He appears to have a strong support system through his family and has agreed to check in with me on a weekly basis.
>
> I have also agreed to sit in with him on mid term FP evaluation.
>
> It is important that we document all the communications and concerns that we have regarding our attempts to better understand his learning needs. I have indicated our support to assist him with the challenges so that he can become a confident and competent future Family Doc.

[149] Based on this communication, it is evident that Dr. Whiteside perceived Dr. Kelly to have an ongoing medical condition that would affect his residency and that required "interventions" by the Program. It is also clear that Dr. Kelly was cooperative and provided the Program with requested educational and medical information.

January 9, 2006 – Dr. Whiteside's "Emerging Concerns" Email

[150] On January 9, 2006, Dr. Whiteside sent an email to Dr. Kernahan and others advising that there were "emerging concerns" with Dr. Kelly. It states:

> Morning All,
>
> Clearly there are emerging concerns about Carl Kelly. This is a verified by the many early warnings that have been coming in from his various (first and second) rotators.
>
> As I will be in Kelowna tomorrow and will be attending the site meeting in the evening might I suggest that those listed above, who are in Kelowna, meet a little early to discuss this situation.
>
> I appreciate the early warning that we have had from various faculty re Carl. Thank you.
>
> Clearly, as with any patient, we deal with it would be ideal to have Carls PH available in order to maximize our ability to form a rational hypothesis.
>
> Jill is it possible to get more info from the UOA on his story?

January 10, 2006 – Dr. Whiteside's Summary of Dr. Kelly's Paediatrics Rotation

[151] On or about January 10, 2006, Dr. Whiteside prepared a summary of Dr. Kelly's rotation, met with Dr. Kelly's Kelowna preceptors, and added notes of that meeting to his summary. He then forwarded the summary to Dr. Kernahan. Dr. Kernahan testified that she only receives such information about a resident, or gets involved, when a resident is having difficulty.

[152] Amongst other things, Dr. Whiteside's summary included the following comments:

> - Some suggestions of "illness"/knowledge base/??
> - Apparently complete only 6 weeks of peds (late start??)
> - Started FP in Vancouver at Mather Building Dec19/05
> - Jan 06 [name] spoke with me regarding concerns of the FP preceptors about his performance. Not sure what the main problem are but general concerns about his Knowledge base and possibly attitude
> - [name] to document and forward to me for files
> - Jan 9th 11 am met with Carl and shared the peds results with him
> - He was in agreement that our concerns may reflect those he had to deal with at the UOA. Thus it made sense to both of us that it would be helpful to review his assessments on the problem done in Alberta.
> - With this in mind he will talk with his doc in Edmonton and have him forward their assessments of his learning problems and any other info which would help us help Carl to move ahead in his residency.
> - Once we have all the data I believe we can be more efficient in establishing a remediation program for Carl that will be effective. He was in agreement with this.
>
> ...
>
> Discussed with [names of preceptors]:
>
> - Tested Hypotheses * Learning Disability/possible psychiatric issues/medication effects
> - Agreed to discuss further when data comes from Edmonton
> - Agreed that he should not continue in the Rural Program
> - [name] and Carl to Discuss with Jill and [name]
> - Carl To meet on Weekly basis and ensure he has support group and get lined up with medical support in Vancouver.
>
> Contact with Dr Myers Appointment arranged Jan 20 at 4 pm Friday
>
> Carl Notified of appt. He is to call Dr Myers today to verify appt.
>
> Carl to Take with him info he has on his medical assessments.

[153] Dr. Whiteside subsequently initiated contact with Dr. Myers and referred Dr. Kelly to him. Dr. Kernahan stated that, in general, such a referral is unusual.

[154] By January 2006, the Program was either aware or hypothesizing that Dr. Kelly had a learning disability and mental illness, and was on medication. It had referred him to a psychiatrist, and had requested access to his previous medical assessments.

January 11, 2006 – Family Practice Mid-Rotation Evaluation

[155] On January 11, 2006, a mid-rotation evaluation was discussed with Dr. Kelly. The comments on the evaluation form are as follows:

> (This was done with the objectives review as this resident started over the Christmas/New Year's break). Carl was informed that he was below average in most

> areas of evaluation (4-5/10); but that he had shown improvement and if the improvements continued he would likely pass his rotation. He was stressed by this discussion. He explained his learning disability and requested immediate, direct feedback. He also requested that we inform him once his evaluation was > or = 5/10.

[156] Based on her review of the documents, Dr. Kernahan believes that the Program, including herself, became aware of Dr. Kelly's learning disability on or about January 9, 2006. They also knew that Dr. Kelly had to remediate his failed paediatric rotation, and that Dr. Whiteside had decided that Dr. Kelly should not have been in the rural program and should be moved to a program that had more structure and ability to observe him.

[157] Dr. Kernahan testified that transferring a physician from their matched program is something that is "virtually never" done. When a student is matched to the rural site, they must be prepared to stay there for two years. She stated that the sites do not have enough capacity to accommodate students moving back and forth between sites. As well, the way in which programs are scheduled makes it difficult to move a resident from one to another. It was also her view that when a resident remains at one site, the faculty is better able to get to know the resident over a period of time. I note, however, that the Program was, in fact, able to move Dr. Kelly between a rural and urban site. I accept that it may have been organizationally difficult or inconvenient to do so, but the evidence demonstrated that it was able to reasonably be done in the case of Dr. Kelly.

Program Referral to Dr. Myers

[158] On January 12, 2006, Dr. Whiteside emailed Dr. Myers to inquire if he was available to provide support to Dr. Kelly during his residency. The emails states, in part:

> We have a resident in our first year who come to us from the UOA in Edmonton with a history of some Psychiatric problems possibly mixed with Learning Difficulties.
>
> Before I go into his issues I guess I need to know if you are still active in practice and if not who you would recommend we refer him to?
>
> Cheers, Carl Whiteside (almost retired)

[159] At or around this time, Dr. Kelly had also provided authorization to Dr. Drebit to release his UOA medical assessments to Dr. Whiteside. This information was provided to Dr. Myers.

[160] Drs. Myers and Whiteside subsequently spoke, and Dr. Myers agreed to see Dr. Kelly. Dr. Myers had little independent recollection of his conversation with Dr. Whiteside. Upon reviewing his notes, he recalled that Dr. Whiteside advised him that Dr. Kelly had had difficulties in the rural site program, that Dr. Whiteside felt that Dr. Kelly had minimal support, and that he was not succeeding. His notes also record that Dr. Whiteside told him that Dr. Kelly had a history of ADHD and learning difficulties. This was followed by a list of medications, which he assumes reflects what Dr. Whiteside was told by Dr. Kelly about the medications he was taking at that time.

[161] Dr. Myers testified that, at this point in time, he had not diagnosed Dr. Kelly. Rather, he was alerted by the information provided to him of things that he should look for in assessing Dr. Kelly. For example, the medication indicated that Dr. Kelly had been treated for depression and ADHD.

[162] Dr. Myers did not recall receiving any other instructions from Dr. Whiteside regarding his meeting with Dr. Kelly. He stated that if Dr. Whiteside had wanted him to be in a reporting capacity to the Program, or to do an independent medical examination ("IME"), it would have been a different type of referral and he would have conducted a different type of visit with Dr. Kelly when he first saw him on January 20, 2006.

[163] Dr. Myers understood that he had accepted a typical role as a treating psychiatrist toward a patient.

January 20, 2006 Visit

[164] Dr. Myers met with Dr. Kelly on January 20, 2006. Again, Dr. Myers had little independent recollection of the visit, and at times could not determine whether comments that he had written in his notes were his own observations or conclusions, or whether it was something that Dr. Kelly raised as a possibility with him. For example, while his notes refer to a NVLD, he believes this must have been something Dr. Kelly mentioned, as he would not usually diagnose such a condition only a few minutes into an interview.

[165] Dr. Myers testified that Dr. Kelly told him that he was referred to Dr. Drebit while in third year medical school at the UOA. Dr. Drebit prescribed both anti-depressant and ADHD medications for Dr. Kelly. Dr. Myers recalls wondering whether a different ADHD medication might benefit Dr. Kelly.

[166] Dr. Myers did not recall what, if any, diagnosis he made at the conclusion of his meeting with Dr. Kelly, and his notes do not reflect a complete diagnosis. He did recommend an increase in a specific medication, and was going to contact Dr. Drebit about Dr. Kelly. He did not recommend that Dr. Kelly discontinue his residency. He testified that if he had thought that Dr. Kelly should not be working or that there would be a risk of him harming a patient, he would have written that down.

[167] I note that Dr. Myers continued to regularly see Dr. Kelly until January 2008 and, at no point did he indicate that he considered there was a risk that Dr. Kelly would harm a patient. There was no evidence that Dr. Kelly ever did harm a patient during the period of his residency.

[168] Dr. Myers subsequently called Dr. Drebit to obtain background history about Dr. Kelly's treatment. Dr. Drebit suggested that Dr. Kelly stay on his current medication, together with another suggested medication. Dr. Drebit also advised Dr. Myers that he would provide him certain documentation, which included Dr. McLung's 2002 evaluation done for the purpose of assessing a NVLD. Dr. Myers did not recall reviewing Dr. McLung's report, but it is on his file and I accept that it was provided to him.

[169] Dr. Myers recalls that his plan for Dr. Kelly at that time was to continue seeing him, and that Dr. Kelly would continue medication for ADHD and a mood disorder.

January 30, 2006

[170] Dr. Myers next saw Dr. Kelly on January 30, 2006. Amongst other things, they discussed his medication, his previous treatment in Alberta, and his progress in the Program.

[171] Dr. Myers' notes indicate that Dr. Kelly told him that he was doing "okay" in his current rotation, but was not yet performing up to the expected level. However, Dr. Kelly also advised him that one preceptor had told him he was doing "fine." Dr. Kelly also advised Dr. Myers that he was coming to accept that he was going to be transferred from the rural program in Kelowna to an urban site in Vancouver. Dr. Myers put an asterisk beside that note, and testified that meant the move to Vancouver may be more psychologically difficult for Dr. Kelly than previously thought. He modified Dr. Kelly's medication at the end of the visit.

Extension of Rotation from February 14 to April 28, 2006

[172] Dr. Kernahan testified that a decision was made to extend Dr. Kelly's family medicine rotation to allow further teaching and observation of Dr. Kelly. She stated that extending a rotation is uncommon.

[173] In this case, Dr. Kelly's family practice rotation was originally scheduled to finish on February 13, 2006, but was extended to April 28, 2006.

[174] Dr. Kernahan explained that the scheduling of residents is done at the beginning of the year, and that a new group of residents would have been scheduled to commence on February 14 for a two-month block. She noted that in regard to scheduling preceptors for the residents, the UBC clinic is different than most other clinics. In the UBC Clinic, the patients are associated with the clinic itself and not an individual physician. Virtually all the patients are seen by the residents. There is a series of preceptors who work half days at the clinic, and they oversee the residents who are assigned to the clinic.

[175] Dr. Kernahan testified that the extension of Dr. Kelly's rotation for a further two and one-half blocks would have meant that there were more residents scheduled at the clinic during that period. However, she testified that the clinic had moved locations and had more available exam rooms at that time.

[176] The evidence demonstrated that the Program was able to provide Dr. Kelly with an extended rotation.

February 14, 2006

[177] Dr. Myers next saw Dr. Kelly on February 14, 2006. Dr. Kelly self-reported at that time that he was quicker in assessing patients in a clinical setting and Dr. Myers concluded that the new combination

of medications was working well. He scheduled another appointment for six weeks, which was a common time frame. He testified that, overall, he was pleased with how Dr. Kelly was doing.

March 15, 2006 – Meeting to Discuss Dr. Kelly's Educational Needs

[178] On March 15, 2006, a meeting was held with Dr. Kernahan, Dr. Mary Donlevy (Site Director for the Greater Vancouver Site), Dr. Betty Calam (Site Director for SPH) and Dr. Christie Newton, Director of the UBC Family Medicine Clinic. The purpose of the meeting was to discuss Dr. Kelly's educational needs and determine which urban site would best be able to meet those needs.

[179] During the meeting, Dr. Newton summarized Dr. Kelly's progress during the last three months of the family medicine block at the Mather Clinic. The notes of the meeting record her observations as follows:

> Christie Newton reviewed Carl's progress during the last three months of Family Medicine Block time at the Mather clinic. The information provided had been gathered from the group of preceptors at Mather.
>
> Carl appears to be doing better with time. It was noted that he improves with consistent, immediate feedback. A number of concerns were still present. Anxiety seemed to affect his performance. His histories were not focused and he often included extraneous details in his presentation of cases to his preceptors before he presented the salient details. It was noted though that he did obtain the relevant history.
>
> Carl's performance has been noted to be inconsistent. There were occasional episodes of defensiveness.
>
> His ability to perform procedures was felt to be average.
>
> Christie indicated that Carl would pass this rotation, although it was a weak pass.

[180] As of mid-March, therefore, Dr. Kelly's preceptors were of the view that he would pass his family medicine rotation.

[181] After discussing which urban site would be most appropriate for Dr. Kelly, agreement was reached that Dr. Kelly should first remediate the paediatrics rotation. It was felt that Dr. Kelly needed to be attached to a peer group of residents, and that he should be assigned a mentor. If Dr. Kelly successfully remediated his paediatrics rotation, then he would be attached to postgraduate year one resident group (PGY 1).

[182] Dr. Calam took responsibility as Dr. Kelly's Site Director as of July 2006. In the interim, Dr. Kernahan oversaw him.

[183] The notes record that the following plan was agreed upon to address Dr. Kelly's educational needs:

> If Carl successfully remediates his paediatric rotation, he will be attached to the incoming PGY 1 group from St. Paul's as of July 1, 2006.

> We will structure the remainder of his PGY 1 year along with this group. These rotations are mainly St. Paul's Hospital based.
>
> For his PGY 2 years, Christie has indicated that she is willing to have him continue at the University Health Clinic (previously called Mather). We will structure other rotations to meet the requirements of the program, but rather than using the horizontal model of St. Paul's, we will create a "vertical" structure using rotations from both the St Paul's and Greater Vancouver programs.
>
> Jill will meet with Carl next week to discuss the plan.
>
> Once the paediatric rotation and the mentor are confirmed, the remediation letter will be drawn up.

[184] Dr. Kernahan explained that the Program needed to find extra space for Dr. Kelly as he was supernumerary to the new PGY 1 group coming into SPH. She described SPH as a very busy teaching hospital, with a number of residents rotating through all the specialities, including family medicine.

[185] Dr. Kernahan explained that SPH does block rotations in the first year (vertical structure), and in the second year has a ten-month horizontal component. During that year, the residents get longitudinal exposure to patients over a period of ten months. Woven into that are experiences in mental health, surgery, psychiatry, and some of the electives. Residents are responsible to develop their schedules. They are provided a template that they fill in, and need to be proactive and review their experience with the Site Director to ensure they are receiving the required experience.

[186] Dr. Kernahan testified that she had not modified the standard program at any site before. Occasionally, residents had remediated a rotation, but it was usually done within the current structure at the site.

[187] Dr. Kernahan also explained that a mentor is made available to every resident, though some residents choose never to speak to their mentor. A mentor is someone not associated with the Program, but who is knowledgeable about the Program and family medicine. The resident can speak confidentially to a mentor without fear that the program, including evaluators, will know about these conversations.

[188] However, as of March 15, 2006, Dr. Kelly did not yet have a mentor. Dr. Kernahan's husband was ultimately assigned to be Dr. Kelly's mentor. Dr. Kernahan did not advise Dr. Kelly of the availability of her husband to be his mentor until April 10, 2006.

[189] There was no evidence that either Dr. Kelly or his treating psychiatrist were invited to, or did, participate in these discussions about the "plan" moving forward.

April 3, 2006

[190] When Dr. Myers next saw Dr. Kelly on April 3, 2006, Dr. Kelly advised him that he was relieved he had "officially passed F.P." and was starting at SPH for six months. Dr. Myers thinks that F.P. might refer to a family practice rotation. Dr. Kelly did not, in fact, pass his family practice rotation, though he

would not have been advised of this at the time of this visit with Dr. Myers. I note that as of March 15, the indications were that Dr. Kelly would pass the rotation and, as noted in Dr. Kernahan's April 5 email described below, he had also been given a pass at mid-rotation. As well, in a March 28 email from Dr. Newton to Dr. Kernahan, Dr. Newton expressed the view that she was uncomfortable passing him, but "based on the standard format, I think he will do so."

[191] I find it reasonable to infer that, at or around this time, Dr. Kelly reasonably believed he would be successful in the rotation.

[192] Dr. Kelly also told Dr. Myers during this visit that he felt "better than I ever have before." Dr. Myers also put an asterisk beside this note as he was excited that Dr. Kelly seemed to be improving. Dr. Myers questioned whether Dr. Kelly had "SAD", but could not recall whether he meant social anxiety disorder or something else, or why he was concerned.

[193] His overall assessment of Dr. Kelly's health status at that time was that he was doing well. He scheduled a further appointment for six weeks later.

April 5, 2006 – Dr. Kernahan's Email to the PG Deans that Dr. Kelly will Fail

[194] On April 5, 2006, Dr. Kernahan emailed Drs. Sivertz and Rungta advising that even though Dr. Kelly had been given a pass at mid-rotation on the block, it was felt necessary to fail him on the rotation. She also noted that while the initial plan was for him to start a remedial rotation in paediatrics, she was considering proceeding directly to probation.

[195] The email referred to a situation that had arisen in late March regarding signatures on a prescription, which Dr. Newton had advised had not resulted in any harm to a patient. Dr. Kernahan, however, advised Drs. Sivertz and Rungta that there was "some concern re patient safety." She did not elaborate. The email also referred to Dr. Kelly's unavailability while on call.

April 5, 2006 – Meeting with Dr. Kelly

[196] On April 5, 2006, Dr. Kernahan met with Dr. Kelly and Dr. Newton. During the meeting, they discussed the two incidents involving the signature and the lack of availability while on call. After this discussion, Dr. Kernahan advised Dr. Kelly that she did not expect residents to be perfect and acknowledged that residents do make mistakes from time to time. She expected that residents would learn from their mistakes. She indicated that she would review the prescription issue with the PG Deans and inquire if there was a process to remove the documentation from his file.

[197] Dr. Kelly was also advised that he would be continuing at the UBC Health Clinic until April 28, and a two-month remedial rotation had been scheduled for him beginning May 1. It does not appear that he was advised that he would fail the rotation.

April 10 or 20, 2006 Meeting with Drs. Kernahan, Newton and Kelly

[198] Dr. Kernahan testified that she met again with Dr. Kelly to discuss concerns she and Dr. Newton had regarding his mental health. While her notes of the meeting are dated April 10, 2006, the ASF records the meeting as occurring on April 20. Nothing turns on this date.

[199] The course of action that was undertaken at that time was to direct Dr. Kelly to meet with Dr. Myers, and ensure he was well enough to undertake the remedial rotation. If he was not well enough, he could be provided with a medical leave of absence. He was also advised that the physicians from the clinic would meet to discuss his performance on the family medicine rotation, and Dr. Newton would provide feedback. As noted earlier, however, Dr. Kernahan had already informed the PG Deans that he would fail.

[200] Dr. Kernahan did not speak directly to Dr. Myers. She also did not put any specific questions to Dr. Myers about Dr. Kelly's failed rotations. She agreed that she did not take any steps to speak to any other physician or psychologist at that time about her concerns about Dr. Kelly's failed rotations, and that it was only discussed within the Program.

[201] Despite what Dr. Kernahan had indicated in her earlier email to the PG Deans, she did not pursue the probation option, but went the remedial route with Dr. Kelly.

April 23, 2006

[202] On April 23, Dr. Kelly provided a written response to Dr. Kernahan regarding both the prescription incident and his unavailability while on call with Dr. Donlevy. There was no evidence that any disciplinary steps were taken by the Program in regard to these two incidents, and Dr. Kelly commenced his remedial paediatrics rotation in May.

April 27, 2006

[203] Dr. Myers next saw Dr. Kelly on April 27, 2006, which was a little over three weeks from his last visit. He did not recall why he saw Dr. Kelly earlier than the usual six-week period, and assumes that Dr. Kelly asked to see him earlier. Dr. Myers' notes refer to "a couple of incidents." His notes record that Dr. Kelly told him about the two incidents referred to earlier and that the incidents had been reported to the PG Deans. Dr. Kelly acknowledged the prescription incident was a mistake.

[204] Dr. Myers was not sure of his assessment of Dr. Kelly's health status at this point since it is not recorded in his notes. He did recommend increasing one medication if Dr. Kelly felt he needed to, and that he scheduled another appointment in a month's time.

April 27, 2006 – Dr. Kernahan's Email to Dr. Kelly regarding Remedial Rotation

[205] Also on April 27, Dr. Kernahan emailed Dr. Kelly regarding his remedial paediatric rotation. She mentioned that Dr. Newton was arranging to meet with him and provide him feedback on his family medicine rotation.

[206] Dr. Kernahan attached the objectives of the remedial rotation to her email, provided information about Dr. Khangura (a paediatric emergency physician), who would evaluate Dr. Kelly's performance, and indicated she would like to meet with him weekly to discuss his progress on the remedial rotation.

[207] Dr. Kernahan testified that the Program entered into an agreement with Kelly regarding the paediatric remediation, as required by Section 6 of the Policy. The unsigned and undated remediation letter that was provided to the Tribunal, and which indicates that it was discussed with Dr. Kelly by phone on April 27, sets out that the remediation period was from May 1, 2006 to June 25, 2006. It also states that Dr. Kelly was assigned a remedial supervisor (Dr. Kangura), that he was to be provided with daily feedback forms, and that he would be assisted in achieving the objectives of remediation by:

- clarifying the difficulties the resident is having with knowledge base,
- providing extra teaching in clinical matters,
- providing supervision and training in procedural skills, and
- directing the resident to other specific sources of information on teaching.

[208] Dr. Kernahan agreed that daily feedback forms were part of Dr. Kelly's remediation and also part of how residents are generally evaluated in paediatric emergency in that they should be provided with feedback each shift.

[209] At the time, Dr. Kangura was responsible for overseeing all the medical students in emergency. She agreed to review the end of shift evaluations that the attending physicians in emergency would fill out on Dr. Kelly each day, and to notify Dr. Kernahan if there was a problem. She was also going to help deal with teaching and clinical matters, supervision, training and procedural skills. She might delegate these tasks if another emergency physician was on shift, but there would always be an emergency physician overseeing Dr. Kelly.

[210] Dr. Kernahan testified that these are normal obligations that any remediating supervisor would undertake.

[211] Dr. Kernahan also testified that, in her view, the Program followed its obligations in the remediation process, and provided Dr. Kelly with the support identified in the remediation letter. She first testified that she was unaware that Dr. Kelly actually had difficulty in receiving the daily feedback forms and was not given them on a daily basis as outlined in the remediation agreement. After being referred to an email from Dr. Kelly to her in which he advised her that he was having difficulty with obtaining the end of shift feedback forms, she agreed that Dr. Kelly did raise that concern with her and that, notwithstanding this difficulty, he passed that rotation.

Evaluation Forms May 2-18, 2006

[212] Copies of Dr. Kelly's paediatric emergency medicine resident end-of-shift evaluation forms for the period of approximately May 2-18, 2006 were on Dr. Myers' file. There was only one day where Dr. Kelly was rated below expectations in two areas, but it was also noted that he improved during the day. The other evaluations were all either meeting or above expectations, or outstanding.

Reinstatement with Training Extended

[213] The remediation letter identified three options upon the completion of the remediation period. These were:

- reinstatement as a resident, with training extended as recommended by the Program Director and the Residency Program Committee based on time lost due to unsatisfactory performance;
- an additional period of remediation; or
- placed on probation.

[214] Upon completion of Dr. Kelly's remediation rotation, he was reinstated with training extended. Dr. Kernahan agreed, in cross-examination, that if she had had concerns about Dr. Kelly, the process would have permitted her to put him into an additional period of remediation, and that if he had failed, she would have had the option to either put him into an additional period of remediation or place him on probation.

[215] However, since Dr. Kelly passed the rotation, he was moved into the family practice ward rotation with Dr. Kason, commencing the beginning of July 2006.

[216] Dr. Kernahan agreed that Dr. Kelly's first rotation (paediatrics) in Kelowna (November 1, 2005 to December 18, 2005) was shorter than a standard eight rotation because of his late start into the Program. He had the full eight weeks for his remediation rotation and passed it.

Family Practice Rotation Evaluation

[217] On May 10, 2006, Dr. Kelly met with Drs. Kernahan and Newton, who advised him that he had failed his family practice rotation, and that he would be starting training with the SPH cohort beginning with a rotation on the family practice in-patient ward on July 1, 2006.

[218] The summary of his final formal family practice evaluation, prepared by Dr. Newton on July 19, 2006 and reviewed with him on July 20, states:

> In general, Carl is a hard working resident with a number of deficiencies. At Carl's mid-term evaluation he was advised that should he continue on his apparent performance trajectory he would likely pass his rotation. Unfortunately, the UBC Health Clinic preceptors do not feel that Carl successfully followed that trajectory and uniformly recommended that he fail his family practice rotation. On the evaluation scale of 1 to 10 Carl scored 5 or less on all of his competencies. Reasoning for this decision is described in detail in the following evaluation.

[219] The overall evaluation was Needs Improvement – Fail, with the comments:

> Carl is a hard working resident with a number of deficiencies. Carl has failed his Family Practice rotation. The team at UBC Health Clinic feels that he needs to demonstrate further improvement prior to proceeding. The team also feels that a dedicated one-on-one/resident-preceptor Family Practice rotation for remediation might better suit Carl's learning needs.

[220] As well, in addition to the identified weaknesses, the evaluation contained positive comments, such as "I believe that with time he will be able to attain the skills and professionalism necessary to complete his training." (see tabs 164-165)

May 12, 2006 – Dr. Kernahan's email to Drs. Sivertz and Rungta and Steps to Set Up Family Practice Ward Rotation

[221] On May 12, Dr. Kernahan emailed Drs. Sivertz and Rungta about Dr. Kelly and his remediation plan. In her email she noted:

> It's really going back to square one for this resident, even so, given some of the weaknesses documented in Christine Newton's evaluation, I am not optimistic about success.

[222] Despite her reservations, while Dr. Kelly was completing his paediatrics remedial rotation, Dr. Kernahan took steps to arrange his family practice ward rotation and integration into the SPH PGY 1 cohort, commencing July 1.

[223] Dr. Kernahan testified that when new residents arrive, they are assigned preceptors. On June 8, 2006, Dr. Kernahan emailed Dr. Calam advising that she was having difficulty finding a preceptor for Dr. Kelly. She inquired whether there was an alternative rotation that he could be scheduled on for the summer. She expressed hope that things would ease in the fall, and a place could be found in Vancouver for him to remediate his family practice rotation. She advised that if not, she would be approaching the PG Deans for an out-of-province rotation in the fall at an appropriate site.

[224] Dr. Calam replied that:

> We could insert him into the July orientation and have him work on the FP ward half time. If Jason Kason as acting Ward Director would be willing to supervise him. Perhaps we could give him a limited case load, and ask that Jason do a review with him on a regular basis (would there be an honorarium for Jason to do this?). I can ask him, and would feel better if there was something to "sweeten the deal".
>
> What do you think?

[225] Dr. Kernahan responded that she would be happy to provide an honorarium for mentorship. Dr. Kason agreed to supervise Dr. Kelly on the Family Practice ward for a rotation from July 1 to July 30, 2006.

[226] Dr. Kernahan explained that it had been difficult to find a preceptor for Dr. Kelly because all preceptors who agreed to take PGY 1 residents in their office had been taken. It was a required part of

the rotation for the PGY 1 to be assigned to a family practice teaching ward, and usually the preceptor would not receive an additional honorarium, such as Dr. Kason received for supervising Dr. Kelly. Regardless, the fact is that Dr. Kernahan was able, with reasonable effort, to find a preceptor for Dr. Kelly.

[227] In addition to retaining the services of Dr. Kason as preceptor, Dr. Calam, as SPH Site Director, started a series of weekly meetings with Dr. Kelly as of July 1. Dr. Kernahan testified that it was unusual for a Site Director to meet with a resident on a weekly basis.

[228] At some point, Dr. Kelly disclosed to Dr. Calam that he had a NVLD and difficulty in auditory processing. Dr. Kernahan was unable to recall if, when determining his training prior to July 17 (when reference to it is recorded by Dr. Calam in her notes), she considered his NVLD. Dr. Kernahan did say that she thought about providing a modified, more intensely supervised rotation, with fewer patients and more time to review with Dr. Kasan, with another resident on the ward to handle the work that needed to be done. She could not recall whether she knew Dr. Kelly had a NVLD with auditory difficulty at that time, and acknowledged that when she organized modifications to Dr. Kelly's program at this time, she had not spoken to his treating physician.

July 6, 2006 – Dr. Myers Contacts the Program

[229] While Dr. Kernahan had not spoken directly to Dr. Kelly's treating physician prior to organizing this rotation, on July 6, 2006, Dr. Myers contacted Dr. Knell, who was Acting Program Director in Dr. Kernahan's absence. Dr. Myers believes that they were discussing what assistance he might be able to provide as Dr. Kelly's psychiatrist. In particular, he was concerned that Dr. Kelly be followed closely in light of the past history of academic concerns. He was advised that Dr. Calam had arranged for Dr. Kason to assess Dr. Kelly's ability to take first call on the Family Practice ward, and that a second year resident would provide back-up call.

[230] Dr. Myers also agreed to speak to Dr. Andrew, who was Acting Site Director in Dr. Calam's absence, and did so shortly thereafter. He recalls that they spoke about close supervision of Dr. Kelly on the rotation. These were the first discussions that the Program had had with Dr. Myers since Dr. Whiteside's initial referral in January.

[231] In cross-examination, Dr. Myers was referred to notes of a July 25, 2006 meeting between Drs. Calam, Knell, Andrew and Kernahan which contain the following comment: "Dr. Andrew had also spoken with Dr. Myers who advised that Carl required close supervision while on call, and commented on "complete lack of insight into work record."

[232] Dr. Myers testified that he could not imagine that he said something like that. Dr. Myers did not recall the purpose of their conversation, except that he was trying to get a sense of how Dr. Kelly was

doing at work and whether or not he needed to do anything from his end as his psychiatrist. Dr. Andrew did not give evidence. I accept that Dr. Myers did not make that comment, and find it more probable that the notation reflects a comment made by Dr. Andrew.

July 24, 2006 – Dr. Kelly's Interim Evaluation

[233] On July 24, Dr. Calam spoke with Dr. Kason about his interim evaluation of Dr. Kelly (which had been completed on July 17). Her notes of that conversation state:

> Spoke with Dr. Jason Kason. He has done an interim verbal evaluation with Carl, and will send a written copy to me ASAP.
>
> He feels Carl is not lacking in knowledge, but that he has some difficulties in appreciating the "big" picture and bringing together an assessment and management plan. He made specific suggestions to Carl last week for improving areas of weakness, and he feels that Carl has followed his suggestions closely, and has shown steady improvement in his decision-making capacities and conduct. Dr. Kason will work with Carl this week to assess if he meets expectations for the FP Ward experience, keeping in mind that he is assessing Carl as if he were a "new" resident, and also taking into consideration that Carl needed to balance the demands of the July Introductory course with the FP Ward schedule.
>
> I emailed this information to Dr. Kernahan.

[234] Dr. Calam's email to Dr. Kernahan that day includes the following:

> Jason summarized his interim evaluation approximately as follows:
>
> C. has made some significant improvements over the last week on the Family Practice Ward in the areas that were pointed out to him as needing improvement. When he started on the ward, he didn't seem to lack basic knowledge, but seemed to have some difficulty in appreciating the "big picture" when undertaking diagnostic and management plans. He has taken all of Jason's suggestions for improvement very seriously, and has worked hard to address them, with steady improvement over the last week. Jason will be continuing to assess him this week, and will let him know this week if he meets/doesn't meet expectations prior to the summative evaluation at the end of the week.
>
> So my impression is that while Jason wasn't convinced that C. would pass the FPW rotation based on the first 10 days, he is now somewhat more favourably impressed, and will continue with the current structure and observations for the next 3 days and make a final decision by Thursday. I'll send you all documentation I receive ASAP.
>
> Perhaps we can chat about Plan A or B if he passes or fails the FPW, and if he passes, then what his next rotation should be: a typical CTU rotation, or something a bit more structured and supported? Let's talk about CTU....I have mixed feelings: on the one hand, it would be a straightforward well-structured typical brisk rotation that he'll have to tackle at some point, and he's already familiar with the hospital, emerg., some of the consultants, the computer system etc...On the other, it might be a real pressure-cooker if the attending happens to be uninterested in specific resident challenges and if there are so-so medical students requiring supervision by CK on top of the usual stresses of the rotation. I wondered if you might prefer something like having him shadow someone doing inpatient care (maybe Garey at MSJ???) for a couple of weeks while we try to get a preceptor for outpatient care organized.

> I also wonder if we should look at getting another psychoeducational assessment done with him: how recently was the last one done? Is it possible for me to take a look at it?

July 24, 2006 – Dr. Calam's Discussion with Dr. Kelly

[235] In Dr. Calam's notes of her discussions with Dr. Kelly, she wrote on July 24 that if he succeeded in meeting expectations on the family practice ward rotation, then he would try the CTU rotation. If he did not meet expectations, then they would consult with Dr. Kernahan and consider a further four weeks on the family practice ward, or a suitable alternative to allow him to strengthen areas of weakness.

[236] Ultimately, despite not meeting expectations on the family practice rotation, Dr. Kelly went on to a CTU rotation and was successful in that rotation.

July 25, 2006 Meeting

[237] On July 25, Dr. Kernahan met with Dr. Calam, Dr. Knell, and Dr. Andrew, the Site Director for the International Graduate Medical Program at SPH who had been acting for Dr. Calam while she was on holidays. The purpose of the meeting was to discuss Dr. Kelly's progress during his combined SPH site introduction and Family Medicine ward rotation in July.

[238] Dr. Kernahan recalled discussing that Dr. Kasan's mid-rotation evaluation indicated that Dr. Kelly was on a failing trajectory. I note, however, that Dr. Kason had also indicated that Dr. Kelly was showing improvement, and that Dr. Calam's email advised Dr. Kernahan of this observation.

[239] During this meeting, Dr. Calam summarized her earlier conversation with Dr. Kasan about Dr. Kelly's performance, and noted that she had referred Dr. Kelly to the Centre for Physician Renewal (the "Centre"). The Centre is funded through Providence and works with both physicians and hospital staff to deal with critical incidents and other types of physician stress.

[240] The physicians also discussed several negative observations or comments they had received about Dr. Kelly. For example, Dr. Andrews spoke about "unsolicited feedback" on Dr. Kelly that he had received from a clinical nurse leader. Dr. Knell discussed what the notes refer to as "an episode of disassociation during a behavioural medicine rotation" (which appears to an impressionistic observation since there was no reference to an actual diagnosis of such an episode). It was felt that Dr. Kelly required more intense supervision.

[241] Dr. Kernahan testified that there was discussion about what was the most appropriate rotation for Dr. Kelly at that point, and concern was raised as to whether he would be able to handle the CTU rotation.

[242] Dr. Kernahan testified that the group "turned our minds" to the suitability of a career in family medicine for Dr. Kelly. The notes of the meeting record the following:

> Discussion also took place regarding whether Carl would be able to function as a family physician. It was the opinion of the group, that, no matter the degree of supervision and modification of the program, Carl did not demonstrate the ability to practice independently, nor did he demonstrate the ability to take specific instruction/feedback from one rotation to the next (e.g. the issues of being available for call, being on time etc.) despite showing some improvement on a rotation with intense, specific feedback, such as he received at Mather regarding on call etc.

[243] They also discussed "our plan" and that Dr. Kernahan would meet with the PG Deans to discuss next steps. Dr. Kernahan envisioned further discussion with Dr. Myers regarding Dr. Kelly's ability to function and learn, Dr. Calam was requesting a neuropsychological assessment, and they spoke about the potential for having a rotation out-of-province in a designated family practice teaching unit. They also spoke about career counselling.

[244] In regard to Dr. Kelly being assigned the CTU rotation, they discussed Dr. Myers' advice that Dr. Kelly could become fatigued on call and needed supervision. Since CTU utilized a team approach, they discussed changing the role of the team, provided the supervisors would agree to such a change.

[245] They also discussed the telephone calls that Dr. Knell and Dr. Andrews had had with Dr. Myers earlier in the month.

[246] It is clear that by July 25, and well prior to receipt of the Gibbins report, that Dr. Kernahan and others had already formed the opinion that "no matter the degree of supervision and modification of the program", Dr. Kelly would not be suitable for a career in family medicine. Despite Dr. Kelly's subsequent success in rotations and the expert advice of Dr. Gibbins, he was unable to dispel this perception.

Discussion with Dr. Sivertz

[247] After this meeting, and on the same day, Dr. Kernahan spoke with Dr. Sivertz. Dr. Sivertz made the following notes of that conversation, which set out the Program's plan at that time:

- Neurological assessment?
- Permission to talk to Mike M.
- Possibility of a rotation out of BC is ok
- Letter from Mike M. asking for accommodations
- Allow him to do CTU rotation.

[248] Dr. Kernahan arranged to meet with Dr. Kelly and Dr. Calam on July 28. She testified that everyone was in agreement with neuropsychological testing. Dr. Kernahan also testified that she felt the information from that assessment was necessary to determine how to proceed with Dr. Kelly.

[249] Dr. Kernahan explained that while the option of looking for a rotation outside of British Columbia had been discussed, she made no inquiries in that regard. She indicated the sequence would

be to obtain the neuropsychological assessment and then look for the out-of-province placement. However, she also acknowledged that once she got the neuropsychological assessment, she still did not look for such a rotation. Rather, the Program asked for an IME. She further testified that, after Dr. Kelly was put on leave in September, she felt there was no reason to pursue such inquiries.

July 26, 2006 - Dr. Calam's Discussion with Dr. Myers

[250] On July 26, Dr. Calam spoke with Dr. Myers about obtaining the name of an individual to conduct a neuropsychological assessment. Her notes of the conversation state:

> Re: neuropsych testing. Dr. Meyers could suggest a name of a consultant to consider – I will check with Dr. Kernahan regarding funding – possibly [illegible] ext. Health benefits might be able to pay, if not, look for potential funding from within the res. program.

[251] Dr. Kernahan testified that Dr. Calam checked with her about funding for the assessment, and that she agreed to fund it. She also stated that it was not "normal" to provide such funding. I note there was no evidence about the actual cost of the assessment, the Program's budget, or what, if any financial constraints were faced by the Program in funding the assessment.

[252] Dr. Myers' notes of the conversation state that Dr. Calam had noted mixed behaviours on Dr. Kelly's part, but that Dr. Kelly had made significant improvements on the family practice ward and "pulled himself up" since July 17. It was noted that Dr. Kelly was applying specific feedback and learning, and that Dr. Sivertz had indicated that Dr. Kelly should continue rotations. Dr. Calam asked whether Dr. Kelly had any health restrictions and Dr. Myers replied that he did not, regarding his mood disorder. There was no comment about ADHD.

[253] Dr. Myers testified that he was "okay" with Dr. Kelly continuing his rotations. He felt that Dr. Kelly was not clinically depressed to the point that Dr. Myers was worried about his safety with his patients. His notes contain the comment that "Dr. Kasan says 'no lack of safety', but he does not recall what was meant by that statement.

July 26 – Dr. Calam's Inquiry about Health Restrictions to Dr. Myers

[254] Dr. Calam emailed Dr. Myers after that conversation, requesting a "short letter" outlining his opinion on "any restrictions for health reasons that you feel would be necessary for the resident in his next planned rotation," which was CTU (internal medicine). The letter would be provided to Dr. Kernahan.

[255] In her email, Dr. Calam described CTU as fairly busy with an often moderately heavy workload. She stated that the call was often busy enough to prevent the resident from getting a few hours of sleep in 24 hours. After describing the rotation, she asked Dr. Myers to note if any modifications were warranted, such as a change in call frequency/duration, time for physician/health monitoring visits, or

similar things. She noted that she would only "forward-feed" health-related restrictions to the rotation supervisor in order to ensure an unbiased educational assessment as well as the resident's and patient's safety.

[256] Finally, on Dr. Kernahan's behalf, Dr. Calam asked if Dr. Myers could facilitate a referral for a neuropsychological assessment for Dr. Kelly.

[257] Dr. Myers responded later that day with suggestions about Dr. Kelly's CTU rotation. These included, but were not limited to:

- Regarding his health, when he gets especially busy and/or tired, he is at risk for irritability, inner frustration and disorganization. This could affect his clinical judgment with patients and their families. Because of the potential for this to happen while he's on call, I think it is important for the senior resident and/or attending to be able to step in and provide more supervision and/or assistance. The resident himself told me he would find this reassuring, knowing that the supervisor could help out without judging him adversely. He fears that if the supervising person knows that he has some 'special needs' then that person would immediately jump to the conclusion that he is 'dangerous'. I tried my best to disavow him of that thinking.
- I will see him weekly over the next while to monitor closely his health. Those will be 30 minutes visits and maybe his supervisor could be appraised of the need for him to be away from his duties for this time. My office is right here at the hospital so that's easy. If he's not doing well then we can make modifications if we need to.
- I agree re repeat and more detailed neuropsychological testing. I will explore this. Funding may be necessary and very helpful. I want to find a psychologist who has experience testing and advising physicians with this type of problem.

[258] The suggestions also included steps that Dr. Kelly should take, including asking for help as required. Dr. Myers further noted that Dr. Kelly's pattern is to improve with time. Dr. Myers did not recall Dr. Calam or anyone else from the Program getting back to him with any questions about his recommendations.

[259] Dr. Calam forwarded Dr. Myers' response to Dr. Kernahan the next day.

[260] Dr. Myers testified that he was supportive of further neuropsychological testing for Dr. Kelly. He felt that if this could be done by someone in the Greater Vancouver area who was an ADHD expert, then the findings could assist in planning a course of action for Dr. Kelly, and would also be helpful to assist him in the medications he was using to treat Dr. Kelly, the form of psychotherapy that might be helpful, and to set out suggestions for support in the educational or workplace environment.

[261] Subsequent to this email, Dr. Myers contacted Dr. Margaret Weiss about Dr. Kelly. As will be discussed later, Dr. Gabrielle Weiss, who is the mother of Dr. M. Weiss, ultimately ended up seeing Dr. Kelly in 2007 and provided an assessment report. Dr. Myers identified both individuals as experts in ADHD in both children and adults.

[262] Dr. Myers also saw Dr. Kelly on July 26, 2006. He was not certain whether he discussed the letter he had written to Dr. Calam with Dr. Kelly, and could not recall, explain or expand upon many of the references in his notes. In regard to a notation about "no wellbutrin" and anxiety, he did recall that, at some point, he took Dr. Kelly off this drug and that it makes some people anxious. He also stated that it is not a medication that is usually prescribed for anxiety.

July 27 and 28, 2007 – Dr. Kason's Final Evaluation of Dr. Kelly

[263] On July 27, Dr. Kason completed a detailed written narrative evaluation of Dr. Kelly's family practice ward rotation. He attached this narrative to the formal standardized evaluation which he completed on July 28. The narrative contained the following summary:

> In short, Carl has difficulty multitasking. He has trouble anticipating potential issues. He has few solid approaches to different chief complaints. It seems that Carl cannot manage without direct instruction. Carl does well if he is told exactly what to do but seems that he cannot transfer those principles to other mildly similar situations. This rotation was unique in that Carl was continually supervised and was having to deal with the SPH orientation month sessions, I believe that if Carl was the sole resident on the ward this month he would have failed this rotation.

[264] The evaluation did not indicate whether Dr. Kelly had passed or failed. Dr. Calam wrote on the formal evaluation form "NB – ask Jason if he could support a "fail" or a "can't decide". The note did not ask whether Dr. Kason could support a pass.

[265] Dr. Kason added the following addendum to his evaluation:

> Given that the Family Practice Ward Rotation that Carl just completed was not a typical FP Ward rotation, I cannot say whether or not he failed the rotation. What I can say is that Carl needs further assessment and evaluation before any firm conclusions can be made.

July 28, 2006 – Dr. Calam's Discussion with Dr. Kason and Meeting with Dr. Kelly

[266] On July 28, Dr. Calam had a further discussion with Dr. Kason about his evaluation of Dr. Kelly. Her notes state:

> D/W Dr. Kason. He feels that Carl had insufficient time on the FP ward for him to decide on pass/fail. He recommends further evaluation time, as Carl had a somewhat more abbreviated rotation than a "usual" R. FPW rotation given the July intro that he also attended.
>
> He will send his final eval, narrative report, and a follow-indication of the above.

[267] Also on July 28, Dr. Calam and Dr. Kernahan met with Dr. Kelly. Dr. Calam's notes record the following:

> We discussed Carl's interim eval on FP Ward rotation, and how it pointed to similar areas needing improvement in his FP [illegible] rotation that he subsequently failed.

> We noted Dr. Kason's verbal indication of improvements and we awaiting the final evaluation.
>
> We have organized a CTU rotation to start next week ideally, and he is keen on this path.
>
> We also note that he needs to apply for and rewrite his MCCQEI and he is aware to apply to the Oct/Nov 06 exam held in Vancouver. We reviewed the letter that Dr. Myers sent regarding any restrictions for health-related reasons for CTU and he is in agreement that we forward a letter to his CTU Attending to notify him of the health restrictions. The letter will be worded in a way that does not disclose specifics of health concerns, but does give some clarity around possible modifications needed for the rotation.
>
> We will F/U as soon as we have confirmation on the start time and team/attending.

[268] Dr. Kernahan explained that they were discussing Dr. Kelly's interim evaluation and that the areas identified as needing improvement were the same as the ones identified in his previous rotation at the UBC family medicine clinic. They were awaiting Dr. Kason's final evaluation and noted his verbal indication that there was some improvement. It was also confirmed that they would organize a CTU rotation starting the next week, and they talked about Dr. Kelly applying to write the medical council qualifying exam, which he had failed at the end of medical school. They also spoke about advising the CTU attending about Dr. Kelly's restrictions and necessary modifications.

July 28 – Dr. Kernahan's Comments on the Final Evaluation

[269] In a July 28, 2006 email, Dr. Kernahan commented on Dr. Kason's evaluation as follows:

> I note Jason did not commit to a pass or a fail. However, it is NOT a pass. If this is what he is comfortable with, then its OK. There are still lots of red flags in the report, particularly with regards to things like [other resident] report about the discharge order, since a previous similar concern had been previously documented in the mid rotation evaluation so Carl was aware of the expectations regarding D/C orders.
>
> What we will have to do is decide what we would need to do to move him to a pass or fail. Most likely this would be more time on the rotation. Because of the time away from the ward to attend the July orientation, Carl has had less overall clinical time on the ward than other PGY 1's.
>
> Could you chat with Jason to see what he feels would be appropriate action and how much time it would take to allow a definitive decision to be made about Carl's performance. Perhaps another month on the ward when [name] is back, with clear expectations that Carl performs at the level of his peers. He has had the intro, been closely supervised and received lots of formative feedback but now he must demonstrate that he is at a Fam Med PGY 1 level. This will be easier for [name] as he has a lot more experience evaluating than Jason.

[270] Also on July 28, Dr. Kernahan sent the following email to the Medical Education Acting Coordinator and Dr. Calam regarding the CTU rotation:

> I'm assuming [name], that you will send the letter regarding health restrictions to [name]? Or is there an attending or supervisor that it might be more appropriate to coordinate with?

[271] Dr. Calam sent Dr. Kernahan the following email in reply:

> Thanks Jill: we'll send the letter as soon as we find out who the attending is.
>
> FYI Jason called, and he is more comfortable with recommending further evaluation rather than a fail, given that the rotation was more structured and put less typical demands on the resident than usual. He would favour another rotation, (perhaps with [name] down the line) where the resident is expected to perform the way any R1 would. He'll send a note to that effect.

[272] Dr. Kernahan testified that, based on her consideration of this information, she was of the view that Dr. Kelly would require a rotation that was at a level more comparable to what "all the other residents were doing" to demonstrate whether he would pass or fail.

August CTU Rotation

[273] Dr. Kelly commenced the CTU rotation in August. During the CTU block, the resident is not in the clinic, but remains in the hospital. It is a clinical teaching unit, so there is no assigned preceptor. The residents are divided into teams, with a physician overseeing the clinical unit or group of patients. The teams are generally set up a year in advance. Dr. Kelly was added to the clinical teaching unit, which has some flexibility in its numbers. Again, the evidence demonstrated that the Program was able to accommodate Dr. Kelly's rescheduled rotations.

[274] Prior to the commencement of the CTU rotation, Dr. Calam emailed the rotation supervisor requesting specific accommodations based on Dr. Myers' July 26 email.

[275] The letter Dr. Calam wrote states, in part:

> I have received a note from Dr. Kelly's personal physician outlining some health-related issues that may arise during his rotation. He will be expected to attend weekly 30-minute visits with his physician, which will take him away from clinical duties for brief periods.
>
> Dr. Kelly also may request some additional support from his Senior Resident or Attending during periods of time when he is particularly tired. I have suggested to Dr. Kelly that he request assistance during those times to review cases and to seek advice regarding his management plans for patients. He may also occasionally request time for rest, within PAR BC guidelines, should he have a particularly demanding 24 hours on duty.

[276] Consistent with Dr. Myers' recommendations, modifications were made to the call system in the CTU rotation. Dr. Kelly passed this rotation. Dr. Kernahan testified that no other accommodations proposed by Dr. Myers had been put in place prior to this point.

[277] Dr. Myers had also recommended Dr. Gibbins to do the neuropsychological testing. Dr. Kernahan was trying to ensure it moved forward, and Dr. Kelly advised her that it would be scheduled once he concluded the rotation.

Dr. Myers' August Visits with Dr. Kelly

[278] Dr. Myers saw Dr. Kelly on several occasions in August 2006. On August 18, his notes indicate that he added a medication to Dr. Kelly's drug regime. Dr. Myers agreed in cross-examination that, by this time, certain medications were helping Dr. Kelly, but that he did get tired postcall so one of the medications was increased.

[279] Towards the end of August, Dr. Kelly advised Dr. Myers that he had received an evaluation and was "relieved by it". Dr. Myers could not recall whether or not he was contacted by anyone from the Program about Dr. Kelly around this time. He testified that it is his practice to make a record of such contact, and since he has no notes of any contact, he believes it did not occur.

August 28, 2006 –Internal Medicine/CTU Pass

[280] On August 29, 2006, Dr. Kelly emailed Dr. Myers a copy of his CTU evaluation. The evaluation had the notation "pass" on it, but also noted that it was provisional as "two weeks is too short a time to adequately evaluate any adult young professional." Amongst other things, it noted that he had worked "extremely hard", that the charge nurse was impressed with his dedication to patient care, that he had been improving his notes, and that his knowledge was not an issue. It also stated that Dr. Kelly should be given the opportunity to perform, and be evaluated, outside the highly structured CTU environment.

September Emergency Rotation Successful Completion

[281] Dr. Kelly commenced his Emergency rotation in September, ending September 24, 2006. He passed that rotation.

Attempts to Find Family Practice Preceptor for Next Rotation

[282] During September, Dr. Kernahan was trying to find a family practice preceptor to do a remedial family practice medicine rotation with Dr. Kelly following the Emergency rotation.

[283] She had received an email from Dr. Calam, dated September 6, 2006, which contained the following comments on Dr. Kelly's progress, after noting that he had just passed his last two rotations:

> I see from the evals that he seems to demonstrate a consistent pattern of difficulty integrating knowledge into an action plan, difficulty presenting information, and is slow, inconsistent and continues to miss important learning opportunities like rounds and fails to consistently respond to pagers and attempts to locate him. There are positive comments about his hard work and honesty. He seems to need improvement in most of the evals, although nobody has outright failed him on any final eval. I don't see any change over time, and am inclined to believe that he has a significant neuropsychological/learning disability that prevents him from being able to integrate manage and present clinical knowledge, make clinical judgements or respond to pages and/or requests in a timely manner.
>
> What I am seeing here makes me feel that the bottom line for evaluation will be found in a regular outpatient family practice clinic that exposes him to the real world, with no special supports or circumstances other than the necessary ones for his and patient

> safety. I don't know what [name]'s practice is like from that perspective. [Name] would be ideal. Also, 3 Bridges might be helpful, but I think it would need to be a special contract that would give the preceptor some protected time to do more intense in depth evals...
>
> I'm feeling that it is getting close to time for the bottom line, so that if he isn't able to meet expectations, he can find some support for the next steps and his decisions about his career.

[284] It is evident that, despite the fact that Dr. Kelly had just passed his CTU rotation (which was the first rotation that specifically incorporated accommodations suggested by Dr. Kelly's psychiatrist), Dr. Calam was also less than optimistic about Dr. Kelly's ability to successfully complete his training.

[285] Dr. Kernahan responded to this email as follows:

> I agree with all you have said Betty.
>
> I did approach [name], but he had already worked with Carl in the Mather Clinic and refused to supervise him further. Perhaps 3 Bridges is the way to go. [name] was going to speak with [name] to see if she was interested but otherwise might fit him in her clinic.
>
> If I hear anything I'll let you know.
>
> Any word on the neuro psych assessment yet?
>
> This guy is costing us a fortune!!!

[286] Dr. Kernahan subsequently emailed Dr. Calam and the Medical Education Coordinator on September 8 about plans for Dr. Kelly's rotations. In her email, she criticized the "short speciality rotation" evaluators and contemplated what the Program would do if Dr. Kelly was successful in passing his rotations. Specifically, she stated:

> Do we have a rotation for Carl to do after the 24th?
>
> Betty, you had mentioned 3 Bridges, the other alternative is a real fam med ward rotation since he doesn't have a pass on that yet.
>
> What we are seeing here I think, is a tendency for the short speciality rotations to give passes as they don't really have the capacity for in depth evaluation that we have in the more extended or supervised blocks. I think we have a good grasp on this fellow's problems, and from an overall on going point of view, if he passes all his rotations, will then have to consider what to do in terms of a global assessment of his functioning as a physician, and what one would put in a letter to the CPSBC about his abilities as a physician.
>
> I haven't heard back from [name] yet about Raven Song as a site for family medicine. It turns out that [name] as a preceptor for greater Vancouver has a resident already.
>
> I think its almost time to explore Plan B, ie sending Carl out of province for family med. This will be hard to arrange, plus I still would like to see the neuro psych stuff so we can do some planning, so if we can put in place 3 blocks of rotations (perhaps a one month 3 bridges could be remedial) this would help greatly.

[287] The Medical Education Office replied that day, indicating that while no plans had been made for Dr. Kelly after he finished the emergency rotation, contact could be made with 3 Bridges to see if

they had any availability for a four-week rotation. Dr. Kernahan considered that to be a reasonable approach. However, she went on to testify that she was unable to arrange a preceptor for Dr. Kelly. In that regard, she commented that the Program recognized that Dr. Kelly needed a modified rotation, but they were not able to find anyone able to do that within their practice setting which, for that rotation, was a physician's private office.

[288] I note, however, that on September 12, 2006, Dr. Calam sent the following email to Dr. Kernahan:

> Hi Jill:
>
> Just spoke with Todd, and the only time he could fit CK into a remedial 3 BR rotation would be Jan 15-Feb 11, 07. He wants to know within the next 4 weeks if we need the spot.
>
> So we could try instead for 4 weeks surgery starting on the next rotation Sept. 25, and then leave it open for you to work out with the PG Deans the 3 month remedial FP office-based experience.
>
> As a wild card, what would you think about calling on one of the really experienced rural preceptors to do a 1-2 month rural remedial? I'm thinking [names]?? Just a thought. They may be swamped with rural residents, but boy are they good at evaluation!

[289] This email makes it clear that there were scheduling options available that could have been pursued by the Program. Such options were not pursued. Rather, once an email that Dr. Kelly had sent to some other residents on August 4, 2007 came to the attention of Dr. Calam in September, he was placed on study/educational leave and never returned to the Program.

[290] In cross-examination, Dr. Kernahan explained that she did not take any further steps to organize a rotation at Three Bridges for the New Year because "it was five months away" and they had not yet received the neuropsychological testing report. When it was drawn to her attention that Three Bridges had indicated that a rotation could be in place for January 15 to February 11, she then stated it was not arranged because "I don't arrange rotations."

[291] Dr. Kernahan also testified that Three Bridges would not, in her view, have given Dr. Kelly a rotation in family practice as it would count as an inner city medicine rotation. She described it as a specialty family practice rotation, and said it would not replace the required family practice rotation within the SPH site. No explanation was provided, however, as to why it could not have been scheduled as an inner city medicine rotation.

[292] In cross-examination, Dr. Kernahan also agreed that she did not follow up on Dr. Calam's "wild card" suggestion of a rural preceptor. She said she considered it and concluded it was not appropriate as a remediation. She had a specific concern about whether a rural preceptor would have the time to provide the level of supervision that Dr. Kelly required, but acknowledged that she did not make any

inquiries to determine whether they did, in fact, have the time and would be prepared to commit to do so.

[293] Dr. Kernahan further agreed that she never arranged the additional assessment in family practice. She explained that "as things transpired," there was no point in pursuing it. She stated that "if things had continued" on a successful trajectory, it might have been different. She also agreed that this decision was made after the CTU rotation which Dr. Kelly passed, and during the emergency rotation, which he also then passed.

[294] When asked to explain why she did not consider this to be a sufficiently successful trajectory to try the family practice remediation, she testified that the email incident occurred at this time and, in consultation with the PG Deans, they put Dr. Kelly on leave because of that incident and suspended their attempts to find any rotations for him.

Discussions about Dr. Gibbins Between Dr. Myers and Dr. Kelly in September

[295] Dr. Meyers continued to regularly see Dr. Kelly throughout September. His notes record that on September 14, 2006, Dr. Kelly emailed him with questions about the neuropsychological testing. In particular, he noted that he had been in contact with Dr. Gibbins, who had some questions about what kind of testing the faculty wanted him to do. Dr. Kelly inquired whether Dr. Myers would be willing to speak directly with Dr. Gibbins, or whether he should have either Dr. Calam or Dr. Kernahan call him.

[296] Dr. Myers recalled speaking with Dr. Gibbins at some point, during which he advised Dr. Gibbins that Dr. Kelly was his patient, explained the difficulties Dr. Kelly was having in the Program, and noted that Dr. Kelly had had previous neuropsychological testing. However, Dr. Myers did not recall what, if any, action he took in response to Dr. Kelly's September 14 email.

[297] He does recall that he considered Dr. Gibbins to be "very important", and was hoping that an assessment or report from Dr. Gibbins would help him regarding Dr. Kelly's actual clinical treatment, as well as provide direct guidance to Dr. Kelly and to the Program.

September 14-15, 2006 – Email Incident and Study Leave

[298] On or about September 14, 2006, Dr. Calam received a copy of an email that Dr. Kelly had sent to fellow students at VAC (Vancouver Academic Curriculum) on August 4, 2006. Based on information provided to her by a resident, she recorded "grave concerns" about Dr. Kelly's psychological status, the "psychological safety" of his peers and the potential impact on other persons. She shared the contents of the email with Dr. Kernahan and it was determined to suspend arrangements of any further clinical rotations for Dr. Kelly, pending discussion of the situation with Dr. Kernahan, and the PG Deans.

[299] I pause to note that no investigation was undertaken to assess whether any of the information provided to Dr. Calam, apart from the email, was reliable. There is no evidence that Dr. Kelly was advised

of the information provided to Dr. Calam by the resident (except for the email), or given any opportunity to respond to it.

[300] Drs. Kernahan, Calam, and Sivertz met on September 15, 2006. Dr. Calam communicated her concerns to them, and advised that she would like to arrange neuropsychological testing as soon as possible to understand "concretely the nature of his educational difficulties, and their possible relationship with his style of communication with his educational colleagues."

[301] Also on September 15, 2006, Dr. Calam emailed a summary of next steps to Dr. Kernahan (which included the cancellation of any further rotation planning, fast tracking neuropsychological testing with Dr. Gibbins and an IME from an arms-length psychiatrist), and requested that a copy be sent to Dr. Sivertz. Dr. Kernahan forwarded the email to the PG Deans (Drs. Sivertz and Rungta).

[302] Handwritten on the email are a number of comments, including the following:

> PGY 1 – ... <u>pervasive</u>, <u>repetitive</u> issues of erratic function, poor integration of info, poor learning from previous errors and supervision. Repeat very modest improvement on rotations so will borderline pass but no generalization of learning to new rotations or new venues.
>
> ...
>
> - He is known to be seeing Mike M. who wrote a letter to program saying for medical reasons, he should not be allowed to get fatigued.
> - various supervisors have said "he's odd", "we can't read him, "he does not communicate/read people normally", "we don't think he is suited to medicine."
>
> They had asked him to have neuropsych testing
>
> Then the big issue last week with the group email to PGY 1
>
> It strikes me as having
>
> i) an undercurrent of violence
>
> ii) subtle thought-form disorder.
>
> The aggressive and sexual themes are consistent with psychotic MS.

[303] It should be noted, at this point, that there was no evidence of any violence, or any diagnosis of "subtle thought-form disorder" or psychosis in regard to Dr. Kelly. In my view, these comments, Dr. Calam's earlier comments, and the referenced comments from the supervisors, are examples of stereotypical labelling and rushes to judgment when faced with an individual who has a little-understood disability. The supervisors' perceptions and the speculative diagnosis in the absence of any examination or testing, were never raised with Dr. Kelly, and he never had the opportunity to respond to them. These perceptions, however, were the background against which decisions were being made about his future.

[304] The notes go on to itemize what the writer knew about Dr. Kelly, which included that were some learning challenges, that there had been an issue with a prescription and an email, and that arrangements had been made to meet with Dr. Kelly.

[305] Also itemized was further information the Program needed to understand about Dr. Kelly, including his background in more detail, obtaining a second opinion and doing the neuropsychological testing, and having time to reflect on this information before moving forward. It is my understanding that the notes were written by Dr. Sivertz, though they are identified in the document index as from Dr. Kernahan. Nothing turns on whether Dr. Kernahan or Dr. Sivertz, who is a psychiatrist, wrote the notes. What is significant is that the notes reflect an assessment by an authoritative individual within the Program.

September 18, 2006 – Dr. Sivertz' and Dr. Myer', Discussion

[306] On or about September 18, 2006, Dr. Myers received a phone call from Dr. Sivertz. She told him about the August 4 email incident, advised him that they were extremely concerned about the content of the email, that it had been hurtful of fellow residents, that there had been some inactivity by recipients to take action, but she had been made aware and it seemed "as if things were escalating."

[307] Dr. Myers' notes record that the Program "sat on" on the email because it did not do anything about it, or at least contact Dr. Kelly, until over a month later. His notes also state that he supported a second opinion from an independent psychiatrist or psychologist, but he could not recall whether he or Dr. Sivertz suggested a second opinion. He recalled that Dr. Sivertz, who is a psychiatrist and former colleague of his, were conferring about an IME since he was the treating psychiatrist and it would be better to have someone who could give an independent opinion about Dr. Kelly. Dr. Sivertz advised him that they would be meeting with Dr. Kelly and Dr. Myers arranged to meet with him after that.

[308] Dr. Sivertz advised Dr. Kernahan about her conversation with Dr. Myers. It was arranged for the Gibbins report to go to both Dr. Kernahan and Dr. Myers.

September 21, 2006 – Meeting with Dr. Kelly

[309] Dr. Kernahan met with Dr. Kelly on September 21, 2006, together with Dr. Calam and Dr. Sivertz. Dr. Calam's notes of the meeting record, and Dr. Kernahan agreed, that Dr. Kelly had been advised that the plan was that he would "consider" an educational leave of absence so that he could complete the neuropsychological testing; that a second opinion would be sought from someone other than his treating physician to assess his psychological status; that he could assist in obtaining his undergraduate records; and he would study for the MCCQE Part I exams that he had previously failed. Dr. Kelly agreed to this. When he inquired about a timeline, he was advised that decisions would be made once the appropriate information was in place.

[310] The notes of that meeting also record a discussion about Dr. Kelly's email, his explanation for it, and how he could apologize to his peers as way of "clearing" the air. Dr. Kelly explained that the email was satirical and that his language was not meant to be denigrating or negative. He had not intended for anyone outside his peer group to see the email. They discussed a process to address the issue by having him apologize to his peers, and a process to address any group dynamic issues that had resulted from the circulation of the email. A "reparative approach" was adopted to the situation, and Dr. Calam was going to consult with other persons for directions on how best to approach the reparative process. She asked Dr. Kelly to await the results of that consultation.

[311] Plans were made for follow-up once the assessment process was underway, and Dr. Kelly was advised to see his personal physician for ongoing support. He was also advised that since he was on an educational leave, he was not expected to attend usual program sessions until he received the "go-ahead" from Dr. Sivertz.

[312] There is no indication in this communication that Dr. Kelly was going to be disciplined in any way for the email, nor any evidence that any disciplinary action was taken at any point. Rather, the matter was approached from a remedial perspective.

[313] Dr. Kelly commenced educational leave following his last shift in emergency on September 24, 2006.

September 21, 2006 – Dr. Myers' Visit with Dr. Kelly

[314] Dr. Myers also saw Dr. Kelly on September 21, after Dr. Kelly's meeting with the Program representatives. He recalled discussing the email incident with Dr. Kelly, and recorded that Dr. Kelly told him "they're going to give me some time off" and that Dr. Kelly wondered whether it would be all of November. Dr. Kelly indicated that he would use the time to study.

[315] Dr. Myers recalled reading the email in Dr. Kelly's presence. Dr. Kelly explained that he felt he was being satirical and humourous in the email, but that it was obviously not received that way. He referred to it as "Irish humour" and told Dr. Myers that he now understood why it could be considered offensive.

[316] Dr. Myers did not develop any treatment plan for dealing with the incident because Dr. Kelly had told him that he already contacted one or more of the people who had been offended, that he had apologized profusely and that he had met with someone in authority about it.

September 22, 2006 - Apology

[317] Dr. Kelly subsequently emailed the SPH R1 residents on September 22, 2006 apologizing for the email and explaining the context in which he had written it. A copy of that email was also provided to Dr. Calam.

[318] Dr. Calam emailed Dr. Kelly on September 27, 2006 expressing her appreciation at his motivation to rebuild ties with his group. She also indicated that she would be seeking advice as to how best to address any group issues.

[319] There was no evidence called by UBC to dispute the context in which the email was written as outlined in Dr. Kelly's apology to the residents. Considering this context, and its "over the top" tone, while I find the email to be inappropriate, I also consider that it was most probably written, as Dr. Kelly explained, as a satirical comment on recent discussions within the VAC group (including what he described as a debate on the taking of a patient's sexual history), and was not a serious reflection of his own views.

[320] Having said this, the email was inappropriate and UBC acted responsibly in cautioning Dr. Kelly not to engage in such communications, and in addressing the recipients about it. It over-reacted, however, in making hypothetical psychiatric judgments about Dr. Kelly, which were ultimately not sustained by any medical evidence. I also note that the Program received an email from the majority of Dr. Kelly's resident group expressing their view that his removal from class activities, based on the email, may be an over-reaction.

September 25 - October 2006 – Visits with Dr. Myers

[321] Dr. Myers continued to see Dr. Kelly while he was on leave.

[322] When he saw Dr. Kelly on September 25, Dr. Kelly was very angry and frightened. Dr. Myers was reassuring. There was no change to Dr. Kelly's medications.

[323] Dr. Myers again saw Dr. Kelly on September 27, during which time they again discussed the email, and Dr. Kelly expressed contrition and concern that it had been circulated beyond his first year peer group. He felt angry, bad, frightened and embarrassed in reaction to the situation. A further appointment was scheduled for two weeks later.

[324] Dr. Myers again met with Dr. Kelly on or about October 10 (the date is not clear on the exhibit). At that time, Dr. Kelly advised that he had spoken with Dr. Rayner, the Associate Dean of the UOA, regarding the provision of his educational records, and that most of the psychological testing had been completed by Dr. Gibbins, with the balance to be done by November 22 or 23. Dr. Myers was looking forward to seeing the report and the results of the testing undertaken by Dr. Gibbins.

[325] Dr. Myers next saw Dr. Kelly on or about October 13. Dr. Kelly was not sleeping well at this point in time and, amongst other things, was questioning what he should do in the future. Dr. Myers increased his medications.

November 2006 - Debriefing Session

[326] In November 2006, Dr. Kelly was advised by fellow residents that a "debriefing session" had been held the week before about the email. He mentioned in a November 21 email to Drs. Calam and Kernahan that he had spoken to each of his fellow residents and they had seemed happy to see him and informed him the debriefing session had been productive and put the email issue to rest. While he had expected to be invited to the session and had not been advised of it, he expressed appreciation that the issue had been resolved. He also inquired when he would be starting his next rotation.

[327] In her response to him, Dr. Calam did not disabuse Dr. Kelly of his understanding that the email issue had been dealt with. She advised him that the Program continued to await the results of the neuropsychological report and to then determine next steps.

[328] Dr. Kernahan acknowledged in her evidence that Dr. Kelly kept her up-to-date on the status of the neuropsychological assessment, and that he continued to comply with her directions regarding the assessment and remaining on leave.

[329] Dr. Kernahan also acknowledged that as of November 21, Dr. Kelly had released his undergraduate records, and the two outstanding matters were the neuropsychological report and the IME. She further acknowledged that, while Dr. Sivertz had undertaken to arrange an IME for Dr. Kelly, by end of November, no date had yet been scheduled.

November 22, 2006

[330] Dr. Myers again saw Dr. Kelly on November 22. During that visit, Dr. Kelly advised Dr. Myers that he had his final appointment with Dr. Gibbins the next day and then the report would be provided to UBC. He also noted that he had written his medical qualifying exams for the second time. Dr. Kelly passed those exams.

December, 2006 – Inquiries upon Resumption of Residency

[331] Dr. Kelly emailed Dr. Kernahan in early December advising that Dr. Gibbins' report should be available shortly and again asking for some indication about when he might resume his residency.

[332] In an email dated December 5, 2006, Dr. Kernahan advised Dr. Kelly that she would need to review the report, and then try to plan out his next rotation before she would know the date of his return. She doubted that this would occur before Christmas.

[333] Based on the foregoing, I conclude that the email issue had been "put to rest" by the apology and debriefing session. No investigation was undertaken in regard to any of the residents' comments about Dr. Kelly. No disciplinary action was taken against Dr. Kelly. Rather, as noted by Dr. Calam in her earlier email, a "reparative approach" had been adopted by the Program. Steps were still underway to

obtain further medical information and to then plan Dr. Kelly's next rotation after a review of that information.

The Gibbins Report

[334] The Program received Dr. Gibbins' report in late December or early January. Dr. Kernahan reviewed the report and thought that it was useful to know that Dr. Kelly had been diagnosed with ADHD and a NLVD. She also noted that the diagnosis was the same as the information provided by Dr. Drebit to Dr. Whiteside.

[335] Dr. Kernahan felt that the report confirmed what they had seen in Dr. Kelly's clinical performance, and let them know that Dr. Kelly's deficits were life-long.

[336] Dr. Kernahan also felt, after reviewing the accommodations recommended by Dr. Gibbins, that the Program had already made changes in Dr. Kelly's program that reflected many of the accommodations. She testified that she also "realized" that it was not possible for the Program to make the other accommodations recommended by Dr. Gibbins.

[337] Despite this conclusion, Dr. Kernahan did not recommend Dr. Kelly's dismissal from the Program until August 2007. She explained the delay on the basis that there remained an unanswered question as to whether Dr. Kelly was fully and adequately treated, and that this was a question that was going to be answered by the IME examiner. If, for example, he required different medications that could have improved his function, then that information might have made a difference to her recommendation. She agreed in her evidence that she did not receive an answer to that question prior to recommending Dr. Kelly's dismissal from the Program.

Dr. Myers' Reaction to the Gibbins Report

[338] Dr. Myers recalled that he received a copy of Dr. Gibbins' report, dated November 28, 2006, and reviewed and considered the recommendations in his treatment of Dr. Kelly. He considered the report to be extensive.

[339] Dr. Myers testified that he was very impressed with the sophistication of the Gibbins report, and felt "very respectful" of its findings, particularly since there had been a long interview process and testing. Dr. Myers stated that the report confirmed that Dr. Kelly met the criteria for a DSM-IV diagnosis of ADHD and explained some of the difficulties that Dr. Kelly had been reporting to him. Dr. Myers felt that it was important to maintain Dr. Kelly on a psycho-stimulant. He testified that, at this point, it was becoming clearer that Dr. Kelly was not going to be invited back to the Program and he was becoming increasingly demoralized and angry.

[340] Dr. Myers did not make any recommendations for Dr. Kelly's treatment to anyone based on the Gibbins report, and was not asked by anyone to make recommendations, modifications or restrictions for Dr. Kelly based on the report.

[341] In his report, Dr. Gibbins recommended that Dr. Kelly would benefit from working with a counsellor or coach who was experienced in working with people with ADHD. Dr. Myers testified that he was not providing the type of goal-directed, focussed counselling to Dr. Kelly that was recommended by Dr. Gibbins.

[342] Dr. Myers does not recall when he received a copy of the Gibbins report, and he agreed, in cross-examination, that he may not have received it until August 2007, which was well after Dr. Kelly had advised him on February 23, 2007 that he could not release any information to UBC. I find it more probable that Dr. Myers received the Gibbins report at or near the date it was released. The report was significant to Dr. Kelly and they were continuing to discuss his relationship with the Program and resumption of his residency.

[343] Having said this, what is significant from my perspective is not when Dr. Myers received the Gibbins report, but that the Program did not contact him, either directly or through Dr. Kelly. While Dr. Kelly withdrew his consent in February for Dr. Myers to speak to the Program about his health, this did not preclude the Program from requesting Dr. Kelly to have Dr. Myers provide it with current information about his medical condition and any limitations or accommodations that could affect his residency, particularly when it had identified Dr. Kelly's medications as an issue it required more information about, prior to determining whether to recommend he be dismissed from the Program.

January Discussion with PG Deans

[344] Dr. Kernahan sent the Gibbins report to the PG Deans Office in or about the third week of January. She also sent the following email to Drs. Sivertz and Rungta on January 23, 2007:

> I have sent the report in paper copy, but wanted to let you know where I see problems delivering the kind of support needed for this learner within the Family Medicine program and within Family Medicine as a career. The main identified difficulties seem to relate to relative weaknesses in retaining verbal memory of things heard only once, relative difficulty retaining visual information, difficulty aligning priorities, missing social cues, and deterioration of function under time duress.
>
> All these, of course are important both in Family Medicine training and practice. It seems plausible that there might be a nice practice that this individual might fit into once he graduates, however, we have to train him to meet the requirements for a full license. Providing the educational experience necessary will be challenging, particularly if we try to incorporate Dr. Gibbons recommendations of things such as a longer familiarization period, more time or repeated exposure to new material, clear written instructions and clear specific goals for an activity (I read this as something far more detailed than a list of objectives at the beginning of a rotation) and "learning all the steps involved in a new task with minimal time constraints."

> As we know, this individual spent 5 months on what was to be a 2-month rotation in Family Medicine, and still did not achieve the objectives of the rotation.
>
> Although the suggestion of a one on one preceptorship for the fam med rotation may work from Carl's learning perspective, the reality of our family medicine teachers is that they are for the most part in FFS practices that would not allow this kind of time commitment from a preceptor. Even if the supervision was remunerated there is the issue of ongoing practice demands.
>
> One possibility might be a community clinic, however, in that environment there are complex, challenging patients, multiple preceptors and multiple learners, and again, time constraints, so that too would not be ideal.
>
> I'd appreciate meeting with you and Betty some time to discussion our options in this regard.

[345] In my view, this email demonstrates Dr. Kernahan's resistance to providing Dr. Kelly any further opportunity to be successful in the Program, in part because it was challenging to make the necessary arrangements. While it may have been challenging, there was evidence that it had been possible to do so on the family practice ward rotation.

[346] Dr. Kernahan also had conversations with the PG Deans about how next to proceed. Subsequently, the IME was finally scheduled with Dr. Stephen Kline for February 23 to see if any modifications to Dr. Kelly's treatment might help his performance. However, the IME did not take place.

[347] By this time, Dr. Kelly had contacted PARBC, who commenced communications with the PG Deans and Dr. Kernahan on behalf of Dr. Kelly.

February 1, 2007- July 2007 – Dr. Kelly's Interactions with Dr. Myers and PARBC and the Weiss Reports

[348] The evidence about events between February 2007 and the recommendation to dismiss Dr. Kelly from the Program in August, was primarily in regard to Dr. Kelly's continued visits with Dr. Myers, PARBC discussions with Dr. Myers and the PG Deans and the Weiss reports. I will briefly review these.

[349] Dr. Myers saw Dr. Kelly on February 1, 2007. Dr. Kelly advised him that he had consulted PARBC, and its Executive Director was going to meet with Dr. Sivertz. Dr. Kelly also advised that he had an IME scheduled with Dr. Kline, a psychiatrist, for February 23. Dr. Myers modified Dr. Kelly's medication.

[350] Dr. Myers testified that he had not been contacted by anyone in the Program since his conversation with Dr. Sivertz in September 2006. He noted, however, that by February 23, 2007, Dr. Kelly had advised him that PARBC had instructed him not to release any information either orally or in writing to UBC. Dr. Myers stated that Dr. Kelly's mental state at this time was "not good", with excessive ruminating, fears he was going to "crack", insomnia, and feeling traumatized.

[351] The appointment with Dr. Kline was subsequently cancelled.

March 2, 2007

[352] Dr. Myers, with Dr. Kelly's consent, spoke to PARBC's Executive Director on March 2, 2007 by telephone about Dr. Kelly. During the call, he recommended Dr. M. Weiss for a second opinion on Dr. Kelly, ADHD and his continued participation in the Program. Dr. Myers also recommended additional psychological testing for Dr. Kelly, including a projective test and personality inventory. He recalled there had been a concern about Dr. Kelly regarding a breach of professionalism respecting a prescription, as well as the inappropriate email. He thought that this type of testing might reveal whether Dr. Kelly had a personality disorder. He was careful to say that this was not something he was picking up as his psychiatrist.

March 29, 2007

[353] PARBC arranged for Dr. Kelly to see Dr. G. Weiss, and advised the PG Deans of this assessment. The PG Deans advised PARBC that it did "not require Dr. Weiss's opinion on Dr. Kelly's being able to successfully finish a Family Medicine residency training program or any other discipline", but that it would welcome her opinion on the Gibbins report, and specifically "if any or all of the accommodations listed would be amenable to therapeutic interventions and in what time frame."

June 2007 – Dr. Myers speaks to Dr. G. Weiss

[354] Dr. Myers subsequently spoke to Dr. G. Weiss in June 2007. Dr. G. Weiss had seen Dr. Kelly and advised that she would send Dr. Myers her report. She also advised Dr. Myers that she thought Dr. Kelly could continue his residency with accommodations.

[355] Dr. Myers later received and reviewed a report from Dr. G. Weiss dated May 23, 2007. He considered the report to be thorough. In it, Dr. G. Weiss confirmed a diagnosis of ADHD, NVLD and an adjustment disorder, anxiety. She also noted that Dr. Kelly had no "disorder of thought content or form."

[356] She stated that changes in Dr. Kelly's medication would be required over time, and that she would be meeting with Dr. Kelly to discuss strategies for coping with both ADHD and anxiety. Dr. Myers speculated that Dr. Kelly might have been referred to cognitive behaviour therapy, which he had not been doing with Dr. Kelly.

June 4, 2007 – Letter from Dr. G. Weiss

[357] Dr. Myers also received and reviewed a letter dated June 4, 2007 from Dr. G. Weiss which detailed her conclusions regarding Dr. Kelly. It is similar, but not identical, to her May 23, 2007 report. The May 23 report was not addressed to anyone, and is the date on which Dr. G. Weiss conducted her assessment of Dr. Kelly. It is possible that the May 23 report are her draft notes of that assessment, but the reasons for the differences in the reports were not explored in the evidence. The differences are not material, except for her final suggestion, and I note that the PG Deans received both reports. Dr. Myers testified that the differences did not arise as the result of any prior discussion with him.

[358] In the June 4 letter, Dr. G. Weiss noted that Dr. Gibbins had conducted a comprehensive psychoeducational assessment in November 2006, which resulted in a detailed report and several suggestions which "would enhance Carl's possibility of success in the rotation."

[359] Her suggestions were as follows:

> i) To continue with current medication.
>
> ii) Accommodations described in great detail in Dr. Gibbon's report from the psychoeducational assessment if carried out would definitely enhance Carl's ability to profit from the program he is in. Possibly these accommodations can be worked out between PAR BC and the medical school. It seems they are ready to work with Carl to enhance his ability to profit from his training program. I wish him success in the program.

[360] Dr. Myers did not take any action in response to this report and was not requested by Dr. Kelly or UBC to provide the Program any comment on it.

June 7, 2007 – PG Deans Await Receipt of Weiss Report

[361] On June 7, 2007, the PARBC Representative sent Dr. Myers an email which contained the following paragraph:

> I believe it is important for you be fully informed as to what likely lies ahead as I think it will be a difficult time for Carl because it is my impression UBC will not let him back voluntarily. In fact, it is my understanding that the program was set to terminate him for unsuitability and would have done so had I not convinced the PG Deans to wait on the report from Dr. Weiss. But, Dr. Rungta was quite clear. The final decision is up to the program, and I am not optimistic, assuming Dr. Weiss' report is positive for Carl, that UBC will revise its assessment that Carl is unsuitable for FP. In all honesty, I believe the decision was made a while ago and UBC is simply going through what it believes to be due process prior to making its final decision. That being said, ever the glass is half full type of person, I am cautiously optimistic that should Dr. Weiss' report be favourable, essentially support and supplement Dr. Gibbins' report, that I may be able to convince UBC to put in place the necessary accommodation to allow Carl the opportunity to successfully complete training.

[362] I accept that, based on discussions between PARBC and the PG Deans, UBC was awaiting the Weiss report prior to making a final decision regarding Dr. Kelly's residency. (See also paragraphs 48-49 of the ASF.)

[363] Dr. Myers testified that he was encouraged that something might be done to accommodate Dr. Kelly, and he continued to treat him. He would have been willing to discuss Dr. Kelly further with the Program, provided he had Dr. Kelly's consent, and if it had contacted him. He does not recall anyone doing so, or inquiring about any restrictions or modifications to Dr. Kelly's training after Dr. Weiss' report.

June 12, 2007 – Discussion with PARBC

[364] On or about June 12, 2007, Dr. Myers spoke with the PARBC Representative and Dr. Kelly. He believes that he was told during this discussion that Dr. Rungta had advised that the Program "very much" wanted to terminate Dr. Kelly as unsuitable. He recalls the PARBC Representative stating that if this occurred, Dr. Kelly could appeal the decision and that it would be a human rights case. It was the PARBC Representative's understanding that the Program based its conclusion of unsuitability on Dr. Kelly's ADHD. They also discussed that if Dr. Kelly was terminated, he would receive benefits, but no salary and, because he did not have a licence, he would not be able to practice medicine.

July 20, 2007 – Visit with Dr. Myers

[365] Dr. Myers saw Dr. Kelly on July 20, 2007. He believes the PARBC Representative was also present and that they reviewed Dr. Weiss' report. Dr. Kelly was now on medical leave, having previously been on educational leave.

[366] Dr. Myers was advised that Dr. Weiss' report had been sent to Dr. Rungta.

[367] There was some modification to Dr. Kelly's medication arising out of this visit.

August 2007 – Discussion of Part-Time Residency with PARBC Representative

[368] Dr. Myers next saw Dr. Kelly, together with the PARBC Representative, toward the end of August. They reviewed the Gibbins' report and its recommendations to the Program. They discussed accommodations that would allow Dr. Kelly to complete his residency, including a part-time residency. This would require more time for him to acquire the same degree of skill and proficiency, and he would not be able to see as many patients as a resident who does not have ADHD.

[369] Dr. Myers could not recall who suggested the option of a part-time residency and candidly acknowledged that neither he, Dr. Kelly or the PARBC representative were experts in family medicine or the operations of a family medicine program. However, they were wondering about the feasibility of such an approach.

[370] Dr. Myers saw Dr. Kelly once more in August, at which time they discussed his activities of daily living and his medication. They also discussed developments with the Program. Dr. Myers testified that he observed a "big" clinical difference in Dr. Kelly compared to when he saw him in April 2006 when Dr. Kelly had stated he had never felt so good. In Dr. Myers' view, by August, the "life had gone out of him," he had a deflated sense of self, was demoralized, sad, humiliated and not very hopeful.

Dismissal Recommendation

[371] On August 8, 2007, Dr. Kernahan prepared a package of material, which included Dr. Kelly's file, and sent it to the Family Practice Department Head, Dr. Woollard. She recommended Dr. Kelly's dismissal from the Program. Her letter is as follows:

I am sending along this resident's file for your review. After careful consideration, review with the Resident Performance Subcommittee of our Postgraduate Education Committee, and discussion with the Postgraduate Deans, I feel we must move to dismiss this resident for unsuitability for training as outlined in the Resident Evaluation and Appeals Policy of the Postgraduate Dean's office, Section 8. Immediate Dismissal "unsuitability for training".

"8.1 Sections 6 and 7 of this Policy document the usual procedures for when a Resident's weakness is remediable. However, there will be instances in which Residents may be deemed by the Program Director to be unsuitable for the program for reasons that cannot be remediated. Such reasons may include, but are not limited to, the following:

(a) The lack of a basic skill (such as physical dexterity in the case of a surgical specialty);

(b) The presence of a personality problem related to the Resident's ability to practice medicine;

(d) Conduct unbecoming a member of the medical profession; or

(e) Other qualities of the Resident which make them unfit for the practice of medicine.

8.2 The decision to dismiss a Resident because they are unsuitable for the program is made by the Program Director but must be approved by the Head of the Resident's Department in the Faculty of Medicine prior to any action being taken."

In this case, I believe section 8.1 a is applicable.

I have enclosed Dr. Kelly's file for your review. Subsequent to his difficulties on clinical rotations, the Program obtained a neuropsychiatric assessment to better determine his abilities and to see if we could reasonably accommodate his needs. The report is in the file.

The Program has already made several accommodations for Dr. Kelly including moving him from the Rural Site in Kelowna to Vancouver, lengthening an 8-week rotation in Family Medicine at UBC clinic to 20 weeks, attempting to reintroduce him to the program by placing him in the St. Paul's site in the July 2006 introduction and hiring a preceptor to provide intensive supervision and training on the Family Practice ward at St. Paul's.

Dr. Kelly has been on leave from the Program since September of 2006 following an incident regarding a disturbing email sent by him to the resident group. This is documented in Dr. Kelly's file.

The Postgraduate Dean's Office had arranged a second psychiatric opinion for Dr. Kelly subsequent to the psychologist's assessment in the neuropsychiatrist report of October/November 2006 to determine if any modification in Dr. Kelly's treatment could improve his function. On the advice of Par-BC this was cancelled by Dr. Kelly, and after some delay was rescheduled with another psychiatrist. Dr. Kelly has requested that this not be shared with the Program.

I will be drafting a letter of dismissal for review with you, the Postgraduate Deans and University Council.

I would appreciate it if you could review the file as soon as possible as I need it to write the letter of dismissal.

[372] It bears emphasizing that the basis of the dismissal recommendation in this letter was 8.1(a), which is that Dr. Kelly lacked a basic skill (such as physical dexterity in the case of a surgical speciality). The basic skill(s) that Dr. Kernahan had concluded Dr. Kelly lacked was (were) not identified in this letter.

[373] It should also be noted that while the IME with Dr. Kline had been cancelled, the PG Deans had agreed with PARBC to await the assessment of Dr. G. Weiss. Dr. Weiss' report was provided to the PG Deans. Dr. Kernahan indicated in her letter that she had discussed Dr. Kelly with the PG Deans (who had the opportunity to review the report). Given Dr. Kernahan's evidence about the ongoing discussions between herself and the PG Deans, it is reasonable to infer that she was aware of the Weiss reports, or at least aware that the PG Deans were awaiting receipt of a further report on Dr. Kelly. Dr. Kernahan did not disclose this information to Dr. Woollard.

[374] I also note that the documents provided to the Tribunal indicate that the Resident Performance Subcommittee (the "SubCommittee") meeting was held on August 23, 2007, which is well after the date of Dr. Kernahan's letter to Dr. Woollard, and after she had already made the decision to dismiss Dr. Kelly from the Program. This is not consistent with the information she provided to Dr. Woollard. Dr. Kernahan also did not indicate in her letter that, prior to going on leave, Dr. Kelly had passed his last two rotations.

[375] The reference to a policy in the letter was to the Policy previously identified in this decision. As noted earlier, sections 6 and 7 ("Identification of Weaknesses and Remediation" and "Probation", respectively) of that Policy apply when a resident's weakness is remediable. The only evidence that the Section 6 or 7 process was applied to Dr. Kelly was in respect of the paediatrics rotation, where he signed a remediation letter which detailed several measures that had been implemented to support and supervise him during the remediation. As noted earlier, Dr. Kelly passed that remedial rotation.

August 8, 2007 – Dr. Woollard's Reply

[376] On or about August 8, Dr. Woollard replied to Dr. Kernahan by way of a handwritten note. In this note, he states:

> Like you, on the basis of the documentation available and brief periods of clinical work with Dr. Kelly, I feel we must come to the conclusion that his performance is not consistent with a successful career in Family Practice. The neuropsych assessment tends to re-enforce the observation that it is precisely situations of unstructured uncertainty requiring a broad ability to synthesize, prioritize and apply diverse solutions that enhance his anxiety and compromise his performance. It would be unfair to him and to his future patients to pretend that we could provide an educational program to correct a deficiency which is described by Dr. Gibbins as "...neurodevelopmental disorders which are lifelong..." (p. 10). Like you, I wish him well in such alternative paths as his life may take him but share the reluctant conclusion that we would be failing our social obligations if we were to persist in trying to produce and at risk practitioner.

[377] In my view, this email demonstrates the Program's focus on the fact that Dr. Kelly had a "life-long" disorder, and its relative disregard for Dr. Gibbins' advice that, amongst other things, with increased time and familiarization, he would expect the effect of the disorder to be reduced.

August 23, 2007 – Family Residency Subcommittee Meeting

[378] On August 23, 2007, the SubCommittee, which included residents, considered whether, as a Program, it would recommend to the PG Deans that Dr. Kelly be dismissed for unsuitability.

[379] The question posed to the SubCommittee was:

> Should we as a program move to recommend to the Postgraduate Deans that this resident be dismissed for unsuitability for training? Reason being that this resident has a learning disability and that further accommodation cannot be made to allow him to meet the learning objectives of the Program? If accommodations are made, it is just a different route for the resident to finish as a proficient family practitioner as others do? The resident has had difficulty through most rotations.

[380] The SubCommittee discussed Dr. Kelly's health issues, progress, challenges, and other matters. The SubCommittee meeting minutes include the following:

> *Have any further reports been received from Dr. Gibbons?*
>
> Dr. Gibbons was a consultant hired by the program so there is no ongoing relationship with the resident and Dr. Gibbons. Resident has a treating physician with whom they have ongoing contact. If the resident was to return to work, the program (as an employer) could request a note stating that the resident is fit to return.
>
> *Is there any indication that the resident was going through any other difficulties (family circumstances, anxiety, depression) outside of medicine that may have affected their performance?*
>
> These ongoing difficulties during the past two years are similar to troubles over seven years of medical school. Dr. Gibbins' report gives a lot of personal detail and doesn't allude to anything extenuating.

[381] I find the latter statement rather remarkable, given that the Gibbins' report disclosed a diagnosis of ADHD, a NVLD, a history of anxiety and dysthymia and suggested numerous accommodations that might assist Dr. Kelly in successfully completing his residency. I also note that the Program did not have ongoing contact with Dr. Kelly's treating physician and had not, in fact, spoken to Dr. Myers since September 2006. As well, I note that the minutes do not contain any review of either specific limitations to implementing Dr. Gibbins' recommendations, or ways in which the recommendations might be implemented to facilitate Dr. Kelly's successful completion of the Program. Rather, it was approached from the general perspective of "Program has done everything possible", "obviously unsuitable", "...many accommodations – where are we going with this."

[382] After this discussion, the question before the SubCommittee was reframed as "Do we feel we are comfortable recommending to Postgraduate Deans, in harmony with item 8.2 of the Resident

Evaluation and Appeals Policy November 2004, that the resident be dismissed because of unsuitability for training in Family Medicine?"

[383] The Committee decided to recommend that Dr. Kelly be dismissed because of unsuitability. The Minutes record the meeting concluding with the following discussion:

> Program Director commented on being struck by how many people had interacted with this person and how uniform the opinions are. Shows how far this resident has gone in the program. Further comments ensured that as site directors and trainers of future family physicians, they had a real duty and obligation to make this decision, as difficult as it may be for the resident in question, but absolutely right in view of patients and the public. This is a reminder that preceptors require education and reminders to be courageous and 'call a fail a fail.' Remediation and intervene early. This is a sad situation of a snowball effect from first year medical school to now, 10 years later.

[384] Dr. Kelly was not invited to this meeting, and was not provided any opportunity, either in writing or otherwise, to respond to any questions from any SubCommittee member. No physician who had treated Dr. Kelly was asked to participate in the meeting, or to provide any clarification or answer any questions from the SubCommittee members. There was no evidence in the minutes, or in other evidence presented during this hearing, that Dr. Kelly's medical care had been harmful to either a patient or the public. Further, despite the criticism of the preceptors' evaluations, the fact is that qualified physician educators, who had personally observed and assessed Dr. Kelly, had passed him in several rotations (including a remedial rotation).

[385] I also note that much of the discussion recorded in the minutes was anecdoctal and not based on a qualitative assessment, unlike Dr. Kelly's evaluations and the Gibbins and Weiss reports.

August 23, 2007 – Letter to PG Deans

[386] On August 23, 2007, Dr. Kernahan sent a detailed letter to PG Deans setting out her recommendation to dismiss Dr. Kelly from the Program for unsuitability. While this letter does not refer to a specific subsection of s. 8.1 of the Policy, Dr. Kernahan testified, as noted earlier, that she was not recommending Dr. Kelly be dismissed because of a personality disorder or because of conduct unbecoming a member of the medical profession.

[387] The letter reviews Dr. Kelly's history with the Program and notes, in particular, the following:

- Dr. Kelly entered the Program in October 2005 after being matched to the rural site in the 2005 Carms match.
- Dr. Kelly's graduation from the University of Alberta was delayed, which resulted in first rotation, paediatrics, being only two weeks (or blocks) rather than four weeks. He failed this rotation.
- Dr. Kelly was scheduled for two blocks of family medicine at the UBC clinic in Vancouver. Certain accommodations were made, and his rotation was extended from two blocks to almost five. Dr. Kelly did not pass this rotation.

- Dr. Kelly was transferred from the rural site and assigned to the St. Paul's site, to start with the 2006-2008 cohort. A modified program that allowed increased supervision was planned.
- Dr. Kelly remediated his paediatric rotation. He received a pass, needs improvement on one block of Paediatric Emergency and passes, meets expectations, on two weeks each of intermediate Nursery and community Paediatrics.
- Dr. Kelly was assigned to a family practice rotation in July 2006. The evaluator could not pass (but also could not fail) Dr. Kelly.
- Dr. Kelly then did one block on CTU Internal Medicine at St. Paul's, where he received a pass, needs improvement.
- Dr. Kelly went on to do one block of Emergency where he received a pass, meets expectations.

[388] Dr. Kernahan went on to state that the majority of residents receive "pass, meets expectations." She also noted that an issue had arisen regarding an email sent by Dr. Kelly in September 2006, after which he went on study leave, "with a plan to seek a psychological assessment, funded by the Program, to further understand Carl's educational challenges."

[389] Dr. Kernahan went on to review Dr. Gibbins' report, and Dr. Kelly's diagnosis of ADHD and NVLD. She specifically noted that:

> Dr. Gibbins' report sets out a number of accommodations that could help Carl in his training, including a longer familiarization period, clear instructions, ideally in writing, recipes or templates to follow, minimal time constraints to complete tasks, identification of areas of special interest and ability for Carl to pursue, counseling and a one on one preceptor resident rotation in Family Practice.

[390] She also reviewed areas in which Dr. Kelly might have challenges that could impact his ability to train and practice as a family physician. In Dr. Kernahan's view, the Program had already made significant alterations to Dr. Kelly's program to accommodate his special learning needs, and she felt that several of these alterations aligned with Dr. Gibbins' recommendation. These alterations were identified as:

(1) The move from the rural site to Vancouver;

(2) The use of the UBC clinic over a private practice;

(3) Scheduling longer than usual appointments at the UBC clinic;

(4) Extension of the family medicine rotation from two blocks to almost five;

(5) The hiring of a one on one supervisor for the Family Medicine ward;

(6) A reduced patient load on the family medicine ward;

(7) Re-entering the Program via the St. Paul's introductory month to associate him with a new peer group; and

(8) Modification to on call requirements and supervision during the CTU/internal medicine rotation.

[391] Dr. Kernahan then reviewed the accommodations that had been suggested by Dr. Gibbins and explained either why she believed the accommodations had already been implemented, could not be implemented, or if implemented would not assist Dr. Kelly and would undermine the academic and clinical goals of the program. I will review her explanations in detail shortly.

[392] Dr. Kernahan concluded her letter by stating:

> Even if it were possible for the Program to provide the level of accommodation requested by Dr. Gibbons we do not believe that Dr. Kelly would be able to successfully complete the family medicine training program, or be successful in future practice. As Dr. Gibbons' report states, Carl's deficits are life long.
>
> Family medicine is a field that requires dealing with multiple complex problems in a short time frame. To be successful in Family Medicine residents, and practicing family physicians need to have a broad ability to synthesize, prioritize and apply diverse solutions to a myriad of problems. Time stresses and multiple complex problems are part of the daily practice of family medicine. Juggling multiple tasks, accessing infrequently used information, retaining verbal information heard only once, dealing with complex social situations, the ability to pick up non verbal cues and understand social nuances are crucial to success in training and practice.
>
> We hope that there may be some other avenue that Dr. Kelly can pursue that is more consistent with his abilities or that can more readily accommodate his limitations. Despite our, and Dr. Kelly's considerable efforts, we have concluded that Dr. Kelly should be terminated from the program on the basis of unsuitability.
>
> Thank you for your consideration of the termination, and with your help throughout this process.

[393] There is once again emphasis on the fact that Dr. Kelly's disabilities were life-long, and a rejection of the potential positive impact that Dr. Gibbins' recommended accommodations might have on Dr. Kelly's ability to successfully perform within an environment that requires dealing with multiple problems, prioritizing and applying diverse solutions, particularly with increased familiarity with that environment.

[394] I will review Dr. Kernahan's response to Dr. Gibbins' recommended accommodation in detail.

Dr. Kernahan's Response to Dr. Gibbins' Recommended Accommodations

- *Longer Familiarization Period*

[395] The first recommended accommodation by Dr. Gibbins stated, in part, that Dr. Kelly "may at times need a longer familiarization period and may benefit from more time or repeated exposure to new material if he has difficulties initially." Dr. Kernahan explained that this indicated to her that he would need a longer time on rotations and meant that he would not be functioning as an equal with the other trainees of his level who are expected to appear on the rotation after a half-day orientation and take on their rotation responsibilities from that first day. She testified that if Dr. Kelly was not able to take on full responsibility initially, the rotation would need to be lengthened and this would have a negative impact on other learners in the program. She stated that if Dr. Kelly did not take a full load,

then the load would fall on other learners. There was also an issue as to who would supervise him and provide the longer familiarization period. As a result, Dr. Kernahan testified that she did not believe that they could implement that recommendation on an ongoing basis.

[396] I note, however, that she provided no specific example of any resident's progress in the Program being negatively affected as a result of any accommodation made for Dr. Kelly. As well, while there was evidence that she encountered difficulty in securing a supervisor at times, she ultimately was able to do so. I also note that the evidence demonstrated that in CTU and emergency, the rotations were able to be structured so as to accommodate Dr. Kelly, and that he passed both those rotations.

[397] In cross-examination, Dr. Kernahan agreed that Dr. Gibbins had not stated that Dr. Kelly would require a longer familiarization period for every rotation. She agreed that she did not investigate this, or telephone or write Dr. Gibbins for any clarification about whether a longer familiarization period would be required for every rotation. The evidence demonstrated, and Dr. Kernahan's prior experience with Dr. Kelly was that, in fact, a longer familiarization period was not required for the CTU or emergency rotations, both of which Dr. Kelly passed.

[398] In my view, Dr. Kernahan inaccurately interpreted this recommendation in assuming that it meant "a longer familiarization period with each rotation". She also based her rejection of it on a subjective perception of its potential impact on other learners, rather than any objective evidence of a negative impact. Further, while she indicated in her letter that a longer familiarization period would "significantly interfere" with Dr. Kelly's ability to function as a part of a team, she provided no objective evidence of such interference.

- *Clear Instructions, Ideally in Written Form*

[399] The next recommendation was that Dr. Kelly would benefit from clear instructions, ideally in written form, stating what he is intended to accomplish and making clear the specific goals of an activity.

[400] Dr. Kernahan testified that, given the manner in which teaching is done on inpatient clinical rotations, instructions are virtually always verbal (e.g., teaching clinical bedside medicine). She explained information is imparted through discussion, and that there would not be someone available for those rotations to provide written instructions. She also explained that, unlike a medical student, a resident is expected to function independently during the day and to go about doing the tasks required of them.

[401] Dr. Kernahan did not provide any evidence about what, if any, inquiries she made to determine whether it is possible to provide written instructions for the general objectives of rounds or the specific goals of the rotation. I note that Dr. Kelly was provided with specific objectives and instructions for his remedial paediatrics rotation, which he passed.

[402] I also note that Standard B.6 requires the Program to provide feedback sessions, including face-to-face meetings, as part of the evaluation process and, if there are serious concerns, to inform the resident and give the resident an opportunity to correct their performance. It would be reasonable to assume that serious concerns would be communicated in writing.

[403] In my view, Dr. Kernahan took an overly broad approach to this recommendation. For example, she stated in her letter that "a resident who must rely on written instruction is not capable of meeting the fundamental goals of the program or of assuming the responsibilities of a family physician." However, Dr. Gibbins did not state that Dr. Kelly would need to rely on written instructions in practice, or that he required written instruction for every task. Dr. Kernahan would have known that this was not the case in the CTU and emergency rotations, and that general guidelines and objectives had been sufficient in the paediatrics remedial rotation.

- *Provision of a "Recipe" or Template*

[404] Dr. Gibbins also recommended that it "can often be beneficial to have a 'recipe' or template that Carl can follow to help supplement his working memory and help him recall the key steps in the process." Dr. Kernahan testified that she did not see family medicine as being reducible to templates. She stated that every case, and the circumstances surrounding it, is unique. She explained that when a physician sees a patient, they do not know why the patient is there and therefore, in her view, it is not possible to have a template regarding what the patient brings to the office that day. She also noted that on specialty rotations, templates are unavailable for the things that need to be done each day. She explained that the fundamental goal of family medicine is to produce a physician who can be rapidly adaptable to changing situations so that as a patient presents a history, the physician moves down a differential track and asks different questions based on every answer the patient is telling you. In her view, a template might be detrimental to this process.

[405] While Dr. Kernahan expressed the view that templates may not be practical, there was no evidence that she investigated whether the utilization of checklists, or general templates was possible, perhaps through the utilization of current technology. I also note that she approached this recommendation as if every matter required a template, as opposed to the provision of a clinical resource for reference as required. Further investigation or inquiry may have revealed practical alternatives that supported training.

[406] In my view, Dr. Kernahan again interpreted this recommendation rigidly and overly broad. For example, she stated in her letter that "templates for all problems presenting to a practice or for in patient work do not exist", and that a "resident who must rely on templates for practice is not capable of meeting the fundamental goals of the program or of assuming the responsibilities of a family physician." Dr. Gibbins' recommendation was not for a template for each problem, and he did not state that Dr. Kelly would need to rely on templates in practice.

- *Counselling*

[407] Dr. Gibbins had advised that Dr. Kelly would benefit from working with a counsellor or coach experienced in working with people with ADHD. Dr. Kernahan simply stated that "this was not something that was available for us to provide."

[408] However, in cross-examination, Dr. Kernahan agreed that Standard 3.6 provides that the Program must establish mechanisms to provide career planning and counselling for residents. She then stated that the Program met that standard, and that it did have mechanisms in place to provide career planning and counselling for residents.

[409] When it was put to her that she did not have any discussion with Dr. Kelly about an alternate career or counselling, Dr. Kernahan did not disagree. Rather, she stated that Dr. Kelly had been meeting with Dr. Calam, and she believed there was some discussion in Dr. Calam's notes that Dr. Kelly had been meeting with a mentor. Dr. Kernahan suggested that it was Dr. Kelly's mentor who would have taken on that role, and that the Program would not be privy to conversations between a mentor and a resident. Dr. Kelly's mentor was not, however, identified as an expert in ADHD, a career counsellor or any other type of professional counsellor. In the absence of any evidence that Dr. Kelly's mentor actually assumed such a counselling role, I am not prepared to infer such a relationship.

[410] There was no evidence that the Program actively engaged in any discussion with Dr. Kelly about the provision of the type of counselling that Dr. Gibbins recommended. There was also no evidence that the Program considered whether it could require Dr. Kelly to participate in such counselling as a condition of his continued residency, with or without cost to it.

[411] Dr. Kernahan also agreed in cross-examination that the Standards would not have prohibited the Program from discussing an alternate residency with Dr. Kelly prior to his termination. She further agreed that prior to terminating Dr. Kelly's residency, she did not have any discussion with him about an alternate residency, and agreed that other residents have switched their residency.

[412] Dr. Myers testified that he did not have resources available to him to facilitate the type of counselling recommended by Dr. Gibbins in his report. He stated that if he had been asked, he could have made inquiries to identify individuals trained and experienced in working with persons with ADHD to provide such counselling. The Program did not, however, request that he make such inquiries.

[413] Dr. Kernahan stated in her letter that "If Dr. Kelly were able to arrange counselling of this nature it is difficult to know at this point whether the recommendations of such counselling would need to be, or could be, accommodated by the Program." This is precisely the type of information that, had it been obtained, would have assisted the Program in assessing whether it was able to further accommodate Dr. Kelly.

- *Time Pressures*

[414] Dr. Gibbins noted that "it is most effective for people with ADHD to first concentrate on thoroughly learning all the steps involved in a new task with minimal time constraints, and then work on improving speed and fluency once the basic skills themselves are mastered."

[415] Dr. Kernahan testified that time pressures are part of family practice, both in residency and in clinical practice and that she knew "of no way to alleviate this demand". In her view, Dr. Kelly needed to be able to move quickly through each day. She stated that it was not possible to anticipate, at the beginning of the day, how much time might be needed for each patient, and there was always time pressure.

[416] I note, however, that the Program was able to modify a rotation to reduce the number of patients that Dr. Kelly saw, and that he did not fail that rotation (though he also did not pass). In addition, as noted by Dr. Gibbins, once a person with ADHD becomes familiarized in an area, speed increases. Dr. Kernahan seemed focussed on speed during residency, as opposed to the development of knowledge or skill.

[417] Once again, in my view, Dr. Kernahan interpreted Dr. Gibbins' recommendation overly broad in assuming that it would apply throughout Dr. Kelly's educational and professional life, rather than considering or investigating strategies or coping skills (e.g., such things as time management skills, anxiety management, part-time residency, recommending a condition of practice that he have a reduced patient load) that might have assisted Dr. Kelly to appropriately deal with the demands of residency and practice and to develop skill and knowledge first and speed second.

- *One to One Resident-Preceptor Rotation*

[418] Dr. Kernahan testified that the Program had arranged for Dr. Kason to spend increased time with Dr. Kelly to assist him on his ward rotation, but that this had not been successful. I note, however, that it was also not unsuccessful. Rather, Dr. Kason felt more time was required to properly assess and evaluate Dr. Kelly "before any firm conclusions can be made."

[419] Dr. Kernahan testified that eight months of the two-year Program is spent in private practice, so the physicians teaching for the Program also have responsibilities to their patients and must address a number of needs related to patient care, office operation, etc. In her view, it would not be possible for one of the Program's teaching family physicians to decrease their clinical responsibilities to the level required to supervise Dr. Kelly without adversely affecting their clinical practice and compromising their ability to provide the services they are required to provide to their patients. She noted that they had asked a number of practising physicians to undertake this responsibility, without success, and had also looked at community clinics.

[420] Dr. Kernahan testified that when she was attempting to find a placement for Dr. Kelly's family practice remediation rotation (while Dr. Kelly was in his emergency rotation), she canvassed both

community clinics and private practice physicians and was unable to find a placement for him. However, the evidence established that Three Bridges was prepared to provide a placement in early 2007 for four weeks (even if it was as an inner city rotation) and that she essentially stopped her efforts to find a placement in September 2006.

- *Pursuing Interests*

[421] Dr. Gibbins also recommended assisting Dr. Kelly to identify areas of specialization which were a particularly good fit for his interests and areas of strength. Dr. Kernahan rejected this recommendation. She explained that family practice residency is one that provides a comprehensive base in all the areas that a family practice physician requires competency. She stated that it is after graduation from the Program that the physician may choose a special area of interest, but not during residency. During residency, the resident is required to meet all expectations and outcomes in family medicine. No reasonable explanation was provided, however, as to why the Program did not, or could not, at least identify areas of specific interest with Dr. Kelly and provide support and encouragement in those areas. For example, there was no exploration of whether Dr. Kelly's mentor could play a supportive role in this regard if the mentor had been apprised of the situation.

[422] In cross-examination, Dr. Kernahan was asked whether there was anything in the Standards that prevented the implementation of accommodations or modifications as long as, at the end of the residency, the resident met the standards. She agreed that there was not. She also went on to state that there were other standards which were not provided to the Tribunal (e.g., "red book standards") that must be complied with (which, amongst other things, outline the rotations a resident needs to complete). If there was to be any modification to those standards, then approval would need to be obtained from the Board of Examiners of the College of Physicians of Canada. For example, if a resident could not do a specific rotation, a letter would need to be written seeking approval from the College for that modification. She agreed that she never sought approval for any accommodations or modifications from the College for Dr. Kelly.

[423] Dr. Kernahan agreed, in cross-examination, that the Standards required that residents "must be informed when serious concerns exist and given opportunity to correct their performance," and that the Program was required to comply with this Standard. As well, she agreed that Dr. Kelly was on leave from the time he completed his emergency rotation in September 2006 and that, after the Program received and reviewed the Gibbins report, he was not provided an opportunity to return in order to correct or address any performance concerns. Instead, he was dismissed for unsuitability.

[424] She also agreed that Dr. Kelly did not have the opportunity to return to the Program after the Weiss report in order to correct or address any performance concerns.

[425] Dr. Kernahan further agreed, in cross-examination, that she did not refer to, access, or research any of the resources that Dr. Gibbins had attached to his report and referred to in his last recommendation. She also did not contact any other family practice programs to explore whether they had any experience organizing accommodations for residents with ADHD. Finally, while Dr. Gibbins noted at the bottom of his report that, if there were any questions, to contact him, neither Dr. Kernahan nor anyone else from the Program contacted him to discuss his recommendations.

Program Modifications

[426] In her August 23, 2007 letter, Dr. Kernahan described various modifications that she said the Program had provided to Dr. Kelly. In cross-examination, she agreed that there were no modifications in place for Dr. Kelly's first paediatrics rotation in Kelowna. She further agreed that the first modification that was put in place was when Dr. Kelly moved from the rural site in Kelowna to the urban site in Vancouver. This was officially done in April 2006.

[427] Dr. Kernahan also agreed, in cross-examination, that when Dr. Kelly initially arrived in Vancouver, he first spent time in the Mather clinic and then the UBC clinic. She acknowledged that when she was referring to the use of the UBC clinic over a private practice as a modification, she was referring to the Mather/UBC Clinic rotation. She also agreed that the third modification she listed in her letter refers to the Mather/UBC clinic and the scheduling of longer than usual appointments. The fourth modification also was in relation to the Mather/UBC Clinic and the extension of that rotation from two to five blocks.

[428] Notwithstanding these five modifications, Dr. Kelly was not successful in the Mather/UBC clinic rotation. Dr. Kernahan agreed that the only involvement in structuring those modifications that the Program had had with Dr. Kelly's physician at that time was Dr. Whiteside's referral of Dr. Kelly to Dr. Myers. She also noted that the referral was as a private patient, and not as a consultant to the Program. She agreed that this was the only medical intervention during the first five modifications.

[429] Dr. Kernahan acknowledged that modifications five to seven at page three of her August 23 letter were in regard to the family medicine rotation with Dr. Kason (one-on-one supervisor; reduced patient workload and re-entering the Program via SPH). The last modification related to the on-call requirements on the CTU/internal medicine rotation. Dr. Kernahan agreed in cross-examination that there were no modifications in place during the emergency rotation. She also agreed that the last modification was the only modification made with the benefit of Dr. Myers' advice.

Response of PG Deans to Dr. Kernahan's Recommendation

[430] The PG Deans jointly approved Dr. Kernahan's recommendation and Dr. Kelly was dismissed from the Program for unsuitability. Dr. Kelly was provided no opportunity to respond to Dr. Kernahan's letter prior to the PG Deans reaching their decision.

[431] Drs. Rungta and Sivertz wrote to Dr. Kelly on August 29, 2007, advising that:

> After much effort and careful consideration of training accommodations, the Family Medicine Residency Education Committee, with the support of their Department Head, Dr. Woollard, has recommended that you be dismissed from further training.
>
> The Postgraduate Office is in support of this recommendation and so we are forwarding to your attention the letter from the Family Medicine residency program.

[432] Dr. Kelly was also advised that he could appeal this decision in accordance with the Policy.

[433] UBC provided no evidence as to what substantive consideration either Dr. Sivertz or Dr. Rungta gave to the Weiss medical reports in reaching their decision, except that the reports were provided to them prior to making their decision.

[434] Dr. Myers recalled receiving a copy of the PG Deans letter from Dr. Kelly. Neither Dr. Sivertz nor Dr. Rungta had contacted him prior to their decision.

September 6, 2007 – Grievance and Appeal

[435] On September 6, 2007, Dr. Kelly filed both a grievance and notice of appeal.

[436] The grievance proceeded to arbitration and was dismissed for the reasons set out in *Health Employers' Association of British Columbia and Professional Association of Residents of British Columbia* (Taylor, unreported, November 2009). The arbitration award did not involve the respondent in this case. I will address some of the findings, however, in that award, later in this decision.

[437] The Appeals Committee denied Dr. Kelly's appeal on September 6, 2010. As noted earlier, the Appeals Committee was specifically asked by the parties not to address the human rights issue. Therefore, any reference to "accommodation" in its decision is not made within the legal context of the duty to accommodate under human rights law, and it did not consider whether Dr. Kelly's dismissal from the Program constituted discrimination under the *Code*.

[438] The Appeals Committee dismissed Dr. Kelly's appeal. I will review certain parts of the Committee's Analysis and Rationale. In particular, the Appeals Committee stated:

> Dr. Kelly's difficulties with professional behaviour and clinical performance were significant and had these existed in isolation, i.e., not associated with a diagnosis of ADHD, either could have been grounds for dismissal. Were the case for dismissal in the absence of ADHD based on clinical performance, however, expectations would have been for documented remediation in Family Practice followed by formal probation. This did not occur. Viewed through a lens without the diagnosis of ADHD the process leading to dismissal for weakness in clinical performance would have been considered abbreviated to a degree that would not have been acceptable.

[439] In other words, the Committee concluded that, if Dr. Kelly had not suffered from a disability (ADHD), the process leading to his dismissal from the Program would have been too short and unacceptable.

[440] The Committee also concluded that:

> Were the case for dismissal in the absence of ADHD based on inappropriate professional behaviour, the process would not have been viewed as abbreviated.

[441] As noted earlier, however, Dr. Kelly was not disciplined for any misconduct, and his dismissal was not based on inappropriate or unprofessional behaviour.

[442] The Committee further concluded that accommodations that were recommended, but not implemented, were not viable for the Program.

> The Committee notes that the treatment of adult ADHD is in its early stages. Dr. Gibbins testified that as late as 2002 the blending of counseling and drug therapy was not common. There are no robust outcome studies of the treatment of this disorder in situations such as Dr. Kelly's to guide one on the likelihood of success, nor are there indicators of which patients are more likely to succeed. Because ADHD exists on a spectrum of severity, anecdotal reports of professionals functioning with this disorder are not helpful. The hypothesis that with treatment in combination with a substantially modified training program, Dr. Kelly may be successful in continuing his training might work is accepted; proof of the hypothesis sufficient to risk the integrity of an established training program is not.

[443] The Committee accepted that Dr. Kelly may be successful if provided with a modified training program, but concluded that it would risk the integrity of the program to provide the suggested modifications. As I will refer to shortly, on the facts in evidence before me, there is no basis upon which I could reasonably conclude that the implementation of Dr. Gibbins' recommended accommodations would risk the integrity of the Program. Dr. Kelly was not requesting that the Program modify it standards of patient care or professional education. He was requesting specific accommodation to support his unique learning needs.

[444] The Committee noted that it would be critical of a program that could not offer reasonable accommodation, but that it would not expect a program to significantly damage itself to prove that an accommodation was unworkable. It is hard to imagine how the provision of such things as counselling, clear instructions, time management skills, or a one-on-one preceptor could do "damage" or impair the integrity of the Program. Such a conclusion would require persuasive evidence, which was not present in this case.

No Policy

[445] Dr. Kernahan testified, in response to a question from the Tribunal, that there was no policy available to her within family medicine to provide guidance regarding the accommodation of residents for disability-related reasons.

LEGAL FRAMEWORK AND ANALYSIS

[446] Dr. Kelly filed his complaint under both s. 8 and 13 of the *Code*. He bears the onus of proving, on a balance of probabilities, that UBC discriminated against him, because of a mental disability, under either of these sections of the *Code*.

[447] In order to establish a *prima facie* case of discrimination, Dr. Kelly must prove that he had, or was perceived to have, a mental disability, that he was treated adversely in his employment (s. 13) or in the provision of a service customarily available to the public (s. 8), and that it is reasonable to infer from the evidence that his disability was a factor in the adverse treatment: *Health Employers Assn. of B.C. (Kootenay Boundary Regional Hospital) v. B.C. Nurses' Union,* 2006 BCCA 57; *Wheatley v. Emergency Health Services Commission (No. 3)*, 2009 BCHRT 106 [reported 66 C.H.R.R. D/413], para. 148; *Armstrong v. B.C. (Ministry of Health),* 2010 BCCA 56 [reported 67 C.H.R.R. D/332], para. 21.

[448] It is not necessary that the disability be the sole factor in the adverse treatment, provided it is at least a factor: *O'Connor v. Town Taxi,* 2000 BCHRT 9 [CHRR Doc. 00-031], para. 55.

[449] As noted by UBC, there is no separate requirement for Dr. Kelly to show that the adverse treatment was based on arbitrariness or stereotypical presumptions. Rather, as noted in *Armstrong,* the goal of protecting people from arbitrary or stereotypical treatment is incorporated in the third element of the analysis.

[450] I also note that the *Code* does not require that there be any intention to discriminate in order for there to be a breach of the *Code* (s. 2).

[451] If Dr. Kelly proves a *prima facie* case of discrimination, then the burden shifts to UBC to establish either a BFOR or a BFRJ for its conduct. If UBC does so, then there is no breach of the *Code*.

[452] As well, as noted by UBC, there is no free-standing duty to accommodate. Therefore, unless Dr. Kelly proves a *prima facie* case of discrimination, it is not necessary to consider whether UBC has proven a BFRJ or BFOR: *Martin v. Carter Chevrolet Oldsmobile,* 2001 BCHRT 37 [reported 41 C.H.R.R. D/88]; *British Columbia (Public Service Agency) v. British Columbia Government and Service Employees Union,* 2008 BCCA 357 [reported 63 C.H.R.R. D/1].

What is Discrimination?

[453] Discrimination is not specifically defined under the *Code,* except to the extent that it includes certain proscribed conduct under various sections of the *Code*.

[454] In *Law Society of British Columbia v. Andrews*, [1989] 1 S.C.R. 143 [10 C.H.R.R. D/5719] ("*Andrews*"), the Supreme Court of Canada said:

> … [D]iscrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities,

> benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed. (para. 37)

[455] In *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital général de Montréal,* 2007 SCC 4 [reported 59 C.H.R.R. D/259], Abella J. referred to the definition of discrimination in *Andrews* and then stated:

> At the heart of these definitions is the understanding that a workplace practice, standard, or requirement cannot disadvantage an individual by attributing stereotypical or arbitrary characteristics. The goal of preventing discriminatory barriers is inclusion. It is achieved by preventing the exclusion of individuals from opportunities and amenities that are based not on their actual abilities, but on attributed ones. The essence of discrimination is in the arbitrariness of the barriers imposed, whether intentionally or unwittingly.
>
> What flows from this is that there is a difference between discrimination and a distinction. Not every distinction is discriminatory. It is not enough to impugn an employer's conduct on the basis that what was done had a negative impact on the individual in a protected group. Such membership alone does not, without more, guarantee access to a human rights remedy. It is the link between that group membership and the arbitrariness of the disadvantaging criterion or conduct, either on its face or in its impact that triggers the possibility of a remedy. And it is the claimant who bears this threshold burden. (paras. 48 and 49)

[456] It is important to keep in mind the discrimination that the *Code* is meant to identify and remedy, and the *Code's* purposes, when determining whether there has been a breach of the *Code*. The *Code's* purposes are set out in s. 3 as follows:

> (a) to foster a society in British Columbia in which there are no impediments to full and free participation in the economic, social, political and cultural life of British Columbia;
>
> (b) to promote a climate of understanding and mutual respect where all are equal in dignity and rights;
>
> (c) to prevent discrimination prohibited by this Code;
>
> (d) to identify and eliminate persistent patterns of inequality associated with discrimination prohibited by this Code;
>
> (e) to provide a means of redress for those persons who are discriminated against contrary to this Code.

[457] As well, whether a breach of the *Code* has been proven must be assessed in a contextual and purposive manner: *Hutchinson v. British Columbia (Ministry of Health),* 2004 BCHRT 58 [reported 49 C.H.R.R. D/348], para. 84. I have done so in this case and, in particular, have had regard to the purpose of the service and nature of employment in question and the context in which the complaint arises.

Is Section 13 of the Code Applicable?

[458] There was no dispute that UBC was providing Dr. Kelly with a service customarily available to the public (an educational training program). There was dispute, however, as to whether the employment provision of the *Code* was applicable to the complaint.

[459] Section 13 of the *Code* provides, in part:

> (1) A person must not
>
> (a) refuse to employ or refuse to continue to employ a person, or
>
> (b) discriminate against a person regarding employment or any term or condition of employment
>
> because of the race, colour, ancestry, place of origin, political belief, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age of that person or because that person has been convicted of a criminal or summary conviction offence that is unrelated to the employment or to the intended employment of that person.
>
> ...
>
> (4) Subsections (1) and (2) do not apply with respect to a refusal, limitation, specification or preference based on a bona fide occupational requirement.

[460] Dr. Kelly says that UBC discriminated against him with regard to his employment. He says that in *McCormick v. Fasken Martineau Dumoulin (No. 2),* 2010 BCHRT 347 [reported 71 C.H.R.R. D/266], the Tribunal noted that the Supreme Court of Canada has "repeatedly stressed that a broad, liberal and purposive approach is appropriate to human rights legislation, and that such legislation... 'must be so interpreted as to advance the broad policy considerations underlying it'." (para. 107).

[461] He also relies on the Tribunal's comments in *McCormick,* where it stated that, in *Vancouver Rape Relief Society v. Nixon,* 2005 BCCA 601 [reported 55 C.H.R.R. D/67], the Court of Appeal "made it very clear that even in a wide variety of circumstances where the legal relationship in question is, not only in form, but also in substance, different from that of employer and employee at common law, there may still be "employment", not as a matter of stretching the definition, but as a matter of defining it correctly for the purposes of the *Code."* (para. 110).

[462] As well, Dr. Kelly relies on *Crane v. B.C. (Ministry of Health Services and others),* 2005 BCHRT 361 [reported 53 C.H.R.R. D/156], rev'd on other grounds, 2007 BCSC 460 [reported 60 C.H.R.R. D/381], and the factors set out therein to assert that he was in an employment relationship with UBC. In particular, he notes that it was UBC that had the power and ability to remedy any discrimination which may have occurred: para. 80.

[463] I am not persuaded that Dr. Kelly was in a traditional form of employer/employee relationship with UBC. His primary relationship with UBC was educational in nature, but included a working component. He received remuneration from Providence for the professional services he performed as

part of his residency requirements. As well, the terms and conditions of his formal employment with Providence were governed by a collective agreement negotiated between Providence and PARBC, to which UBC was not a party.

[464] Dr. Kelly argues, however, that even if he is not in a traditional employment relationship with UBC, it is sufficient that UBC can substantially interfere with his employment to fall within s. 13 of the *Code.* He relies, in particular, on *Hunter v. B.C. (Ministry of Health) and others (No. 2),* 2005 BCHRT 408 [CHRR Doc. 05-512], where the Tribunal stated:

> As frequently noted by the Tribunal, a contravention of s. 13 of the *Code* does not require that an employment relationship exist between the complainant and the respondent: see for example, *Vetro v. Greater Vancouver Transportation Authority,* 2005 BCHRT 383 [CHRR Doc. 05-485]. Specifically, s. 13(1) does not require that "a person" be "an employer" in order for its provisions to apply. The section provides that "a person" must not discriminate "regarding" employment. Several decisions by the Tribunal have contemplated a contravention of s. 13(1) in situations where there was no direct employment relationship between the complainant and the respondent, but where the respondent has the ability to interfere with or influence the employment relationship: see for example, *Middlemiss v. Norske Canada Ltd.,* 2002 BCHRT 5 [CHRR Doc. 02-024]; and *Pettie v. Canada Safeway Limited and Gavin (No. 2),* 2004 BCHRT 440 [CHRR Doc. 04-614]. (para. 20)

[465] I accept that the language of s. 13 of the *Code* is broad enough to capture a variety of relationships that relate to an individual's employment. In this case, UBC had the power and ability to substantively effect Dr. Kelly's employment. As Dr. Kelly notes, UBC determined where he would be placed (e.g., moved him from a rural to urban site), what work he did, and scheduled and evaluated his work. A primary purpose of Dr. Kelly's "employment" was to fulfill his residency requirements. If UBC dismissed him from the Program, then his employment as a resident would also come to an end.

[466] In my view, the situation is similar to both *Mans v. BC Council of Licenced Practical Nurses* (1990), 14 C.H.R.R. D/221 (BCCHR), upheld in *BC Council of Licensed Practical Nurses v. Mans* (1993), 20 C.H.R.R. D/177 (BCCA) and *Duvall v. College of Dental Surgeons of BC,* 2011 BCHRT 236 [CHRR Doc. 11-0236]. In *Mans*, Ms. Mans had an offer of employment from a hospital which required that she be licensed. The BC Council of Licensed Practical Nurses refused her application for licensure because of a criminal conviction. The Tribunal concluded that the wording of the prohibition against discrimination in employment was broad enough to apply to a situation where a third party discriminated against the complainant concerning or in relation to the complainant's employment (or intended employment) with the actual employer (in this case the hospital).

[467] In *Duvall,* Dr. Duvall alleged the restrictions on registration imposed by the College of Dental Surgeons of British Columbia interfered with his ability to practice and constituted discrimination contrary to s. 13 of the *Code.* The College argued that it was not in an employment relationship with Dr. Duvall and, therefore, s. 13 was not applicable. The Tribunal, consistent with the broad and purposive

interpretation it is required by law to give to the *Code's* provisions, concluded that the allegation that the College's restrictions limited Dr. Duvall's ability to seek and secure employment was sufficient to engage s. 13(1)(b) of the *Code*: para. 62.

[468] Similarly, in this case, the nature of the employment and educational relationship between UBC, Providence and Dr. Kelly is so intermingled and related, and UBC's control and influence over Dr. Kelly's employment so pervasive and determinative, that I find it is captured by s. 13 of the *Code.*

[469] At least at one point, even the Program referred to itself as Dr. Kelly's employer. For example, Dr. Kelly points out that the minutes of the Subcommittee meeting record the following comment:

> If the resident was to return to work, the program (as an employer) could request a note stating the resident is fit to return.

[470] While I do not find that UBC was Dr. Kelly's employer, this comment reflects UBC's recognition of the control it exercised with respect to his employment.

[471] In reaching my conclusion, I have also considered Arbitrator Taylor's comments on the relationship between Providence, UBC and Dr. Kelly in *Health Employers' Association of British Columbia v. Professional Association of Residents of British Columbia,* 2009 CanLII 888458 (BC LA), where he concluded:

> The essential points to be taken from all of the above are as follows: UBC controls and is responsible for its Residency Program. UBC, not the employer, makes decisions about assignment of Residents to hospitals under the Program, and termination from the Program. The Employer can only employ as a Resident someone who UBC assigns to it via the Residency Program. (para. 22)

[472] Arbitrator Taylor also commented on the "uneasy" jurisdictional issue that arose due to the relationship between UBC and Providence:

> UBC's duty not to discriminate in the administration of its residency Program is a separate matter, governed by s. 8 of the *Human Rights Code,* which prohibits discrimination in the provision of services to the public, including educational services: see *University of British Columbia v. Berg,* [1993], 2 S.C.R. 353 [18 C.H.R.R. D/310]. (The fact that UBC regards itself as having such a duty is also apparent on the facts: see Kernahan letter.)
>
> That issue is not before me. I am not appointed to adjudicate whether UBC breached its legal duties to Dr. Kelly. I am appointed to adjudicate whether the Employer, which operates the hospital where he was employed, breached *its* legal duties to Dr. Kelly. Those include the duty not to discriminate against a person in respect of employment, which arises under s. 13 of the *Human rights Code* (and also Article 24 of the parties' collective agreement, which subscribes to that legislation). However, no issue is before me with respect to discrimination in the provision of educational services pursuant to s. 8 of the *Human Rights Code.* It is also clear that I have no jurisdiction over UBC's administration of the Residency Program.
>
> This jurisdictional background sits uneasily against the facts of the case. UBC has the exclusive authority to make decisions concerning assignment of Residents to hospitals,

> pursuant to the Residency Program. If someone is terminated from the Residency Program, the Employer cannot employ that person as a Resident. The Employer terminated the Grievor's employment as a Resident because UBC had terminated him from the Residency Program. (paras. 24-26)

[473] Arbitrator Taylor further noted that the "uncertainty around jurisdiction in this tripartite structure is a structural incentive to strategic and technical litigation, and a disincentive to cooperation in getting to the merits", which he considered to be incongruent with the objectives of both the *Labour Relations Code* and the *Human Rights Code* (see paras. 39-42). I concur with, and adopt those comments.

[474] I have also considered UBC's arguments respecting third party licensure in order to maintain employment, and that such third parties should not be held responsible for the employment consequences of a loss of licensing. Such an argument, however, is inconsistent with the Tribunal's jurisprudence in *Mans, Duvall* and other cases. In my view, the language of s. 13 is broad enough to capture any prohibited discrimination regarding terms and conditions of employment, even if it involves a person other than the direct employer. Each case must be determined on its own facts.

[475] Finally, I have considered UBC's argument that since Providence was found not to have discriminated against Dr. Kelly in his employment, it "defies credulity that it could be facing such a finding." I do not consider this potential result to be remarkable. It arises due to the unique and tri-partite relationship constructed by UBC and Providence in regard to residents. Indeed, to conclude otherwise would mean that Dr. Kelly would be deprived of the protection of s. 13 of the *Code* since neither UBC nor Providence could be held accountable in the event that his dismissal from the Program (which also resulted in dismissal from employment), was discriminatory. Such a restrictive interpretation of the *Code* is inconsistent with a broad and purposive interpretation of the *Code.*

[476] Section 13 of the *Code* applies to this complaint. I will now proceed to the analysis of whether or not Dr. Kelly has proven a *prima facie* case of discrimination. As noted by UBC, the test is the same under either s. 8 or s. 13.

Does Dr. Kelly have a Mental Disability?

[477] The first issue to be determined is whether Dr. Kelly had, or was perceived to have, a mental disability.

[478] The evidence was unequivocal that Dr. Kelly has both ADHD and a NVLD. As noted by Dr. Gibbins:

> ...Carl is best characterized as a very bright man with an Attention Deficit Hyperactivity Disorder, predominantly inattentive type who shows a comorbid non-verbal learning disability (NVLD). Both ADHD and NVLD are neurodevelopmental disorders which are lifelong and whose impact varies considerably in adulthood depending on the environment, coping strategies and personal resources and challenges of the individual concerned (Gibbins report, p. 10).

[479] Dr. Kelly also suffered from anxiety and depression from time to time.

[480] I find that Dr. Kelly suffered from disabilities (which UBC admitted), and that UBC was aware of his disabilities from at least December 2005 (see, for example, the emails of Dr. Tereposky) until his termination from the Program for unsuitability. I also find that Dr. Kernahan, the Resident SubCommittee, the PG Deans and the Appeals Committee all perceived Dr. Kelly to have disabilities that limited his ability to learn and practice medicine.

Was there Adverse Treatment?

[481] UBC argues that Dr. Kelly was not treated adversely. It says that Dr. Kelly was dealt with on his individual merits, and in accordance with his personal abilities. In this part of its argument, it reviewed in some detail the modifications that it says it made to Dr. Kelly's Program as a result of the medical information it received about him, and stated:

> Treating Dr. Kelly in this manner is consonant with a duty not to discriminate and does not constitute "discrimination." Given that modifications were made in Dr. Kelly's training to provide him with assistance to meet the standards against which he would be assessed, it is clear he was treated as an individual.

[482] It says that had it ignored the information that it had about Dr. Kelly and required him to meet the same standard as everyone else, then he would have been treated adversely. Instead, it says that it built modifications into its standards and then assessed Dr. Kelly on his individual merits. Consequently, it says there was no adverse treatment.

[483] I am unable to accept this argument. In my view, the use of the term "modifications" does not change the true character of the steps that UBC took in regard to Dr. Kelly`s Program. The steps are properly characterized as accommodations and are relied on as such in UBC's argument concerning the duty to accommodate.

[484] In my view, the reasonableness of the full scope of modifications relied on by UBC are properly considered under the BFOR/BFRJ analysis. As noted by the B.C. Court of Appeal in *Coast Mountain Bus Company Ltd. v. CAW-Canada, Local 111,* 2010 BCCA 447 [reported 71 C.H.R.R. D/134]:

> ...in my view, a failure to accommodate is not a matter that demonstrates *prima facie* discrimination. Rather, once *prima facie* discrimination has been demonstrated, issues of accommodation are considered in determining whether discrimination is justified on the basis of a *bona fide* occupational requirement. It may be that accommodation will ameliorate the effects of adverse treatment, but a lack of accommodation does not, without more, support a finding of adverse treatment. (para. 66)

[485] Similarly, while positive accommodations may serve as a defence to a finding of *prima facie* discrimination, it is improper to collapse the analysis and assess the reasonableness of UBC's accommodations within the *prima facie* analysis.

[486] The very reason that UBC was implementing modifications was because of Dr. Kelly's disabilities. If I were to consider the reasonableness of the full scope of those modifications in this part of the analysis, and concluded Dr. Kelly had proven a *prima facie* case of discrimination, such a conclusion would inevitably result in a finding that UBC could not establish a BFRJ/BFOR.

[487] In this regard, it is also important to recognize that it is not in dispute that UBC accommodated Dr. Kelly to some extent. The focus of the issue is whether it fully discharged its duty in all the circumstances.

[488] Having said this, I find that Dr. Kelly was treated adversely as follows.

[489] First, the decisions not to provide Dr. Kelly with a further opportunity to complete a remedial rotation, or to go on probation, constituted adverse treatment.

[490] Second, Dr. Kelly's dismissal from the Program, and his resultant dismissal from employment, constituted adverse treatment in regard to the provision of a service and with regard to employment, respectively.

Is There a Nexus or Link Between the Disability and the Adverse Treatment?

[491] UBC reiterates under this part of the *prima facie* test that the process leading to Dr. Kelly's dismissal from the Program was detailed and based upon "broad consultation and participation by clinical faculty with accompanying review of material from Dr. Kelly's healthcare professionals." It further says that the decision was made based on an assessment of relevant information, performance, identified deficits and Dr. Kelly's inability to meet the Program's standards despite modification to his training program, and that such an approach is inconsistent with acting in a discriminatory manner "because of" Dr. Kelly's disability.

[492] I consider this argument to reflect another attempt to collapse the BFOR/BFRJ analysis into the *prima facie* analysis. As noted earlier, whether UBC reasonably accommodated Dr. Kelly is a matter to be addressed if Dr. Kelly proves a *prima facie* case of discrimination.

[493] UBC goes on to say that, while Dr. Kelly had a disability, there was no medical evidence that he was experiencing symptoms associated with his ADHD (or any other medical condition) at the time of his evaluations or that his performance was adversely affected by his disability. It says that Dr. Kelly's symptoms were controlled by medication and his previous difficulties with anxiety and depression were largely resolved while he was in treatment with Dr. Myers. It points out that, at one point, Dr. Kelly told Dr. Myers that he felt "better than I ever have before."

[494] UBC also says that there is no reference in Dr. Myers' clinical records to Dr. Kelly complaining that he was unable to function because of problems associated with concentration, organization or anxiety. It says the only reference to these types of difficulties is after the decision was made to place

him on education leave and after his removal from the Program and that these symptoms were reactive to his situation.

[495] UBC says that in the absence of medical evidence, the Tribunal may not infer a connection between Dr. Kelly's inability to meet program standards and his disability, mood or mental state.

[496] I accept that there must be evidence of a connection between Dr. Kelly's disability and his performance. For the following reasons, I find that there is such a connection.

[497] First, I do not consider Dr. Myers' clinical records to be a complete record of Dr. Kelly's symptoms, particularly since he was not assessing Dr. Kelly's organizational abilities or concentration. Further, I am not persuaded that an absence of any reference to such symptoms in Dr. Myers' clinical records is a basis upon which to conclude that Dr. Kelly was *not* experiencing such difficulties. As noted in *Edmundson v. Payer,* 2011 BCSC 118:

> While the content of a clinical record may be evidence for some purposes, the absence of a record is not, in itself, evidence of anything. For example, the absence of reference to a symptom in a doctor's notes of a particular visit cannot be the sole basis for any inference about the existence or non-existence of that symptom. At most, it indicates only that it was not the focus of discussion on that occasion. (para. 36)

[498] Second, there is no dispute that throughout the relevant period, Dr. Kelly had a NVLD and ADHD. In his report, Dr. Gibbins described Dr. Kelly's work functioning and then related described problems to ADHD, such as:

> However, Carl could make errors related to difficulties with attention and working memory, such as losing track of aspects of instructions and making inattentive errors on multi-step problems. Thus, while his academic skills were in the range expected for his ability level, his performance was affected by his difficulties with attention and working memory.

[499] Dr. Gibbins also stated:

> ...As is typical of most people with ADHD, Carl's level of effort and dedication can nonetheless result in inconsistent performance, particularly in situations that emphasize his areas of relative weakness, though he has been able to excel in multiple domains. It is important that Carl's areas of weakness not be viewed as roadblocks to his further progress towards his goals, as neurodevelopmental disorders such as ADHD and NVLD do not preclude attaining a high level of expertise and achievement in areas which individuals are strongly interesting (sic) in, show a strong motivation towards, and which they demonstrate talents in. Carl's strong interest in and passion for medicine and his dedication to and care for his patients provide powerful incentives for him to exert the effort necessary to cope with his challenges, and help minimize the effects of his attentional weaknesses when he is working with patients, in some cases allowing his ADHD traits to become a strength due to the potential benefits of hyperfocusing.

[500] I am able to reasonably infer a connection between Dr. Kelly's disabilities and his performance in the Program based on a consideration of all the information set out in Dr. Gibbins' report.

[501] I also note that Dr. G. Weiss, in her report, stated such things as:

> Difficulties in the Family Medicine Program related to gaps of knowledge and difficulty retaining new information. His clinical performance was inconsistent. Carl was easily distracted and his recall of information was negatively affected by anxiety. When experiencing anxiety, Carl becomes more disorganized. He has some difficulty changing direction when this is required. Prioritizing and time management have also been noted to have been challenges for him. His fine motor problems have affected his writing ability. Concern was raised by supervisors that Carl did not self-monitor well and lacked insight into his difficulties.

[502] I also find that Dr. G. Weiss described a connection between Dr. Kelly's disability and his performance in the Program. She was going to discuss strategies for addressing these issues with Dr. Kelly. She also concluded that the accommodations recommended by Dr. Gibbins, if implemented, would enhance Dr. Kelly's ability to "profit" in the Program. I take this to mean that his ability to succeed in the Program would improve if the accommodations were implemented.

[503] Based on a consideration of the medical evidence as a whole, I find that Dr. Kelly's performance in the Program was affected by his disabilities.

[504] Third, even if the evidence could have been more substantive on this point (though I do not consider this to be the case), as noted earlier, I find that Dr. Kernahan, the Resident SubCommittee, the PG Deans and the Appeals Committee all perceived Dr. Kelly's disabilities to negatively impact his ability to successfully learn and practice as a family medicine physician. This is sufficient to establish the necessary connection between his disabilities and the adverse treatment: *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Montréal (City); Québec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City)*, 2000 SCC 27 [reported 37 C.H.R.R. D/271].

[505] Fourth, I note that at the time Dr. Kelly made the comment about feeling better than he ever had before, I have found that he reasonably believed he was going to pass his family practice rotation, though in fact this did not occur. In my view, Dr. Kelly's feeling at this point in time, taken in context, is not indicative of symptom-free functioning, but reflects optimism about his progress in the Program.

[506] Fifth, the argument that there was no evidence that Dr. Kelly's performance was adversely affected by his disability, and that the available medical evidence was that he was largely asymptomatic, is inconsistent with the conclusion (and perceptions) of Dr. Kernahan, the SubCommittee, and the Appeals Committee that, at least in part because his deficits were life-long, he could not be accommodated within the Program. As noted in *Health Employers,* "there has never been any doubt that the Grievor's disability required accommodation in its Residency Program (Kernahan letter)" (para. 59).

[507] In the alternative, UBC says that if the Tribunal finds a connection between Dr. Kelly's performance and his disability (which I have), then the Tribunal should also conclude that Dr. Kelly was functioning at his optimal level since his symptoms were well controlled.

[508] I cannot accept this argument as factually sound. Dr. Kelly was diagnosed with ADHD, a NVLD, and, at various points, anxiety and depression. He required treatment, such as psychological counselling and medication, throughout most of his residency. His medication was adjusted and varied over the material time. Both Dr. Myers and Dr. Gibbins made recommendations to accommodate the limitations that his medical condition presented in his learning and working environment.

[509] I also note that, consistent with the opinion of Dr. Gibbins, Dr. Kelly was demonstrating improvement with increased familiarization. He had passed his last two rotations, and while he did not pass his family practice ward rotation, he also did not fail it. Dr. Kason recommended more time to assess and evaluate him. Dr. Kelly's performance was on an upward trajectory at the time of his dismissal from the Program. If his performance was optimized, it was at a level of success, not failure. The email incident, for which he was not disciplined or negatively evaluated, brought Dr. Kelly's successful trajectory to a halt. While the incident was resolved informally and without any formal discipline, in my view it reinforced the perception that Dr. Kelly was "odd", and left a factually unfounded perception that he might be psychotic and potentially harmful. As is the case with stereotypical labelling, it is very difficult to overcome the label or to change the perception once it is in place.

[510] I find that there is a clear, direct and substantive link between Dr. Kelly's disability and the adverse treatment. In addition to the facts noted above, I rely on the following in reaching this conclusion.

[511] First, the August 23, 2007 SubCommittee Minutes specifically considered whether it should recommend Dr. Kelly's termination from training because of his disability:

> Should we as a program move to recommend to the Postgraduate Deans that this resident be dismissed for unsuitability for training? Reason being that the resident has a learning disability and that further accommodation cannot be made to allow him to meet the learning objectives of the Program?

[512] It concluded that it should do so.

[513] Second, Dr. Kernahan testified, and her letter to the PG Deans confirms, that she recommended Dr. Kelly's termination from the program because of his disability:

> Even if the program could provide the level of accommodation requested by Dr. Gibbons we do not believe that Dr. Kelly would be able to successfully complete the family medicine training program, or be successful in future practice. As Dr. Gibbons' report states, Carl's deficits are lifelong.

[514] Third, the Appeals Committee specifically concluded that if Dr. Kelly had not had a disability, then it would have expected him to have been provided with a longer period of time in which to remediate.

[515] Unlike many cases in which the evidentiary link between a prohibited ground of discrimination and adverse treatment is proven by reasonable inference based on a consideration of all the circumstances, in this case I find that there is no factual doubt that Dr. Kelly's disability was a factor, if not the sole factor, in the adverse treatment.

[516] Dr. Kelly had disabilities which were directly connected to his assessment and evaluation, denial of access to remedial and probation options, and ultimate dismissal from his residency and his employment. He has proven a *prima facie* case of discrimination under both s. 8 and 13 of the *Code*.

[517] I will now turn to a consideration of whether UBC has met its duty to accommodate his disabilities.

Duty to Accommodate

[518] In *British Columbia (Public Service Employee Relations Commission) v. British Columbia Government and Service Employees' Union*, [1999] 3 S.C.R. 3 [35 C.H.R.R. D/257] (*"Meiorin"*), and *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)*, [1999] 3 S.C.R. 868 [36 C.H.R.R. D/129] ("*Grismer"*) the Supreme Court of Canada set out three requirements that a respondent must demonstrate to justify its conduct:

> 1) it adopted the standard for a purpose or goal that is rationally connected to the function being performed;
>
> 2) it adopted the standard in good faith, in the belief that it is necessary to the fulfillment of the purpose or goal; and
>
> 3) the standard is reasonably necessary to accomplish its purpose or goals. (*Meiorin*, para. 54)

[519] The Court in *Meiorin* elaborated on the third step of the analysis as follows:

> To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer. (para. 54)

[520] Since then, the Court has further clarified the application of this branch of the BFOR/BFRJ test. In particular, in *Hydro-Québec v. Syndicat des employées de techniques professionelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ)*, 2008 SCC 43 [reported 63 C.H.R.R. D/301], the Court stated that the use of the word "impossible" in *Meiorin* relates to undue hardship, and the question is whether accommodation can be accomplished without undue hardship to the respondents:

> The relevance of the approach is not in issue. However, there is a problem of interpretation in the instant case that seems to arise from the use of the word

"impossible". But it is clear from the way the approach was explained by McLachlin J. that this word relates to undue hardship (at para. 55):

> This approach is premised on the need to develop standards that accommodate the potential contributions of all employees in so far as this can be done without undue hardship to the employer. Standards may adversely affect members of a particular group, to be sure. But as Wilson J. noted in *Central Alberta Dairy Pool*, [[1990] 2 S.C.R. 489], at p. 518, "[i]f a reasonable alternative exists to burdening members of a group with a given rule, that rule will not be [a BFOR]". It follows that a rule or standard must accommodate individual differences to the point of undue hardship if it is to be found reasonably necessary. Unless no further accommodation is possible without imposing undue hardship, the standard is not a BFOR in its existing form and the *prima facie* case of discrimination stands. [Emphasis added.]

What is really required is not proof that it is impossible to integrate an employee who does not meet a standard, but proof of undue hardship, which can take as many forms as there are circumstances. This is clear from the additional comments on undue hardship in *Meiorin* (at para. 63):

> For example, dealing with adverse effect discrimination in *Central Alberta Dairy Pool*, *supra*, at pp. 520-21, Wilson J. addressed the factors that may be considered when assessing an employer's duty to accommodate an employee to the point of undue hardship. Among the relevant factors are the financial cost of the possible method of accommodation, the relative interchangeability of the workforce and facilities, and the prospect of substantial interference with the rights of other employees. See also *Renaud*, [[1992] 2 S.C.R. 970], at p. 984, *per* Sopinka J. The various factors are not entrenched, except to the extent that they are expressly included or excluded by statute. In all cases, as Cory J. noted in *Chambly*, [[1994] 2 S.C.R. 525], at p. 546, such considerations "should be applied with common sense and flexibility in the context of the factual situation presented in each case".

As these passages indicate, in the employment context, the duty to accommodate implies that the employer must be flexible in applying its standard if such flexibility enables the employee in question to work and does not cause the employer undue hardship. L'Heureux-Dubé J. accurately described the objective of protecting handicapped persons in this context in *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Montréal (City)*, [2000] 1 S.C.R. 665, 2000 SCC 27 [37 C.H.R.R. D/271], at para. 36:

> The purpose of Canadian human rights legislation is to protect against discrimination and to guarantee rights and freedoms. With respect to employment, its more specific objective is to eliminate exclusion that is arbitrary and based on preconceived ideas concerning personal characteristics which, when the duty to accommodate is taken into account, do not affect a person's ability to do a job.

As L'Heureux-Dubé J. stated, the goal of accommodation is to ensure that an employee who is able to work can do so. In practice, this means that the employer must accommodate the employee in a way that, while not causing the employer undue hardship, will ensure that the employee can work. The purpose of the duty to accommodate is to ensure that persons who are otherwise fit to work are not unfairly excluded where working conditions can be adjusted without undue hardship. (paras. 12- 14)

[521] Under the third step of the *Meiorin* analysis, UBC must establish that it could not accommodate Dr. Kelly without incurring undue hardship. This is a fact specific inquiry: *Central Okanagan School District No. 23 v. Renaud*, [1992] 2 S.C.R. 970 [16 C.H.R.R. D/425]; *Meiorin*, para. 63. The primary responsibility lies with UBC to find and propose a solution that would accommodate Dr. Kelly. However, both UBC and Dr. Kelly are required to participate in the search for an accommodation, and to approach it with common sense and flexibility: *Renaud,* paras. 43-44.

[522] In *Meiorin*, the Court stressed the importance of being sensitive, innovative and yet practical in considering ways in which an individual's capabilities may be accommodated:

> Courts and tribunals should be sensitive to the various ways in which individual capabilities may be accommodated. Apart from individual testing to determine whether the person has the aptitude or qualification that is necessary to perform the work, the possibility that there may be different ways to perform the job while still accomplishing the employer's legitimate work-related purpose should be considered in appropriate cases. The skills, capabilities and potential contribution of the individual claimant and others like him or her must be respected as much as possible. Employers, courts and tribunals should be innovative yet practical when considering how this may best be done in particular circumstances. (para. 64)

[523] While *Meiorin* involved an employment relationship, the principles are equally applicable to a service relationship: *Grismer.*

[524] As noted in *Meiorin*, in *Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*, [1990] 2 S.C.R. 489 [12 C.H.R.R. D/417], the Supreme Court of Canada set out a number of factors that might be considered in determining what constitutes undue hardship, including, but not limited to, cost, morale and interchangeability of facilities. It also set out in *Meiorin* a number of questions which may inform the accommodation analysis, such as whether alternate approaches have been investigated that would not have a discriminatory effect on the individual and whether there is a way to do the work (or, in this case, successfully complete the residency) that was less discriminatory? (para. 65).

[525] I also note that, in *Renaud*, the Supreme Court said that there must be more than a minor interference with the rights of the other employees for the employer to sustain an undue hardship defence. This consideration is particularly applicable to a consideration of UBC's argument respecting the impact of Dr. Kelly's accommodation on other residents and preceptors.

[526] Dr. Kelly also says that the duty to accommodate has both a procedural and a substantive component, and that UBC has met neither. In *Kerr v. Boehringer Ingelheim (Canada)(No. 4),* 2009 BCHRT 196 [reported 68 C.H.R.R. D/28] (appeal dismissed, 2011 BCCA 266 [CHRR Doc. 11-3038]), the Tribunal described its approach to a consideration of these aspects of the duty to accommodate as follows:

> Ms. Kerr argued that the duty to accommodate inquiry includes both procedural and substantive aspects. In *Meiorin*, the Court stated that, while there may be an overlap between these two types of inquiries, it is helpful to consider separately the procedure which was adopted to assess the issue of accommodation and the substantive content

> of an accommodation or the reasons for not offering one. (para. 66; *Parisien v. Ottawa-Carleton Regional Transit Commission*, 2003 CHRT 10 [reported 46 C.H.R.R. D/34], para. 69) In my view, both the procedure of the inquiry, and the substantive results of those inquiries, are the elements that should be considered when determining whether an employer has met its obligations under the *Code* and I follow this approach in this decision. (para. 507)

[527] In my view, it is relevant to consider both the accommodation process and the reasons for Dr. Kelly's dismissal in assessing, in a holistic manner, whether UBC has satisfied its duty to accommodate. My analysis will include a consideration of these relevant factors.

[528] In approaching the BFOR/BFRJ analysis, I have considered the entire history of the residency relationship between Dr. Kelly and UBC, and have taken a global perspective of the parties' dealings with each other (as would be the case in any accommodation analysis): *Hydro-Québec; Buchner v. Emergency and Health Services Commission (No. 2),* 2008 BCHRT 317 [reported 64 C.H.R.R. D/41], at para. 404. In particular, I have considered the modifications that UBC did make to Dr. Kelly's training program.

[529] At the outset of this analysis, I note that UBC says that Dr. Kelly is not entitled to a perfect result, or to a "pass" in his rotations because he has a disability. It says that it was not required to lower its practice standards or to permit him to proceed when he did not qualify. Dr. Kelly did not argue that UBC was required to do either of these things. Rather, he says that UBC failed to reasonably accommodate his disability.

[530] UBC also says that whether it accommodated Dr. Kelly to the point of undue hardship is a contextual judgment which must reflect, in this case, that Dr. Kelly was engaged in a professional academic program administered by experienced physician educators, and that "the context of the decisions being made must reflect the requirements for a practising family physician." I accept that the Program physicians were experienced practitioners and educators, with a sound understanding of Program standards and expectations for a resident to qualify as a family medicine practitioner.

[531] I also note that there is no dispute that the regular evaluation standards utilized by UBC were reasonable and adopted in good faith. The issue in dispute centres on the third step of the analysis, whether UBC discharged its duty to accommodate Dr. Kelly.

[532] UBC says the following facts are relevant to the issue of accommodation:

- As early as January 12, 2006, Dr. Whiteside sought the involvement of Dr. Myers to provide assistance to the Program in adapting to Dr. Kelly's needs, and also obtained permission to access Dr. Kelly's past medical and academic history.
- The assistance of Dr. Myers was provided to Dr. Kelly for psychological support.
- Dr. Kelly's clinical teachers met on March 1, 2006 to discuss Dr. Kelly's educational needs. As a result, Dr. Kelly was transferred to a more structured environment where support could be provided. Dr. Kelly was also provided with a mentor and his program was customized, utilizing rotations at St. Paul's Hospital and at the UBC clinic, plus the other required rotations.

- The rotation at St. Paul's Hospital was specifically structured to meet Dr. Kelly's needs for a reduced workload, one-on-one supervision with Dr. Kason (at a cost of $1,000) and peer support.
- The Program sought and paid for a neuropsychological assessment from Dr. Gibbins.
- Prior to the paediatric rotation, Dr, Kelly was offered a leave if he was not healthy.
- Prior to the CTU rotation, the Program sought Dr. Myers' clearance and recommendations, and implemented his recommendations.
- Dr. Calam and Dr. Kernahan made attempts to place Dr. Kelly in a family practice remediation rotation without success.
- The process leading to Dr. Kelly's dismissal was broadly-based in terms of consultation and participation. In particular, it included the recommendation from Dr. Kernahan to Dr. Woollard, Dr. Woollard's concurrence, discussion by the Subcommittee, Dr. Kernahan's recommendation to the PG Deans and a decision from the PG Deans, and finally a review by the Appeals Committee.

[533] UBC says that it considered Dr. Gibbins' recommendations and determined that it was not able to implement all the recommendations for the reasons set out in its documentation. It says that it is not legally required to demonstrate that a particular recommendation has failed before it can conclude that the accommodation cannot be implemented, or to accommodate to the point where a disabled person can succeed. It says all that Dr. Kelly is entitled to expect is that UBC made "a conscientious and reasonable attempt to identify his condition and to address his needs": *British Columbia (Ministry of Education) v. Moore*, 2010 BCCA 478 [reported 71 C.H.R.R. D/238], para. 177.

[534] As well, it says that even if it had been possible for the Program to extend further accommodation to Dr. Kelly, that is not the legal test and relies on the following quote from *Hydro-Québec*:

> The test is not whether it was impossible for the employer to accommodate the employee's characteristics. The employer does not have a duty to change working conditions in a fundamental way, but does have a duty, if it can do so without undue hardship, to arrange the employee's workplace or duties to enable the employee to do his or her work. (para. 16)

[535] I agree that the issue is not whether any further accommodation, viewed out of context, was "possible". Rather, the issue is whether UBC could have further accommodated Dr. Kelly, without incurring undue hardship, having regard to the entire context of the relationship between Dr. Kelly and UBC.

[536] In this case, UBC says that it has accommodated Dr. Kelly to the point of undue hardship and that any further accommodation "would change the academic program in a fundamental way." However, while there is reference in the Appeals Committee decision to risking the integrity of the Program, and other similar language, there was no substantive factual foundation to support a conclusion that the Program would be fundamentally altered or its professional standards lowered if it

was to accommodate Dr. Kelly. There is reliance on a negative impact on other residents and preceptors, and on administrative challenges, but as will be more fully explored, much of the evidence was anecdotal and fell far short of the standard necessary to demonstrate undue hardship or a "conscientious and reasonable" attempt to accommodate Dr. Kelly.

[537] UBC relies on several discussions and documents to demonstrate that the Program's conclusions were based upon an individualized assessment of Dr. Kelly. These include:

- the July 25, 2006 meeting with Drs. Calam, Knell, Andrew and Kernahan in which they concluded that, despite showing improvement when he received intensive, specific feedback, it was their opinion that "no matter the degree of supervision and modification of the Program," Dr. Kelly would not be able to function as a family physician.
- the comments of unidentified persons, including other residents, at the Subcommittee Meeting.
- Dr. Wollard's comments after reviewing Dr. Kelly's file. His comments included such things as "It would be unfair to him and to his future patients to pretend that we could provide an educational program to correct a deficiency which is described by Dr. Gibbins as "...neurodevelopmental disorders which are life-long."
- Dr. Kernahan's recommendations to the PG Deans. This included the comment that "In our view, some of the suggested accommodations would not facilitate, and in fact would impede, Dr. Kelly's progress through the Program especially in those areas where the objective is to foster independent function and decision-making in increasingly complex clinical situations."
- The decision of the Appeals Committee which commented, in part, that a longer familiarization period would have a significantly negative impact on the structure and organization of the Program.
- The Appeals Committee also noted that "clear instructions in written form as a mode of case to case functioning are not compatible with the fundamental goals of the teaching program or the responsibilities of a practising family physician" and that the use of recipes or templates as a foundation to treatment would not meet the responsibilities of the Program or practicing family physician.

[538] Finally, UBC criticizes the Gibbins and Weiss reports. It says that the Weiss report simply supports Dr. Myers' treatment of Dr. Kelly. It also says that Dr. Gibbins had no first-hand familiarity with the family practice learning environment, no involvement as an educator in the Program, could not say how Dr. Kelly's deficits or the proposed accommodations would play out in that environment, and did not contact the Program about his recommendations.

[539] I have considered all these arguments. However, for the following reasons, I have concluded that UBC did not discharge its duty to reasonably accommodate Dr. Kelly.

[540] First, I am unable to conclude that further accommodating Dr. Kelly would have resulted in a fundamental change to the Program. The Policy specifically contemplates remedial rotations and probationary periods, which may include one-on-one preceptors, extended rotations or other accommodations that were similar to those recommended for Dr. Kelly. As noted by the Appeals

Committee, had Dr. Kelly not been disabled, he would have been provided a further opportunity to demonstrate whether he was able to successfully complete the Program.

[541] Second, while UBC was not necessarily required to demonstrate that a particular accommodation had failed before it could conclude that it could not be implemented, it could not simply act upon an impressionistic conclusion, feeling or belief. In my view, it was required to demonstrate that it had conscientiously turned its mind to whether it could reasonably implement the recommended accommodations. On the facts of this case, I consider that this process should have included consultation with Dr. Kelly about the proposed accommodations, the Program's specific concerns and how, if at all, the accommodations might be implemented in light of those concerns.

[542] In this regard, I note the following:

- The Program did not follow up on any of the suggested resources that Dr. Gibbins identified;
- The Program took an overbroad and rigid view of some of the suggested accommodations (such as that every rotation must be lengthened, or that every aspect of family practice must be reduced to a template) and failed to explore reasonable possibilities;
- The Program did not meet with Dr. Kelly to discuss the Gibbins report, or seek clarification about any of Dr. Gibbins' recommendations;
- The Program sought no input from Dr. Kelly or PARBC prior to the Subcommittee meeting, Dr. Kernahan's dismissal recommendation and the PG Deans' decision.

[543] I also note that while UBC may not have been required to demonstrate that a particular accommodation had failed before it could conclude that it could not be implemented, the fact is that the Policy already contemplated, and the Program had already demonstrated, that it was, in fact, able to implement accommodations to support residents who were having difficulty in the Program. It unreasonably truncated that process because of Dr. Kelly's disability, at a point in time when Dr. Kelly had been demonstrating success in the Program.

[544] Third, in regard to the various facts relied on by UBC, I find the following:

- While there was a meeting on March 1, 2006 to discuss Dr. Kelly's educational needs, he was not involved in this meeting and there was no medical information obtained from a current treating physician, at that time, to guide the educators in any accommodation decisions regarding Dr. Kelly. I also note that none of the physician educators were identified as experts in ADHD.
- A mentor is available to all residents, and is not a specific accommodative measure designed to specifically address Dr. Kelly's disabilities. In any event, Dr. Kelly was not assigned a mentor until April 2006.
- There was no evidence about whether the $1,000 payment to Dr. Kason was "undue" or "unreasonable" within the context of the Program's or UBC's budget as a whole. There was also no evidence about the actual cost of the Gibbins' report.

- The evidence established that when the Program did provide accommodations to Dr. Kelly, such as a one-on-one preceptor, his performance improved.
- The evidence also established that when the Program implemented Dr. Myers' recommendations, Dr. Kelly passed the rotation. The evidence was insufficient to establish that the Program's professional standards or patient standards of care were fundamentally changed or altered as a result of this.
- While Dr. Calam and Dr. Kernahan did search for a family medicine preceptor for Dr. Kelly, their efforts were suspended once he was placed on educational leave. The placement in Three Bridges was not pursued. While I accept that it was challenging and required extra effort for the Program to locate a preceptor, the evidence demonstrated that it was able to do so in the case of Dr. Kason, and that there were unexplored opportunities in respect of the remedial family practice rotation. The evidence did not establish that the search for a preceptor significantly or substantively interfered with the execution of Dr. Kernahan's, or any other persons', other responsibilities.
- In respect of the July 25, 2006 meeting, I note that none of the physicians were identified as experts or even knowledgeable about ADHD. The Program had not yet received the Gibbins report, and had later identified that it required an IME to assess whether medication could assist Dr. Kelly in successfully completing the Program. As well, Dr. Kelly successfully completed both his August and September rotations after these comments. Despite this, the Program had already concluded that Dr. Kelly would not succeed "no matter the degree or supervision and modification of the Program." This was a premature and unreasonable conclusion, and Dr. Kelly subsequently demonstrated that he could pass rotations.
- In regard to the Subcommittee meeting, I note that many of the comments are mere conjecture, or subjective impressions, as opposed to objective, quantifiable data. For example, "not exaggeration to say that Program has bent over backwards, even if more and more accommodations are made – what kind of physician would be graduated?" "Financially not even feasible" (when in fact there was no evidence of demonstrable or unreasonable financial hardship).
- Dr. Wollard's reliance on Dr. Kelly's "life-long" disorder, does not demonstrate a consideration of whether, with appropriate accommodations, Dr. Kelly may have been able to function as a fully competent and safe physician.
- In regard to the Appeals Committee comment that a longer familiarization period would have a significantly negative impact on the structure and organization of the Program, based on the evidence before me, I cannot find this to be the case. The evidence was primarily anecdotal and speculative. No identified resident was shown to have suffered a negative evaluation or lack of progress in their Program as a result of Dr. Kelly's accommodations. There was no evidence of any negative impact on the educational experience of other residents, and administratively, the Program had been able to place Dr. Kelly in rescheduled rotations. It may have been challenging to accommodate Dr. Kelly, but this is often the case in an accommodation situation. For example, when an employer assigns light duties to a disabled employee or places them on a preferred schedule, other employees may be required to perform some heavier duties or may have to reasonably accept a less preferred scheduled. There may be some resistance and perceived unfairness to such an accommodation, but it is precisely this type of resistance to accommodation that the *Code* is designed to address.
- Further, the Appeals Committee's reference to "clear instructions in written form *as a mode of case to case functioning*" was <u>not</u> the recommendation of Dr. Gibbins and was

not the Program's experience with Dr. Kelly when he successfully passed rotations without "case by case" written instructions.

- The Appeals Committee, like Dr. Kernahan, also took an overly broad approach to the use of templates as a "foundation to treatment" and as a replacement for the doctor/patient relationship. It was viewed as a permanent crutch as opposed to a support tool to assist a practitioner.

[545] In respect of Dr. Kernahan's explanation as to why she rejected the Gibbins recommendations, I add the following comments:

- Longer Familiarization Period – The evidence established that Dr. Kelly demonstrated improvement in his performance as time progressed in a rotation. UBC did not objectively demonstrate that it would constitute undue hardship to provide extended rotations, or that a longer familiarization period would compromise any standard of practice. Dr. Kernahan and others expressed the view that it was difficult to find preceptors and that scheduling was problematic, but the fact is that the Program was able to extend at least one rotation and, while it may have taken additional administrative and operational resources to structure, there was insufficient evidence to suggest that this did or would fundamentally compromise the Program.

- Reduced client load – Dr. Kernahan testified that this placed a burden on other residents. However, the evidence did not demonstrate that this was an "undue" burden, or that it compromised other residents' ability to succeed in their rotations. Her evidence in this regard was primarily anecdotal. There was no evidence that, on the rotation that Dr. Kelly had his client load reduced, any other resident was not successful.

- Written instructions – While Dr. Kernahan testified that it was not possible to provide written instructions, she in fact provided written and clear objectives and goals for the paediatrics remediation rotation. Dr. Kelly was successful on this rotation. The evidence also established that some rotations (e.g., emergency and paediatrics) required written feedback at the end of each shift, and there was a structured evaluation process. Again, while this recommendation may have required more effort by preceptors, the evidence did not establish that it would constitute undue hardship. There was no evidence about how much time this would take, how substantively it might interfere with a preceptor's other responsibilities or how, if at all, it would compromise a practice standard. As well, as noted earlier, Dr. Gibbins did not state that Dr. Kelly would require written instructions for every task.

- Written templates – Dr. Kernahan testified that written templates were not practical and may be detrimental. Again, her evidence in this regard was anecdotal, and consisted primarily of a conclusive statement with insufficient supporting evidence. UBC demonstrated no attempt to discuss or consider how templates or checklists might be utilized in the teaching or practice environment. It is certainly the case that all diagnoses cannot be reduced to a simple checklist. However, it also seems readily apparent that, in certain areas, checklists may be of assistance as a consultative tool. Most importantly, there was no evidence of any discussion with Dr. Kernahan, Dr. Kelly and other relevant or interested persons, such as preceptors, about how, if at all, such a recommendation could be utilized in a rotation.

- Counselling or Coaching – Dr. Kernahan testified that this was not available to Dr. Kelly. I have considered that the Program already assigned every resident a mentor if the resident is in difficulty, and provided one to Dr. Kelly. It also referred Dr. Kelly to Dr. Myers. As noted by Dr. Kelly, the documentation also indicated that the Program considered providing Dr. Kelly with career counselling in the event of his dismissal

from the Program. However, there was no evidence that Dr. Kernahan investigated other possible coaching or counselling options to support Dr. Kelly during his residency, any costs associated with the provision of such support, or that she had any discussion with Dr. Kelly about the utilization of such resources, even at his own cost. In light of Dr. Gibbins' recommendation, this was neither reasonable nor conscientious.

- One-on-one preceptor – Dr. Kernahan testified that UBC implemented this recommendation through the appointment of Dr. Kason for the family medicine ward rotation, but it was not successful. However, Dr. Kelly demonstrated improvement throughout the rotation under Dr. Kason's tutelage, and he did not fail the rotation. He also did not pass. Rather, the recommendation was for additional evaluative time. This could have been due, in part, to the additional VAC demands on Dr. Kelly during that rotation. Dr. Kernahan also testified that there would be a financial burden in finding and assigning a one-on-one preceptor. However, with diligent effort, Dr. Kernahan was able to retain Dr. Kason at a cost of $1,000. There was no evidence about the relationship of that financial cost to the Program's overall budget, and I cannot find therefore that the cost was undue. Even if the cost were undue, there was no evidence that UBC had discussed any contribution from Dr. Kelly toward all or part of the cost of a one-on-one preceptor.
- Dr. Kelly also points out that the Program provides a remedial supervisor who coordinates the overall supervision of the resident when a resident is remediating a rotation. The remedial supervisor provides the resident with extra teaching, clarifies the difficulties the resident has with the knowledge base, provides supervision and training in procedural skills, and directs the resident to other sources of information on teaching. In my view, there was no reasonable explanation as to why UBC was able to provide this to Dr. Kelly on his paediatric remediation rotation but not as a support in other rotations. As noted by the Appeals Committee, had Dr. Kelly not had ADHD, it would have expected him to have had a longer period of time to demonstrate his suitability.
- Dr. Kelly also notes that a rotation was available for him at Three Bridges, but this was not pursued by the Program.
- Pursuit of Areas of Interest – Dr. Kernahan testified that family medicine is a generalist field and a practitioner must be trained in all aspects of it. Therefore, from her perspective, pursuing areas of strength or interest was an impractical recommendation. However, she also testified that other residents have switched to a different residency. There was no evidence that such an option was explored with Dr. Kelly and no evidence that UBC considered whether it could facilitate a transfer to another area.

[546] Fourth, UBC criticizes the Gibbins report because Dr. Gibbins admittedly had no first-hand familiarity with the Program, was not an educator in the Program, and could not say how the deficits exhibited by Dr. Kelly or the proposed accommodation "would play out" in the Program environment. Similarly though, no one in the Program was identified as an expert in ADHD or NVLD, and they also could not say how some of the proposed accommodations would "play out" in the Program environment, since they were not implemented. There was evidence that when certain accommodations were implemented, such as the one-on-one preceptor, Dr. Kelly's performance improved. This is precisely why it would have been reasonable to more fully consider the suggested accommodations. No one from the Program contacted Dr. Kelly to discuss Dr. Gibbins'

recommendations and, in my view, it was incumbent upon them to engage in dialogue about the accommodation process.

[547] The opinions of two specialists in the area of ADHD suggested that, with appropriate accommodation, Dr. Kelly might be successful in the Program. I do not consider it either conscientious or reasonable for the Program to have curtailed Dr. Kelly's access to accommodations that may have been provided to other residents under the Policy, but were not provided to Dr. Kelly because he had ADHD, which is a life-long deficit.

[548] The Appeals Committee concluded that:

> If the diagnosis of ADHD dictated accommodations that could have been implemented by the Department of Family Practice without placing the structure or the educational philosophy of the Program at risk, it would have been appropriate to proceed to remediation that included the accommodation and then to reevaluate.

[549] UBC has not proven that either the structure or the educational philosophy of the Program would have been "at risk" if it was to have provided Dr. Kelly with a further remedial or probationary period to demonstrate his suitability. To the contrary, the evidence demonstrated that it was able to provide accommodations, albeit it with some inconvenience, and that its Policy specifically contemplated such accommodations for all residents, whether or not they were disabled.

[550] As noted earlier in this decision, the backdrop to the Program's decisions from September 2006 was an underlying perception that Dr. Kelly, because of his disability, was "odd", possibly psychotic, and challenging. I find that the Program, in the absence of a solid factual foundation, acted on its stereotypical assumptions about Dr. Kelly and prematurely dismissed him from the Program, at a time when he had been demonstrating success.

[551] I am not persuaded that the anecdotal observations, unquantified financial costs, organizational inconveniences, or overly broad interpretations of Dr. Gibbins' recommendations demonstrate that UBC has discharged its duty to accommodate Dr. Kelly. I note that UBC commented early in its argument that "there is no indication in any of the evidence that any person from, or on behalf of, the Program took the position that persons with ADHD/NVLD can never be family physicians." However, it concluded its argument by stating that family medicine training and practice is not an "ADHD friendly area". In my view, this was reflective of a negative perception of Dr. Kelly, due to his disability, that ran throughout the evidence.

[552] Dr. Kelly argued that from January 29, 2007, when it was suggested in an email that it "looks like we are moving to dismissal for unsuitability", the Program had concluded that he would be dismissed and was just "going through the motions." There is some merit to this argument. There was a discernable tone of resistance to accommodating Dr. Kelly once the Program became fully aware of his disabilities.

[553] Dr. Kelly got off to an unfortunate start in the Program. He did not disclose his disabilities to UBC and, in my view, he should have been candid about his health condition from the outset. Regardless, he did disclose his health condition to the Program by late December and early January 2006, and UBC embarked upon an accommodative process. Dr. Kelly was cooperative, and provided requested medical information to UBC, including the second opinion from Dr. Weiss with the agreement of the PG Deans.

[554] Dr. Kelly's first rotation was shorter than usual and he was in an unfamiliar environment. As well, even a preceptor in that rotation commented that the evaluation standards needed to be more clearly laid out at the commencement of the rotation. For a person with ADHD, these factors were not conducive to success. Dr. Kelly did not pass the rotation.

[555] The Program did refer Dr. Kelly to Dr. Myers, and provided him with some accommodations during his family medicine rotation. However, he was moved from Kelowna to Vancouver, and due to an organizational transition, his Program location was also moved from Mathers to the UBC Clinic. I find it reasonable to infer that these unique circumstances placed an additional demand on Dr. Kelly as he was required to familiarize himself with these new environments. While he demonstrated improvement during this rotation, he was not successful in it.

[556] Dr. Kelly then began to experience a relatively successful, or at least a non-failing, trajectory. He passed his remedial paediatrics rotation, and Dr. Kason concluded that he required more assessment and evaluative time given the unique nature of his family practice ward rotation. As well, despite the Program's conclusion in late July that "no matter the degree of supervision and modification of the program," he would not demonstrate the ability to practice independently, Dr. Kelly did, in fact, demonstrate success by passing his CTU and emergency rotations.

[557] But for the email incident, it is probable that this positive trajectory may have continued, particularly with the benefit of Dr. Gibbins' recommendations. As a result of the email incident, Dr. Kelly was placed on leave pending consideration of a neuropsychological report and an IME in order to determine "next steps" for him. As late as December 5, 2006, Dr. Kernahan was advising Dr. Kelly that she was awaiting a review of the Gibbins report prior to planning his next rotation and advising him of his date of return. There was no indication in this email that Dr. Kernahan was contemplating dismissing him from the Program.

[558] Upon receipt of the Gibbins report, Dr. Kernahan did not accept its recommendations. In my view, she focussed on the limitations that ADHD presented in Dr. Kelly, and not on the positive steps that might have been taken to address those limitations. For example, Dr. Gibbins testified that, while there was no guarantee, he would have expected that, if his recommendations had been implemented, they would have minimized the effect of Dr. Kelly's disorder. Whether or not the accommodations

would have allowed Dr. Kelly to successfully complete his training and practice family medicine now remains unknown.

[559] Dr. Kelly notes that Dr. Kernahan advised Dr. Sivertz, in an email, that she found accommodating his disabilities challenging:

> It seems plausible that there might be a niche practice that this individual might fit into once he graduates, however, we have to train him to meet the requirements for a full license. Providing the educational experience will be challenging, particularly if we try to incorporate Dr. Gibbons' recommendations of things such as a longer familiarization period, more time or repeated exposure to new material, clear written instructions and clear specific goals for an activity...

[560] Dr. Kelly says that the test is not whether it was challenging to accommodate his disabilities, but whether UBC could do so without undue hardship. I agree.

[561] As the Program implemented accommodations, which it demonstrated it was able to do so without unreasonable interference in the Program, Dr. Kelly started to succeed in the Program. However, while the Program originally implemented an individualized accommodation process for Dr. Kelly, it then unreasonably truncated it.

[562] Both Dr. Kernahan and Dr. Calam were identifying family practice remedial rotation opportunities for Dr. Kelly prior to the September email. There were options considered, and not fully explored, such as an out-of-province or Three Bridges rotation. No decision had been made to dismiss him from the Program prior to the email; rather the Program was continuing to accommodate him.

[563] The Program did not provide written notice to Dr. Kelly about any failings, weaknesses or areas that required improvement after his successful CTU and emergency rotation. Regardless, after the email incident, and the negative perception that it created, the Program moved towards dismissal. It did not discipline Dr. Kelly because of the email, and did not identify it as the basis for his dismissal. Yet it appears that from the email forward, Dr. Kelly's die was cast.

[564] Dr. Kelly was not provided the opportunity to demonstrate his abilities, and be assessed against the Program's professional and patient care standards, with the benefit of reasonable accommodation. I have found that Dr. Kernahan, the PG Deans and the Appeals Committee unreasonably rejected Dr. Gibbins' recommendations for accommodation. As well, UBC's reliance on the life-long nature of Dr. Kelly's disorder as a reason to conclude that he would not be successful even if the Gibbins' recommendations were implemented (e.g., see the last page of Dr. Kernahan's August 23, 2007 letter) was unreasonable, particularly in light of Dr. Gibbins' evidence that he would expect the effect of the disorder to be reduced if the accommodations were implemented.

[565] It may be that implementation of the accommodations would have sufficiently reduced the effect of the disorder in Dr. Kelly's learning and work environment to allow him to successfully complete

the Program. If he was not successful in his family practice training after having been provided these reasonable accommodations, then the Program would have been in a factually sustainable position to determine that it was unable to reasonably accommodate him within the Program without incurring undue hardship. As it now stands, it made that decision prematurely.

[566] Dr. Kelly was entitled to the reasonable accommodation of his disabilities within the learning and work environment. I appreciate that the physician educators and Committees involved with Dr. Kelly were dealing with a unique situation and reached conclusions they considered to be in the best interest of the Program. However, the decisions to preclude Dr. Kelly access to further remediation or probation, and to dismiss him from the Program, when assessed within the legal framework of UBC's human rights obligations towards Dr. Kelly under the *Code*, were discriminatory.

[567] Dr. Kelly's complaint under both s. 8 and s. 13 of the *Code* is justified.

REMEDY

[568] Having found the complaint to be justified, I must now determine the appropriate remedies to award pursuant to s. 37 of the *Code.*

Cease the Contravention

[569] An order under s. 37(2)(a) is mandatory when a finding is made that a complaint is justified. Therefore, I order the University of British Columbia to cease the contravention and refrain from committing the same or a similar contravention.

Further Hearing

[570] Further to the parties' agreement, the Case Manager will contact the parties to set dates for a hearing on what, if any, other remedies the Tribunal should order in all the circumstances.

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Enid Marion, Tribunal Member