not fit for duty! dealing with incapacitated professionals

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part 1 - introduction

“It wounds a man less to confess that he has failed in any pursuit through idleness, neglect, the love of pleasure, etc., etc., which are his own faults, than through incapacity and unfitness, which are the faults of his nature.”

Lord Melbourne

Self-regulating professions in Canada demand exacting standards of their members. The pressure to comply is significant as failure to do so can lead to disciplinary action and losing one’s license to practice. What then does a professional do when they begin to question their own capacity to meet these demands due to the onset or progression of a physical or mental illness, or substance use that has gotten out of control? In such an environment, it is unsurprisingly rare to hear of individuals self-reporting mental issues, addictions or other potential issues that can give rise to incapacity. Further, professionals tend to be proud of their membership in their profession, who, like Lord Melbourne, are loathe to report their own failures and deficiencies that threaten to tear them away from their chosen pursuit. Admitting that mental illness or addiction has affected a person’s ability to perform as a professional is a source of deep embarrassment; a stigma both personal and professional surrounds admissions of incapacity.

Understanding incapacity in the professions, the misguided stigma that surrounds it, and how different professions have chosen to deal with the problem, is essential in developing an informed means of protecting the profession, the public, and the individual suffering from incapacitating issues. The focus will be on Ontario professional regulators and case law, but the conclusions are largely applicable to all professional regulators in Canada.

(a) discipline, incompetence and incapacity

There are generally three paths by which a regulator can deal with the failure to maintain the standards exigent on a professional: (i) discipline; (ii) incompetence; and (iii) incapacity. However, not all professions deem there to be a difference procedurally between incapacity and incompetence, and, albeit rarely, some deal with all three under the rubric of discipline. In general, issues pertaining to professional negligence are not in the jurisdiction of the regulator, although there is often overlap between professional misconduct and negligence issues – the latter being a matter to be determined by civil legal remedies by the party affected by the professional negligence. Similarly, there is often overlap between discipline issues and issues of incompetence or incapacity.

Further the role of rehabilitation as opposed to “discipline”, with the connotation of punitive measures, requires analysis. Bringing a professional back within defined standards, rather than making it a threat to ‘get caught’ outside of those standards, is a more effective means of both dealing with incapacity as well as increasing self-reporting rates. The outcome benefits individual professionals as well as the profession at large.

For example, the Health Professions Procedural Code, deemed to be part of each health professions’ enabling legislation, defines incapacity as:
“incapacitated” means, in relation to a member, that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member’s certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practise.”¹

This definition can then be compared to the Health Professions Procedural Code for incompetence, which is found beneath the sections dealing with the composition and function of a panel formed by a discipline committee:

“(1) A panel shall find a member to be incompetent if the member’s professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practice or that the member’s practice should be restricted.

(2) If a panel finds a member is incompetent, it may make an order doing any one or more of the following: 1. Directing the Registrar to revoke the member’s certificate of registration. 2. Directing the Registrar to suspend the member’s certificate of registration. 3. Directing the Registrar to impose specified terms, conditions and limitations on the member’s certificate of registration for a specified period of time or indefinite period of time.”²

Revoking or limiting the professional’s license for incapacity is done for the good of the public. Comparatively, the orders available for a finding of incompetence are similar to those for discipline against an individual practitioner. Regardless of the reason for the order, the potential outcomes for the disciplined professional are largely identical to that for an incompetent professional. Whether the individual’s ability to function as a professional is affected by a source outside of their control or through what amounts to a form of professional misconduct, the regulator’s orders end with the same result.

In comparison, the Professional Engineers Act deals with allegations of incapacity and incompetence through the same Discipline Committee, rather than attempting to construct two paths of regulating professional conduct that falls below the required standards, and effectively arrives at the same destination.³

(b) the meaning of ‘incapacity’

Incapacity can stem from many sources. Substance abuse disorders, including addictions or excessive use of drugs or alcohol, are a common source. For example, addiction rates

² Ibid at s. 52.
³ Professional Engineers Act, s.28(3)(b) definition of incapacity: “the member or holder is suffering from a physical or mental condition or disorder of a nature and extent making it desirable in the interests of the public or the member or the holder that the member of holder no longer be permitted to engage in the practice of professional engineering or that his or her practice of professional engineering be restricted.” Interestingly, the PEA also takes into consideration the member’s own interests as a reason to revoke or limit his or her licence.
among Canadian lawyers are estimated to be between 10% to 20%. High levels of stress, and career related rewards for continuous performance is certainly not unique to lawyers. Such pressures can give rise to mental and emotional disorders, or be the breaking point for managing already existing conditions. Less common but just as difficult for individuals to self-report is physical, cognitive or sensory disabilities linked to health problems.

Of course, all of these sources can just as easily give rise to discipline stemming from professional misconduct (or a lawsuit arising from professional negligence), but the ideal solution is catching an incapacity problem before the public or the profession is impacted through an individual’s conduct. Procedure dealing with incapacity should provide early warning to catch the types of problems and behaviours that, unchecked, can lead to damaging conduct.

(i) case law illustrating the boundaries of incapacity

The case Dr. Gregorio P. Bayang v. The College of Physicians and Surgeons of Ontario\(^5\) provides one example of a tragic outcome from a procedural failure to identify incapacity in a professional. Dr. Bayang, the appellant in the case, was an anaesthetist in Ontario. Originally from the Philippines where he received his medical degree, Dr. Bayang immigrated to the United States, where he interned between 1959 and 1962. He made his move to Canada in 1963, taking a fellowship in rehabilitation medicine at the University of Saskatchewan. His medical career from that point took him to Halifax before finally settling in Whitby as a staff anaesthetist.

Dr. Bayang was brought before the Discipline Committee of the College of Physicians and Surgeons of Ontario (the “College”) on charges of misconduct and incompetence in 1990. He was 57 years old at the time, and had no previous complaints lodged against him.

The incident that led to the eventual charge involved the death of a patient who had been admitted to the Oshawa General Hospital for jaw surgery. During the course of administering anaesthetics in preparation for the surgery, she suffered cardiac arrest. Attempts to resuscitate her were not successful.

During the College’s review of the incident, Dr. Bayang was unable to fully assure the reviewing panel that he had managed the situation to the level required of his profession. As the role of the College’s review body is not disciplinary in nature, it recommended a neuropsychological assessment. The assessment found a general slowing of Dr. Bayang’s mental abilities, such as memory, managing multiple tasks at once, problem-solving abilities, and a deterioration of his muscle coordination and speed. Simply put, he was suffering from dementia.

The College asked for, and received, an undertaking from Dr. Bayang that he would not practice medicine until the question of his mental health could be fully determined. He repeatedly broke this undertaking, for which ultimately his license was then revoked by the College’s Discipline Committee.

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\(^5\) (1993), 63 OAC 141 (ONDivCt) [Dr. Gregorio].
On appeal, the Ontario Superior Court of Justice partially overturned the Committee’s order. The court’s reasons provide a useful analysis of the difference between incompetence and incapacity. The former “carries with it a connotation of ‘mea culpa’ – e.g. (i) voluntary ingestion of alcohol/drugs to a degree that renders the doctor incompetent to provide proper care to the patient, (ii) failure to ‘stay current’” which leads to a deficiency in treatment.”

In fact, the discipline hearing to which Dr. Bayang was subjected was the improper legal route to deal with a failure to meet the standards required of a profession of this nature. Instead, a fitness hearing, not a disciplinary one, is the “proper legal route” for handling incapacity, along with being “the humanitarian route.”

The court admits that the result of both a discipline and a fitness hearing may end up being the same, but the end result does not affect the proper procedure a regulatory body should employ in its review. A fitness hearing is the proper legal route when the cause of the professional’s condition “is through no fault of the [individual].”

Unfortunately for Dr. Bayang, while the discipline based on ‘incompetence’ was dismissed, the revocation of his license was upheld due to his misconduct in repeatedly breaching his undertaking to stop practicing medicine. From his testimony, it is clear that Dr. Bayang, even after receiving his neurophysical diagnosis, did not believe that he was incapacitated and unable to perform his job to the standards required by his profession. He was simply unwilling to admit that fact, which is perhaps the most relatable part of the entire case for any professional, regardless of their field of practice.

The discussion defining the envelope of incapacity continues in Mason v. Registered Nurses’ Association of British Columbia. The decision in Mason illustrates the difference between both incapacity and incompetence when compared to negligence, an issue outside the purview of the professional regulators. Mason is found incompetent by a discipline committee resulting in a suspension of her license for an indefinite period due to numerous errors made administering medicine and record-keeping while on duty. These mistakes were compounded by her recalcitrance when confronted with the errors, which was seen by the regulatory body as indicative of the likelihood of patients being exposed to life-threatening errors in the future.

Mason then appealed to the British Columbia Superior Court. Summarizing from cases submitted to the court by the appellant, the court outlines five principles that help to define incompetence and separate it from negligence:

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6 *Ibid* at para 44.
7 *Ibid* at para 41.
8 *Ibid*.
9 *Ibid* at para 43.
10 It is worth noting that the obiter discussion of the court concerning incompetence stemming from voluntary actions, like drug and alcohol use, would likely be different if the case was decided today, when substance addiction is often treated as a disease rather than the fully voluntary choice of an individual.
11 [1979] 5 WWR 509 (BCSC) [*Mason*].
i. The particular definition placed upon the word ‘incompetency’ should be moulded by the object of the enactment in which the word appears, in this case the Registered Nurses’ Act, as amended. In this respect, it is submitted that the statement of statutory purpose quoted from the Kansas State Board of Healing Arts v. Foote [supra] is appropriate to the statute under consideration here.

ii. All the definitions of ‘incompetency’ focus on the lack of ability, capacity or fitness for a particular purpose.

iii. The want of capacity, ability or fitness may rise from a lack of physical or mental attributes. However, a person not lacking in physical or mental attributes may nonetheless be incompetent by reason of a deficiency of disposition to use his or her abilities and experience properly.

iv. Negligence and incompetence are not interchangeable terms. A competent nurse may sometimes be negligent without being incompetent. However, habitual negligence may amount to incompetence.

v. A single act of negligence unaccompanied by circumstances tending to show incompetency will not of itself amount to incompetence.

The difference between incompetence and negligence is an important one in the development of a means of dealing with incapacity in the professions. It is distinguishable from situations where discipline is best suited to deal with a breach of standards.

The development of jurisprudence surrounding incapacity continues a couple years after Mason with Reich v. College of Physicians and Surgeons (British Columbia), which holds that an inquiry into incompetence is not the same as an inquiry into incapacity. At issue in the case is not the capacity to practice, or the ‘fitness’, of Dr. Reich, but rather his actual technical skill and knowledge.

The discipline against Dr. Reich proceeded under s.48(1) of the British Columbia Medical Practitioners Act. The court found s.48 to be the proper section under which to bring the

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12 R.S.B.C. 1970, Chapter 335 [RNABC].

13 The statement, cited earlier in the ruling, is: “The whole purpose and tenor of the Healing Arts Act [the title of the Kansas health statute] is the protection of the public against unprofessional, improper, unauthorized and unqualified practice of the healing arts. The goal is to secure to the people the services of competent, trustworthy practitioners. The Act seeks to do this through licensure. The licensing by the state, granted only after minimal standards of proficiency are met, amounts to the state’s recognition of the licentiate as a qualified practitioner. The continued holding of the licence may be taken by the public as official indication those standards are being maintained. The object of both granting and revoking a licence is the same — to exclude the incompetent or unscrupulous from the practice of the healing arts”, at para 35.

14 Mason at para 35.

15 1981 CarswellBC 674, 126 D.L.R. (3d) 559 (BCSC) [Reich].

16 S.B.C. Chapter 254.
hearing, and further found that the required procedural elements of the hearing had been followed. In its reasons, the court reviews the sections of the Act that outlines available methods of review:

"Under s.48 the procedure is employed to investigate the skills and knowledge of a member to practice medicine.

Under s.50 the inquiry is directed to charges or complaints made concerning the conduct, mental condition, capability or fitness to practice.

Under ss.55 and 56, action is taken on reports that a member is suffering from a physical or mental ailment, emotional disturbance, or addiction to alcohol or drugs that may constitute a danger to the public."17

This separation of proceedings, though still all grouped under discipline, shows the distinction between incapacity and incompetence. The court does admit that the distinction between an inquiry into "the capabilities or fitness to practice medicine" and the actual technical skills and knowledge "may become a very fine one at times."18 Despite the potential similarities between the two types of proceedings, the court does uphold the distinction and finds that an inquiry into Dr. Reich’s technical skill was the proper procedure. More so, the court further defined incompetence by holding that there was no dispute that Dr. Reich possessed adequate skill and knowledge, but declined to use it, and so was held to "lack those skills when he comes to treat his patients."19

part 2 - dealing with incapacity

(a) the goals of regulating incapacity

Professional regulators must not only ensure that solely qualified practitioners enter into the profession, but also that, once in, practitioners remain capable and practice within appropriate standards.

Providing protection against unprofessional, improper, unauthorized and unqualified practice of professionals is a regulator’s duty to the public. Also, to ensure the success of the profession, and the continued self-regulating existence that the professions in Canada generally enjoy, the public must maintain confidence that a registered member, through the licensing process, will provide services that are competent and trustworthy. Through licensing or registration, the regulator formally recognizes that someone is a qualified practitioner, having met the minimal standards of the profession. The professional, by default, should be seen by the public as possessing the necessary judgment, skill, ability and knowledge to exercise his or her profession.

Dealing with incapacity issues is aimed at the protection of the vulnerable interests of the public, which has placed its confidence in the licensing process of the regulator and its ability to govern the profession.

17 Reich, supra note 15.
18 Ibid at para 8.
19 Ibid at para 13.
In order to redefine incapacity as a reason for rehabilitation, of providing assistance in overcoming or managing incapacity rather than pure discipline, such assistance must comply with the overarching considerations of professional regulators. The four main considerations are:

i. the protection of the public;

ii. the rehabilitation of the professional;

iii. general and specific deterrence, if possible, though this is limited to addictions and their associated behaviour; and,

iv. maintaining public confidence in the profession, and in the professional regulator.

If these considerations are threatened by a professional’s incapacity, there are several methods of remedying the situation. A license can be revoked or suspended for a specified or indefinite period of time. If full revocation is not necessary, specific terms, conditions or limitations on the licence can be ordered, including a term requiring the production of satisfactory evidence of physical or mental wellness in respect of which the sanction was originally imposed resolving the incapacity. In less serious cases, such as those not brought by way of complaint, but through notice provided to a regulator from colleagues or through self-reporting, postponed sanctions can be specified that take effect if terms are not met within a period of time. Finally, the regulatory body can use its discretion to impose appropriate sanctions to protect the public and attempt to remedy any loss of confidence.

The case Law Society of Upper Canada v. Gidron Macdonald O’Carroll Cadogan\(^{20}\) provides an example of a lawyer whose license was suspended due to incapacity, based on the medical evidence of mental and physical issues affecting the lawyer.

The complaint that began the proceedings against Mr. Cadogan stemmed from issues over multiple mortgages and associated monies that were not registered, and funds improperly disbursed or otherwise handled in contravention of Law Society of Upper Canada (“\textit{Law Society}”) standards. Mr. Cadogan was found to satisfy the definition of incapacitated under s.37 of the \textit{Law Society Act}\(^{21}\) which reads:

“A licensee is incapacitated for the purposes of this Act if, by reason of physical or mental illness, other infirmity or addiction to or excessive use of alcohol or drugs, he or she is incapable of meeting any of his or her obligations as a licensee.”\(^{22}\)

Called to the bar in 1997, Mr. Cadogan was a sole practitioner until being joined by his brother in 2000. The complaints arose between September 2005 and April 2006. There were 29 complaints, and Mr. Cadogan was arrested and charged with fraud for amounts nearing $1 million. The medical examiner that conducted a battery of tests on Mr. Cadogan found abnormal brain images which suggested significant memory loss and serious

\(^{20}\) 2009 ONLSHP 42 [Cadogan].

\(^{21}\) SO 1990, c L.8 [LSA].

\(^{22}\) Ibid, s. 37(1).
progressive neurodegeneration. 23 The outlook was very negative, with little to no hope of future recovery to any level capable of meeting the standards required of the legal profession.

The Law Society hearing panel found that Mr. Cadogan was incapacitated. From this conclusion, it was held that Mr. Cadogan could not be held responsible for the misconduct detailed in the complaints against him, and secondly, that Mr. Cadogan’s license be suspended indefinitely until psychiatric evidence could be presented that satisfied the Law Society that he was no longer incapacitated. 24

The indefinite suspension of Mr. Cadogan’s license until it could be shown that the incapacity was gone satisfies the four overarching considerations of the Law Society as best as can be expected. The public is no longer exposed to an incapacitated lawyer. The profession is seen performing its role in protecting the public, and safeguarding the integrity of the profession. Deterrence is accomplished as well by encouraging professions to seek earlier assistance and to watch for warning signs of incapacity. Finally, Mr. Cadogan is protected from liability stemming from any subsequent professional misconduct that would no longer be excusable through reliance on an undetected incapacity.

A further example where the protection of the public takes precedence over the incapacitated professional is the decision of the Ontario College of Teachers in Ellis v. College of Teachers (Ontario). 25 Mr. Ellis, a high school teacher of the Peel District School Board, made a series of complaints to the board that students were being physically and sexually abused at his school, but school officials were covering up the incidents. 26

The Board suspended Mr. Ellis and informed the College of Teachers. The College commenced an investigation into the issue and referred the matter to its Fitness to Practice Committee. The expert evidence relied upon by the Committee was a report by a forensic psychiatrist based upon a brief of documents rather than a direct assessment of Mr. Ellis. The admissibility, and, alternatively, the weight given to the report, was one of the issues on the appeal of the revocation of Mr. Elli’s certificate of qualification and registration to the Ontario Superior Court of Justice.

The report concluded that Mr. Ellis was suffering from a mental disorder giving rise to delusions that were firmly believed by the sufferer. 27 The potential impact on the public of Mr. Ellis’s allegations, along with Mr. Ellis’ lack of any submissions in his defence at his hearing, was deemed a strong enough concern to revoke a teacher’s license without a direct psychiatric examination. The court upheld the decision of the College of Teachers, finding no breach of procedural fairness and no issue with the admissibility nor weight provided to the psychiatric report.

23 Cadogan, supra note 20 at para 16.
24 Ibid at para 22 and 27.
25 2011 ONSC 4134 [Ellis].
26 Ibid at para 3.
27 Ibid at para 10.
Protecting the public is of the utmost importance when balancing interests in an incapacity hearing. In *Ellis*, a swift conclusion to the matter was more important than any delay that would have been caused by waiting for a full psychiatric review.

(b) process for dealing with incapacity

(i) the complexities inherent in developing a process

*Cadogan* provides an example of a regulator process handling professional incapacity. It grapples with the questions at the foundation of establishing a functional process for dealing with incapacity. The procedure to follow will generally be determined by the enabling legislation. However, the process is still an organic one that must adapt to the scenario faced by the regulator.

The first step in a procedure dealing with incapacity is to determine if there is an urgent situation requiring an interim order suspending a member’s license. For instance, is there imminent harm to patients if a doctor or nurse is allowed to continue practicing, or could a client be prejudiced by a lawyer’s actions? Further, is there a need to continue a practice while the professional is incapable of fulfilling his or her duties so that it should be taken over by another professional?

The level of privacy afforded to individuals and to the proceedings of regulatory bodies is also a concern that must adapt to the situation at hand. During an investigation, what information can or must be disclosed, and who is the proper body to receive it is likely to be heavily influenced by the parties involved. Often, this type of information could seriously impact the reputation of the individual, possibly irreparably damaging his or her future professional career. Professional regulators are generally bound by their enabling legislation to maintain all personal information obtained over the course of an investigation in confidence.

Flowing from the issue of privacy is determining whether the individual needs to undergo an examination by a qualified physician. In most circumstances, this should be the obvious next step to establish that the individual is indeed incapacitated. Medical evidence becomes especially important when there is a question of whether to proceed under a disciplinary procedure or to determine fitness for duty. However, it is possible that a mandated examination by a physical in every situation could deter individuals from self-reporting due to a feeling of violation and a lack of trust from the regulator in trusting one of its members.

After the investigation is complete, in deciding whether a matter should proceed by way of a discipline or fitness hearing, it may be difficult to determine where the line is drawn between the two to ensure that the interests of the individual are served, while still satisfying the public that a professional claiming incapacity is not automatically treated preferentially. This decision is likely to be influenced by whether the issue of incapacity is the only issue that needs to be dealt with, or whether there others that should be properly addressed by a different procedure.

Finally, there are also concerns surrounding the impact on the professional outside of the investigation and hearing. Should the hearing and its results be closed or open to the public, and if closed, for how long or to what extent should the results be shielded from exposure to the public and the media? And what of the professional’s practice, should a
trustee take the professional’s place if the infrastructure does not exist to handle the loss of
the professional to the satisfaction of his or her clients?

(ii) sources of discovery

Professional regulators cannot work towards any of the overarching considerations in
dealing with incapacitated professions without some means of identifying members suffering
from or predisposed to incapacitation. Incapacity can come to the regulator’s attention via
five main sources:

1. self-reporting;
2. mandatory third-party reporting;
3. complaints from the public;
4. information obtained by the registrar through some other source; and,
5. investigations.

Establishing a successful means of obtaining information is especially important when it
comes to causes of incapacity that are easily hidden – at least in their early stages. The
ease of hiding signs of incapacity is the reason information concerning incapacity is often
brought into the light only following allegations of incompetence or misconduct.

(1) self-reporting

Encouraging self-reporting by professionals is the single most effective means of identifying
signs of incapacity early and, if possible, treating the problem. Self-reporting allows a
professional regulator to satisfy all of its overarching considerations, as the individual, the
profession and the public are all protected by early detection. But, per the quote that
opened this paper, self-reporting the types of deeply personal issues at the core of
incapacity is difficult to come to terms with for many people, professional or otherwise.

Whether mandatory or voluntary, even without a professional duty to self-report, there is
still an underlying obligation to act in the interests of clients and patients. As such, a
member of any profession should have a duty to cease practising if their physical or mental
state makes practicing a threat to upholding their professional responsibilities. In fact,
voluntary cessation of practice may be one route for the professional who does not wish to
admit to incapacity issues.

The Health Professions Procedural Code contains a rule requiring mandatory self-reporting
of professional negligence or malpractice.28 It is not much of a reach to foresee requiring
mandatory self-reporting of incapacity under threat of fine or other disciplinary action,
though an issue would undoubtedly arise as to when a professional is or should have been
aware of his or her own incapacity.

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28 HPPC, supra note 1, S. 85.6.2(1): A member shall file a report in writing with the Registrar if there
has been a finding of professional negligence or malpractice made against the member.
One of the primary barriers to self-reporting is the inherent fear of social embarrassment stemming from admitting incapacity. This question of public exposure of potentially embarrassing information is dealt with in Law Society of Upper Canada v. Yu-Fui Charles Chu. Mr. Chu was found to suffer from delusions, the conclusion made in a psychiatric examination mandated by the Law Society. However, though Mr. Chu contested its disclosure, it was held that no restriction was necessary on public attendance at the hearing, or a non-publication order, available to the hearing committee under the Rules of Practice and Procedure.

Mr. Chu was understandably vexed about the public disclosure of the medical evidence, which provided extensive detail of the paranoid delusions from which he suffered. During the time of the fraudulent transactions that form the basis for the complaints levelled against Mr. Chu, he believed a malicious presence was targeting him, and only communicating with an entity he believed to be Buddha could keep him safe. He would talk to Buddha, asking advice, and he then followed any advice he believed Buddha gave him, even with regards to his legal practice. The delusions, more than just affecting his mental state, had impacted his physical existence as well. Mr. Chu had begun sleeping in a closet of his home to keep himself safe from the malicious presence while he was unconscious. One can surmise that such acts are indicative of wider impacts on his life, both professional and personal.

While the hearing panel felt that public disclosure of such reports should be allowed, and that anyone reading such reports would feel compassion rather than ridicule towards Mr. Chu, Mr. Chu’s concerns highlight a major problem at the centre of any attempt to increase rates of self-reporting. Even if the professional is aware that mental issues are affecting his abilities to maintain standards required of him or her, fear of derision can be a powerful force to stop an individual from self-reporting unless there is some strong assurance of privacy.

The opposite side of the privacy spectrum is presented in Law Society of Upper Canada v. Tracey Marie Resetar. The court in Resetar granted an in camera order over the medical evidence submitted to prove Ms. Resatar’s incapacity. A suspension of her license for incapacity was ordered, but the reasons provided were extremely limited. While this decision protected the member’s privacy, it also provided no analysis as to what can comprise incapacity in order to guide future professionals in their own self-reporting obligations, nor does it reassure the public as to the finding of incapacity in this instance over a finding of misconduct requiring discipline.

Achieving the appropriate balance between transparency and public disclosure of incapacity hearings and a member’s right to privacy is a difficult one. It requires a degree of ethical arithmetic to determine the best level of public disclosure required to satisfy all of the

29 2008 ONLSHP 011 [Yu-Fui].
30 The case refers to the version of the Rules of Practice and Procedure in effect prior to July 1, 2009.
31 Yu-Fui, supra note 29 at para 19.
32 Ibid at para 18.
33 Ibid at para 27.
34 2007 ONLSHP 71 [Resetar].
overarching considerations of professional regulators, yet sufficient respect for privacy to encourage self-reporting. A fact dependant analysis is likely required in most situations, with a strong leaning towards public disclosure, at least of the basic details and the result of a hearing.

*(2) mandatory third-party reporting*

Third-party reporting can come from several sources. A professional’s peers can be forced to report any conduct that could give rise to a presumption of incapacity. In the healthcare context, facility operators and employers are subject to a mandatory requirement to report any noteworthy conduct to regulators.

The threshold for triggering mandatory reporting is difficult to define. Establishing a common understanding of ‘reasonable grounds to believe a member is incapacitated or unfit to practice’ would be essential in any mandatory reporting scheme. Also, conflicts of interests, both professionally and personally, could arise in such a scheme.

The healthcare professional field has widely adopted a robust mandatory reporting scheme required of both fellow professionals and facility operators and employers. Mandatory reporting is required whenever an employee is dismissed for cause based on professional misconduct, incompetence or incapacity. A report about the dismissal must be submitted to the College to which the healthcare professional belongs within a specified timeframe, for example, thirty days under the *Health Professions Procedural Code*.35 Failure to report within the timeframe can result in a fine.

This mandatory reporting rule functioned successfully in *Johnson v. College of Nurses (Ontario)*.36 The College of Nurses was notified about Ms. Johnson’s potential incapacity by a report from the Hospital Chief Nursing Officer. In response, the College convened a review panel, and commissioned a psychiatric report in accordance with its statutory mandate.

The appointed psychiatrist relied upon primary data from Ms. Johnson herself, but also reports received from Ms. Johnson’s supervisors and colleagues at the hospital. It was the veracity of these reports that formed part of the basis for Ms. Johnson’s appeal to the Ontario Superior Court of Justice of the review panel’s order suspending her license for incapacity.

Based on the data received, the psychiatrist testified at the hearing that Ms. Johnson suffered from “a significant clinical disturbance characterized as obsessive-compulsive disorder features together with a poorly differentiated personality disorder that seriously impairs her insight and judgment.”37 The incapacity identified in the report supported an indefinite suspension of Ms. Johnson’s license. Her mental condition “manifested an extreme rigidity in her thought patterns, including an inability to see the point of view of others or to make clinical judgments considering alternate appropriate approaches to care for clients in diverse settings and contexts and displayed a tendency towards paranoid

35 *HPPC*, *supra* note 1, s.85.
36 2006 CarswellOnt 280, 208 OAC 374 (ONDivCt) [*Johnson*].
thoughts about former employers, colleagues and the College.”38 The finding of incapacity is tailored to Ms. Johnson’s unique professional demands, and the panel’s decision is certainly influenced by third-party reports detailing interactions with her.

The court applied a reasonableness standard of review and agreed with the panel’s findings, noting no reason to overturn the panel’s order.

(3) complaints from the public

The most common and arguably the least effective means of controlling incapacity by regulators is through complaints lodged by members of the public. By the time a complaint is made, it is very likely there has already been a failure to control several of the overarching considerations. The professional is incapacitated to such a point where even a lay member of the public is aware of a violation of the standards, the reputation of the profession is already damaged, and the professional would have likely benefited from help far sooner than by the time the complaint is made.

Public complaints are likely to stem from issues of misconduct and incompetence that most directly affect the client, rather than more general complaints that the professional is incapacitated. The formal requirements for complaints by the public can be employed to control spurious claims made by parties, for example, claims of misconduct after an upsetting outcome to a trial. For example, while the College of Physicians and Surgeons allows verbal complaints, the Professional Engineers of Ontario requires any complaint to be submitted in writing.

(4) information obtained by the regulator

A regulator should also keep an open ear to generally disseminated information, such as any reports of misconduct found in the media or other sources that directly or indirectly raise incapacity issues concerning professionals. An example of this can be a news report on a professional charged with a drug offence. Keeping generally abreast of any publically available information will allow a regulator to limit damage to the public, to the profession and to the people involved by proactively engaging in the situation.

(5) investigation

Learning of incapacity through public information is closely tied to investigation, as a follow-up act to any leads passively gathered by the regulator. In fact, when information concerning a professional’s possible incapacity is obtained, there is an obligation on the regulator to investigate the issue of incapacity.

Ideally, the member cooperates and the issue can be resolved after an assessment is made of the member’s condition. Often, encouraging the member to seek external assistance, such as confidential counselling or treatment, may be the practical solution, which can be resolved through a memorandum of agreement signed by the member.

38 Ibid at para 12.
However, especially where the member is not cooperative, there may be urgent issues regarding harm to clients, and a decision has to be made regarding interim suspensions and possibly a court order regarding custodianship of a professional’s practice.

Many professional regulators also engage in partnerships with private sector agencies or organizations to structure programs designed to accomplish early detection, intervention and, as needed, treatment for impaired professionals. An investigation may find that this type of treatment is all that is required.

Examples of professional programs dealing with substance abuse and addiction, psychiatric and mental health concerns, stress, burnout, other work-related conflict, and sometimes family conflict are the Lawyer’s Assistance Program, offered throughout Canada by provincial law societies, or through arrangements made by the Canadian Bar Association, and the Physicians Health or Professionals Health Program, which is available to physicians and nurses, as well as pharmacists and veterinarians.

Ultimately, if the investigation finds information to support a finding of incapacity, then the investigation committee would have to decide whether the situation should be handled by a referral to discipline for misconduct or incompetence, or if it is better dealt with under a fitness to practice hearing, dependant on the particular situation.

(c) existing methods for handling incapacity

The professions have established methods of dealing with the issues of incapacity. The first step in establishing an approach is to look to the enabling legislation. Second, to develop a practice or process that makes sense to the profession’s membership. The following review of a few different professional regulatory bodies in Ontario is based on publically available information or questions posed directly to representatives of the different regulators.

(i) college of physicians and surgeons

The guiding legislation for the College has been widely cited above. It is of little surprise that the health professions are the most heavily regulated in Canada. The Regulated Health Professions Act, Health Professions Procedural Code and the Medicine Act all govern this regulatory body in Ontario.

The College has a highly developed procedure to handle the identification and treatment of incapacity. The term is specifically defined, and any identified issues go to a Fitness to Practice Committee rather than a discipline committee. There are also onerous mandatory reporting requirements for facility operators and employers, while also ensuring the public complaint process is accessible.

With regards to privacy for the professionals, while the hearings themselves are not public, the decisions are published, but only if there is a finding of incapacity.

The mandatory reporting requirements are outlined at s.85 of the Health Professions Procedural Code. If working as a Facility Operator (e.g. in charge of a hospital or a clinic), that physician will have a mandatory reporting obligation to report a physician’s incapacity.
issues. For physicians who are not Facility Operators, they are not legally obliged but rather have a permissive disclosure regime: they are allowed to report another physician’s suspected incapacity issues, but this is not a mandatory obligation.

Even this regulatory framework is not without conflict. An interesting scenario arises where doctor A, by treating doctor B, learns that doctor B has developed MS and is a surgeon. Patient confidentiality would come into conflict with the doctor’s permissive ability to report, as well as doctor A’s requirement to protect patients.

Concerning complaints from the public, patients can report incapacity issues to the College. Most often a verbal report is made via telephone to the College, where a patient can speak to an experienced physician about a perceived issue. This step allows the College to provide outreach, as well as filtering out unfounded complaints. The complainant can be referred to a College clinician, who will take all the pertinent information from the complainant and advise them of whether the physician’s behaviour was normal or appropriate.

Where inappropriate behaviour is identified, the College will request a complaint in writing detailing the persons, events and timing comprising the incident. This is the preferred method of receiving complaints by the College. However, making a written complaint is not a requirement to substantiate a complaint on which the College will take action.

The decision to follow-up on a non-written complaint is highly situational. The College will review the complaint and the specific physician. The matter may then be referred to an investigator, or the College itself may follow up on the issue directly prior to launching an investigation.

Self-reporting of incapacity is not specifically required of physicians. Self-reporting does exist in other contexts however, such as during the College’s annual license renewal survey, which includes a question about substance abuse problems. However, as previously discussed, such a simple barrier requiring self-reporting cannot be expected to pull the truth from every member of the College.

What about a scenario where a surgeon begins to develop multiple sclerosis, is there a requirement to self-report the potential for incapacity? They are permitted to self-report, but there is no specific mandatory reporting obligation. However, there is a duty for all physicians to act ethically, and if there is an issue, they must act to protect patient health and safety. And so, in this circuitous fashion, it could be found that a duty to self-report potential incapacity exists if there is any way patient care could be compromised.

The types of restrictions, penalties and orders available to the College does provide for both the ability to order rehabilitation and to discipline incapacitated members. If rehabilitation is required, (a substance abuse problem for example), the physician can be ordered to enroll in the Physicians Health Program.

The College may impose restrictions on the physician’s practice, request the physician voluntarily stop practicing in certain areas of medicine, or the issue can be forwarded to

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39 HPPC, supra, note 1 at s.85.2.
40 Ibid at s.85.1.
the Fitness to Practice Committee. The Committee will review the situation and can make various orders. Orders can range from taking no action at all to suspending the physician’s license. Driving the content of an order is the primary concern of protecting the public.

Beyond the initial finding of incapacity, the College can also implement a monitoring process. For example, restrictions can be placed on the physician’s license that requires submitting to monitoring through the Physicians Health Program and the requirement of taking a medical records keeping course. The Physicians Health Program health monitoring guidelines are robust, allowing for involved oversight that ensures a commitment to rehabilitation.42

(ii) association of professional engineers of Ontario43

The procedure around incapacity under the *Professional Engineers Act* is intermingled with incompetence. Hearings for both fall under the mandate of the Discipline Committee, rather than a separate fitness for duty committee:

(3) The Discipline Committee may find a member of the Association or a holder of a temporary licence, a provisional licence or a limited licence to be incompetent if in its opinion,

... 

(b) the member or holder is suffering from a physical or mental condition or disorder of a nature and extent making it desirable in the interests of the public or the member or holder

41 For example, cease conducting tasks or practicing in areas of the healthcare profession that require a particularly high degree of physical endurance or dexterity, or sustained mental alertness.

42 The College defines the role of a Health Monitor on their website, available at http://www.cpso.on.ca/policies/guidelines/default.aspx?id=3316:

“A Health Monitor is responsible for treating a supervised physician for particular health issues. This individual, who is not necessarily a physician (e.g. psychotherapist, etc.) is required to report to the College on a regular basis, as well as when the physician is not complying with treatment recommendations, and/or when the physician’s health may be affecting his/her ability to practice safely.

The College is involved in the monitoring of members with all manner of health conditions which may affect their practices, including physical conditions such as Parkinson’s disease or dementia; substance use disorders; and mental health conditions such as depression or schizophrenia.

A large proportion of physicians being monitored for health reasons by the College are monitored through the Physician Health Program of the Ontario Medical Association (the PHP); specifically, at present, those physicians who have been diagnosed with substance use disorders or Axis-1 mental health conditions (from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). In such cases, the PHP oversees and manages the physician’s health care and practice monitoring. The PHP then reports to the College on a regular and as-needed basis. Other types of health monitoring are conducted directly by the College. The duration and frequency of such health monitoring is determined by the College.

Generally, the physician will have input into the selection of a Health Monitor.”

43 Also known as Professional Engineers Ontario, or, “PEO”.

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that the member or holder no longer be permitted to engage in the practice of professional engineering or that his or her practice of professional engineering be restricted.44

Thus, while defined as ‘incompetence,’ the scope of incapacity under the PEA is comparable to its definition under the Health Professions Procedural Code.

However, the duty to report, either by employers, other professionals, or through self-reporting is far less defined. While the Code of Ethics does dictate a duty to report anything that is in breach of the PEA or its regulations, as well as the duty to the profession and the public, the Code of Ethics is not strictly enforceable.45

Complaints are required to be in writing. The lack of public outreach is not overly surprising, as complaints over the professional conduct of an engineer are more likely to come in a commercial context, be of a less personal nature than found in a healthcare context, and relate to negligence rather than misconduct or incapacity. Complaints are received by the Complaints Committee, who commence preliminary investigation of the issue, and if necessary forward the issue to the Discipline Committee.

For complaints received from the public, there is a specific form on the PEO website to be completed, as well as an information guide detailing the required process.46 The guide talks about the PEO’s jurisdiction as a self-regulated authority, and states that members of the public can call the PEO to discuss any issues. If a complaint form is filed, the formal investigation process follows. Usually the complaint is fairly general, and the investigation elucidates detail.

There is, strictly speaking, no requirement to self-report. However, members are permitted to retire and retain their professional designation, allowing a member aware of a developing incapacity to retain their professional status while no longer practicing, avoiding any embarrassment resulting from submitting to an investigation by their regulatory body.

The PEO can initiate an investigation without receiving an actual formal complaint under s. 33 of the PEA for incompetence. This is a rare and formal procedure, as it requires the involvement of the Registrar. It would usually only arise where there is something egregious reported in the media.

Found in s.28(3)(b) cited above, conditions restricting or curtailing a member’s license can be ordered by the Discipline Committee following a hearing. While the committee will decide what measure to impose, there is no identified rehabilitation program explicitly mentioned. Further, while the regulator will monitor the penalties imposed by disciplinary decisions, there is no strict monitoring program in place, and the process relies to a significant degree on self-moderated compliance with orders.

44 Professional Engineers Act, RSO 1990, c P.28, s. 28(3)(b) [PEA].
45 Professional Engineers Act, Regulations, General, RRO 1990, Reg 941, s. 77.
While not as encompassing as the healthcare profession legislation or the *PEA*, the *Chartered Accountants Act*\(^{47}\) does provide for a similar process as the other statutes already examined. The definition of incapacity in the *CAA* is a mirror of those cited earlier from other professions:

“A member of the Institute is incapacitated ... if, by reason of physical or mental illness, condition or disorder, other infirmity or addiction to or excessive use of alcohol or drugs, he or she is incapable of meeting his or her obligations under this Act.”\(^{48}\)

There is no mandatory reporting requirement with respect to incapacitation. However, there is a strong argument it is caught by the Chartered Accountant *Rules of Professional Conduct* at s.211.1, which requires any member or firm to report to the regulatory any information concerning a breach of conduct, or any information raising doubt as to the “competence, reputation or integrity of a member.”\(^{49}\)

The form that a public complaint must take is not dictated, but information from an Institute representative suggests that a complaint will only be investigated if it is received in writing.

If the regulator receives information suggesting that a member is incapacitated, the registrar may investigate the matter, which can then be followed up with an application to a committee for a determination as to the member’s capacity.\(^{50}\)

If the Capacity Committee determines that it is necessary to obtain the opinion of a physician or psychologist in order to determine whether a member is incapacitated, the committee may, on its own or on motion, order the member to undergo a medical or psychological examination.\(^{51}\)

Interestingly, upon a finding of incapacity, the Capacity Committee has the mandate to order a suspension of a member’s membership, impose restrictions or conditions on the member’s right to practice as a Chartered Accountant, and to make any other order that the committee considers necessary to protect the public interest, except revoking the member’s membership.\(^{52}\) This limitation on the orders available to the Capacity Committee suggests a focus on rehabilitation of a member, rather than discipline. Further, the Institute has an Employee Assistance Program, which is a voluntary program offered to accountants separate from the discipline process. Requiring participation in this form of rehabilitation is open to the Capacity Committee as well.

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\(^{47}\) 2010, SO 2010, c 6, Sch C [CAA]

\(^{48}\) Ibid, s.42.

\(^{49}\) Institute of Chartered Accountants of Ontario, *Rules of Professional Conduct*, s.211.1.

\(^{50}\) *CAA*, supra note 47, s.44 – s.45.

\(^{51}\) *Ibid*, s. 44(3).

\(^{52}\) *Ibid*, s.44(8).
While no formal mentoring or monitoring system is in place, there is an established mechanism for dealing with client files of a member under suspension for incapacity, or any reason. By-law 103 provides for the Institute to apply to a court to obtain an order authorizing a member designated by the Institute to act as a custodian and take possession and control of files and records of another suspended member.\(^\text{53}\)

(iv) law society of upper Canada

Legal professionals in Ontario are governed by the *Law Society Act* and the *Rules of Professional Conduct*, which applies to both lawyer licensees and paralegal licensees. The definition of incapacity in the LSA is:

“A licensee is incapacitated for the purposes of this Act if, by reason of physical or mental illness, other infirmity or addiction to or excessive use of alcohol or drugs, he or she is incapable of meeting any of his or her obligations as licensee.”\(^\text{54}\)

Interestingly, the definition is expanded to include other acts that define incapacity:

“The Hearing Panel may determine that a licensee is incapacitated for the purposes of this Act if the licensee has been found under any other Act to be incapacitated within the meaning of that Act.”\(^\text{55}\)

However, this expansion of incapacity is limited by also providing that if a legal professional is complying with a course of treatment dictated under another act that makes it possible for the individual to meet the obligations of the legal profession, incapacity will not be found.\(^\text{56}\)

Legal professionals have a well-defined duty to report misconduct; however, the rule also includes situations giving rise to incapacity:

“(3) A lawyer shall report to the Society, unless to do so would be unlawful or would involve a breach of solicitor-client privilege

... 

(d) the mental instability of a licensee of such a serious nature that the licensee’s clients are likely to be severely prejudiced, and

(e) any other situation where a licensee’s clients are likely to be severely prejudiced.”\(^\text{57}\)

The commentary to the rule expands on the duty to report when issues of incapacity are noticed by other legal professionals. It provides for instances of misconduct arising from

\(^{53}\) Institute of Chartered Accountants of Ontario By-Laws, By-Law 103.

\(^{54}\) LSA, s.37(1).

\(^{55}\) *Ibid* at s.37(3).

\(^{56}\) *Ibid* at s.37(4).

\(^{57}\) RPC, Rule 6.01(3).
emotional, mental or family disturbances or substance abuse. To encourage lawyers to seek assistance or self-report, it ensures that a lawyer acting as a counsellor for the rehabilitation program Ontario Lawyers’ Assistance Program will not be called upon to testify at a fitness hearing without the consent of the lawyer seeking assistance. However, there is an exception to this limitation when a lawyer believes that another legal professional is “engaging or may in the future engage in serious misconduct or criminal activity related to the lawyer’s practice” (emphasis added).58

How the Law Society handles complaints from members of the public is set out in By-Law 11 of the LSA. While the by-law is not entirely clear, since requests made to the Law Society to have a Complaints Resolution Commissioner review a complaint must be made in writing, it can be assumed that complaints should also be made in writing.

Self-reporting is only made explicit for legal professionals in a very limited context.59 While the duty to uphold the standards of the legal profession always applies, instances of mandatory self-reporting are limited to “serious criminal charges under the Criminal Code and charges under other Acts that bring into question the honesty of a lawyer or that relate to the lawyer’s practice of law.”60

Section 40 of the LSA offers the orders available for a finding of incapacity. The orders are quite detailed, allowing orders for general incapacity in relation to suspension of an individual’s license for a set period, or until terms and conditions set by the hearing panel of the Law Society are met. More specific orders are defined in relation to licensees who require treatment or counselling, “including testing and treatment for addiction to or excessive use of alcohol or drugs,” or require participation in any “other programs to improve his or her health.”61 Further orders provide for restricting the areas of law in which a licensee may practice, restricting legal services a licensee may provide, or allowing the licensee to practice only under specific working conditions.62

Follow-up and monitoring of an incapacity order are self-regulated but compliance is mandatory or a breach of the Law Society’s order will result. The licensee can be ordered to report on compliance with any incapacity order.63 Further, any specific results of tests performed in the course of treatment or counselling “shall be reported pursuant to the order.”64 If these test results deal with the cause of any incapacity dealt with in a hearing by the Law Society, the physician selected by the Law Society who receives the reports of a

58 RPC, Rule 6.01, Commentary.
59 Instances where self-reporting is required is limited to the certain offences included in By-Law 8 of the LSA.
60 RPC, Rule 6.08, Commentary.
61 LSA, supra note 21, s. 40(1)
62 Restrictions on working conditions usually involve ensuring that the lawyer’s work environment is one that provides oversight and monitoring of their actions and behavior.
63 LSA, supra note 21, s. 40(1).
64 Ibid, s.40(3).
licensee may be required to promptly report his or her opinion, but shall not disclose specifics of the test results.\[^{65}\]

**part 3 - rehabilitation versus discipline**

A proper characterization of incapacity is central to applying the principles of rehabilitation and discipline in a way that best satisfies the overarching concerns of regulatory bodies. Professionals must not seem to escape punishment through a finding of incapacity. Laxness in any discipline stemming from incapacity could be perceived by the public as encouraging addiction as a means of avoiding punishment for misconduct. The public and the profession suffer if rehabilitation is interpreted in this way. But just as members owe a duty to their profession, in the high stress, high demand professional field, the regulatory body, acting in the public interest, owes a duty to its members as well. Draconian enforcement of all standards, and treating any breach with harsh discipline is out of step with modern understandings of mental and physical health. A fine line between the two must be tread.

It is easy to see how the two are difficult to untangle; incapacity is not a discipline issue per se, though disciplinary proceedings may already be underway before the question of incapacity arises. Incapacity issues often go unseen but for the unfortunate fact that a practitioner’s incapacity often results in conduct that would generally be disciplined.

Case law reveals that the courts will consider the extent of the incapacity, whether substance-based or a mental or physical illness. If there is a direct enough nexus between the incapacity and the misconduct, then the misconduct issue is handled within the context of the incapacity proceeding. If the two are held to be relatively separate, the situation may require both incapacity and misconduct proceedings occurring jointly or running parallel.\[^{66}\]

Below is a reiteration of the overarching considerations of all professional regulators:

1. the protection of the public;
2. the rehabilitation of the professional;
3. general and specific deterrence, if possible, though this is limited to addictions and their associated behaviour; and,
4. maintaining public confidence in the profession, and in the professional regulator.

While rehabilitation should ideally be the goal of matters involving incapacity, there may be instances where there is a relatively narrow nexus between the misconduct and the incapacity. In such a situation the misconduct cannot be fully explained by the member’s incapacity, and the regulator’s mandate to protect the public demands that more be done.

\[^{65}\] *Ibid*, s.40(4).

\[^{66}\] Another common misconception of the disciplinary role of regulatory bodies is that they are concerned with the same punishment or retribution motivations that underlie criminal law. However, the discipline role of regulatory bodies is part of its overall mandate to protect the public interest and not to dole out criminal punishment.
In other cases, it may be sufficient that the member is suspended on the basis of incapacity alone, especially if there is little chance of recovery in the future.

In the end, it is not necessarily always a choice between rehabilitation or discipline, but sometimes a matter of both.

(a) case law involving both rehabilitation and discipline issues

A question of balance between rehabilitation and discipline arose in Crozier v. Law Society of Upper Canada. The case is an appeal from an earlier misconduct hearing that ended in Ms. Crozier’s disbarment.

As in some of the cases provided above, it is difficult to not feel compassion for the professional with a flawless record who suddenly falls into a state of incapacity. Moving from effective advocate to the cause of numerous problems for his client, or from respected doctor to a potential danger to her patients, is a tragic end to a career.

It is difficult for a regulator to justify ordering only rehabilitative measures for a professional’s incapacity when that person has an existing record of misconduct. By the time the proceedings in Crozier had commenced, Ms. Crozier had already been disciplined by the Law Society twice. Further, she conducted herself unprofessionally at the discipline hearing, often showing up late and unprepared, and failing to appear in several instances.

Conflicting expert evidence complicated this matter. The Law Society-selected psychiatrist diagnosed severe depression, but found no evidence of other mental illness. Ms. Crozier’s own psychiatrist diagnosed an undefined personality disorder.

On appeal from the disbarment order made by the Law Society, further evidence submitted by Ms. Crozier’s psychiatrist accepted by the court was that severe depression can mask the diagnosis of a personality disorder. This statement was followed by the claim that Ms. Crozier had been in therapy throughout the interim period between the hearing and the appeal, and had shown signs of improvement. Based on this fresh evidence, a penalty as severe as disbarment could not stand.

However, in Ms. Crozier’s case, the incapacity did not completely excuse the misconduct. Rather, the court substituted a lengthy suspension of her right to practice. Stemming from her undertaking not to practice after the hearing, and the time that had passed between the hearing and the appeal, her penalty had been served, and no further suspension ordered. However, her incapacity is dealt with by prohibiting her practicing as a sole practitioner, and an order is made that she continue treatment, and regularly provide the Law Society with medical reports.

67 2004 ONLSAP 4 [Crozier].
68 Ibid at para 40.
69 Ibid at para 94.
70 Ibid at para 95.
71 Ibid at para 99.
The court found a strong enough nexus between the incapacity and the misconduct to heavily pull back on the discipline that the Law Society had handed down on her. An opposing example is found in *Lister v. College of Physicians & Surgeons (Ontario)*, where Dr. Lister is charged with misconduct relating to sexual improprieties with a patient. The evidence presented to the court in the proceedings established that Dr. Lister had been suffering from reactive depression during the time of the incidents that gave rise to the charge of misconduct.

While Dr. Lister submitted that the mental illness gave rise to incapacity that should have excluded a finding of professional misconduct, the court held that a discipline committee is entitled to find that any such illness is not an excuse for established misconduct.

*Lister* makes it clear that there must be a tenable connection between the complained of misconduct and the incapacity. A finding of incapacity does not immediately lead to rehabilitation as the sole goal of a proceeding rather than discipline for misconduct.

*Myers v. Law Society (Newfoundland)* presents a novel situation in the case law cited thus far in that the practitioner voluntarily agreed with the Newfoundland Law Society to be listed as non-practicing due to an illness that he suffered. The appeal to the Newfoundland Court of Appeal dealt with Mr. Myers’ attempts to be re-listed as practicing, which the Law Society would only grant after application to the Education Committee and an order from the Committee re-listing him. Mr. Myers’ application was an attempt to bypass the standard procedure.

The Court of Appeal held that requiring Mr. Myers to submit to the Education Committee was akin to requiring disciplinary proceedings. The court felt that it would be incorrect to “place the stigma of disciplinary proceedings on one who because of illness was unable to practice.” The nature of the hearing is “directed to not removing a right from a member but a determination of whether a right should be returned to a person who has either lost it, or relinquished it.” For Mr. Myers’, discipline was not the issue; a competency or fitness hearing was held to be the appropriate procedure in such a situation.

It is important to note in establishing a comprehensive process by a regulatory body that the Court of Appeal held that even though the Newfoundland legal profession legislation was silent with regards to the hearing procedure it ordered, the process was not explicitly prohibited, and thus within the regulatory mandate of the Law Society.

Most of the instances of incapacity above deal with mental illness or physical illness. More controversial is incapacity resulting from an addiction to drugs or alcohol. *Dr. Grant A.*

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72 1987 CarswellOnt 794, 19 OAC 388 [*Lister*].
73 *Ibid* at para 3.
74 (1998), 163 DLR (4th) 62 (NfldCA) [*Myers*].
75 *Ibid* at para 36.
76 *Ibid*. 
Matheson v. College of Physicians and Surgeons of Prince Edward Island\textsuperscript{77} involves a young doctor suffering a narcotics addiction.

Two sets of proceedings were at issue in Matheson, but both stemmed from the same time period of misconduct. Dr. Matheson was found to be addicted to prescription narcotics, which he obtained through the abuse of his status as a health practitioner by over-prescribing to patients and picking up the orders from various pharmacies for his own use. The order made by the College in the first hearing found Dr. Matheson unfit to practice due to his addiction to prescription narcotics, which resulted in a suspension of his license and mandatory attendance at an addiction recovery program. Additional requirements of the order were:

“Dr. Matheson was to cease prescribing narcotics. He was to cease the use of injectable narcotics and to complete the gradual removal of all patients from pain medications or transfer such patients to another physician. He was also ordered to participate in a course for training in the prescription of pain medications, to improve his medical record keeping practices, and pay a fine of $10,000 within 12 months of the date of the order.”\textsuperscript{78}

The order provides a good example of a combination of rehabilitation-based and disciplinary-based orders.

The discipline had already run its course and Dr. Matheson had resumed practice when additional complaints were made against him stemming from the same conduct and same time period. The College’s review panel again made orders against Dr. Matheson suspending his license for 3.5 years, (which could be reduced to 9 months upon the completion of certain training and educational requirements), and imposing a fine of $15,000.\textsuperscript{79}

It is from this subsequent order that Dr. Matheson appealed to the courts, eventually making his way to the PEI Court of Appeal, before which he was successful. The total period of suspension was reduced to 18 months, and the effective date of suspension was suspended for the entire 18 months providing compliance with certain conditions. The court found that the College disciplinary committee had erred in treating each particular instance of professional misconduct as a separate offence and imposing suspensions accordingly. Further, the incapacity suffered by Dr. Matheson decreased his blameworthiness for his actions, though it did not negate his culpability.

While a drug or alcohol addiction may not fully absolve the sufferer from liability compared to a debilitating mental or physical illness, it is still considered incapacity. The Court of Appeal confirmed this stance by restricting discipline and substituting orders providing rehabilitation assistance.

\textsuperscript{77} 2010 Carswell PEI 16, 295 Nfld. & PEIR 56 (PEICA) [Matheson].
\textsuperscript{78} Ibid at para 19.
\textsuperscript{79} Ibid at para 55.
Balancing the identified overarching concerns focused on ensuring the protection of the public, the profession and the member is essential in any procedure handling incapacity. The courts’ handling of incapacity as a separate issue from incompetence and misconduct has evolved substantially since the 1979 decision in Mason.

Keeping in mind the various processes employed by the different professions, and the analysis provided by the courts in the various case law cited, there are a five key principles that can be taken away as guiding principles in the further refining of incapacity procedures.

1. It is of prime importance to remember that incapacity is not truly a disciplinary matter, even though it often involves concurrent disciplinary issues, or significant overlap with aspects of incompetence. It should be handled separately.

2. However, even in handling it separately, incapacity does not always excuse misconduct. It should be a mitigating factor to be taken into consideration at the sanction or penalty stage.

3. The establishment of legislated third-party assessments is necessary in determining incapacity. Allowing for battling experts between regulators and members only hampers quick and effective handling of incapacity issues. Further, third-party assessments can be employed as an ongoing monitoring tool to ensure compliance with regulator orders.

4. Regardless of the nexus between incapacity and misconduct, in determining sanctions, it is the protection of the public interest that is of primary concern; but this interest can be protected while still providing sanctions appropriate to rehabilitate the incapacitated professional.

5. Finally, privacy concerns should be kept at the forefront of any incapacity procedure in order to manage the professional and personal stigma that surrounds these types of issues, and to ensure regulators comply with their own objectives to maintain confidentiality. On the other hand, given the need for transparency, and protection of the public interest using their services, professional regulators must also balance privacy with the need and obligation to disclose in appropriate circumstances. Properly handling these sensitive issues should increase instances of self-reporting, the most effective means of learning of incapacity, as well as increase compliance with orders, and public confidence with professional regulators. A proper balance between privacy controls and public
disclosure ensures that all parties benefit in what will continue to be a difficult and emotional issue for regulators, their members and members of the public.

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a cautionary note

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