A Case That Shaped How Regulators Govern in Ontario

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In 2007, a young woman died after having liposuction. The next 6 years brought a complaint from her family to the regulatory agency, an investigation of a physician, an interim restriction on the physician's practice, several challenges to rulings and the law, a disciplinary hearing, and the physician's appeal to the civil court. Because of the issues raised during this long process, including the use of confidential quality assurance information, physician advertising, license restrictions, and appropriate penalties, this case shaped the way regulators now govern in Ontario.

On September 20, 2007, a 32-year-old mother underwent a liposuction procedure at an outpatient clinic in Toronto, Canada. Shortly after the procedure, her blood pressure dropped, and she was lying listless in the waiting room. No one called 911 for an hour and 15 minutes. Then, she was transferred to a nearby hospital, where she died (Cribb, 2007a, 2007b).

The owner and operator of the outpatient clinic was Dr. Y. Though initially trained as a family physician, Dr. Y started incorporating liposuction and breast augmentation surgeries into her practice. In May 2007, she began performing these procedures exclusively.

Complaint and Screening Committee

The family of the woman who died filed a complaint with the College of Physicians and Surgeons of Ontario (CPSO), the regulatory agency for the practice of medicine in the province.

In Ontario, when regulatory agencies such as the CPSO receive complaints about their members, a screening committee decides whether or not to authorize an investigation. If one is authorized, the investigator reports to the screening committee, which determines whether the case should be sent to the discipline committee for a hearing (Health Professions Procedural Code, 1991, ss. 10, 25, 26, 38, 75, and 79).

In Dr. Y's case, the investigator, who was a plastic surgeon, selected 40 random files from the clinic and attempted to interview Dr. Y and her staff. However, Dr. Y refused to answer the investigator's questions or to allow the nurses who worked the day of the patient's death to be interviewed. These were also prosecuted (See Table 1). The CPSO then obtained an order from the civil court requiring Dr. Y and her staff to participate in the investigation.

The investigator catalogued problems with Dr. Y's preoperative and postoperative procedures. For example, the American Society of Cosmetic Surgeons recommends that only 5 liters of fat be removed during a liposuction procedure. However, in 7 of the 29 liposuction cases the investigator reviewed, Dr. Y removed more than 5 liters of fat. In one case, she removed 7 liters of fat and discharged the patient soon after surgery, allowing her to leave alone in a taxi.

In April 2009, the CPSO's screening committee sent the case to the discipline committee for a hearing.

Challenge to Interim Restrictions

Before a hearing could take place, the CPSO imposed interim restrictions on Dr. Y's license. She was no longer allowed to perform surgeries, although Dr. Y was allowed to assist if she did so in a hospital setting. She was also prohibited from providing any preoperative or postoperative care to surgical patients.

Dr. Y challenged the restrictions in civil court, claiming that the CPSO's decision was unreasonable. She argued that other less-restrictive orders were available. She also claimed that there was a reasonable apprehension of bias by the CPSO and its investigator, suggesting that the restrictions were part of a larger attempt by Ontario surgeons to prevent family doctors from performing lucrative cosmetic procedures.

In June 2009, the court rejected her claims (*Yazdanfar v. College of Physicians and Surgeons of Ontario* [2009] O.J. No. 2478).

Attempt to Use Confidential Information

In October 2009, Dr. Y brought an interim motion before the CPSO's discipline committee, asking for permission to rely on evidence obtained as part of the CPSO's quality assurance (QA) program.

In Ontario, health regulators must have a QA committee and program (Health Professions Procedural Code, 1991, ss. 10 and 80). The QA process was developed as a way to improve patient care and safety in a nonpunitive way. The process encour-

TABLE 1

Discipline and Sanctions for Clinic RPN and RN

A registered practical nurse (RPN) and a registered nurse (RN) who worked at Dr. Y's clinic were prosecuted by their regulator, the College of Nurses of Ontario (CNO) for their role in this case. The CNO's discipline committee found the two nurses guilty for breaching the standards of practice of the profession with respect to their assessment, care, and documentation of a rapidly deteriorating patient; failing to keep records; and engaging in conduct that was disgraceful, dishonorable, or unprofessional.

The RPN was the circulating nurse and responsible for obtaining supplies for the clinic's operating room. She also assisted in handing instruments to those scrubbed for surgery, bringing patients into the recovery room and, on occasion, caring for patients. The RPN admitted that she did not have the knowledge, skill, or judgment to care for patients after surgery. At the time, however, she failed to realize this. The RPN also acknowledged that she never took steps to determine whether it was appropriate to provide nursing care at the clinic and, in addition, that she failed to keep records or recognize that the patient who died needed emergency care.

The RN was the recovery room nurse. She was responsible for assisting in the operating room and providing care to patients after they had surgery. The RN admitted that the patient was too unstable to be managed at that clinic. The RN also acknowledged that she failed to maintain the standards of practice and that, by not seeking emergency care, she acted unprofessionally.

Both nurses' certificates of registration were suspended for 3 to 5 months, and they were required to take remedial steps before they could return to nursing. The remediation included reviewing professional standards, completing online learning and reflective exercises, and meeting with a nursing expert to discuss their poor conduct and develop strategies to better equip them to handle emergency situations. Moreover, for the next 12 to 18 months, the nurses had to notify their employers of the regulator's findings about their misconduct.

For the RN, she had to complete a course in ethics. For the RPN, the sanctions went further. She had to complete a course about staying within her scope of practice, and she was restricted from providing nursing care to patients in the immediate postoperative period or in other circumstances in which patients' needs were complex and unpredictable.

Source: *College of Nurses of Ontario v. Alleyne,* 2012 CanLII 100089; *College of Nurses of Ontario v. Sircar,* 2011 CanLII 99874.

ages health care professionals to openly discuss quality issues with their peers and make improvements to their practices (Health Professions Procedural Code, 1991, s. 80.1; Steinecke, 2014, 9:10). The QA program typically involves a requirement for mandatory ongoing professional development (such as coursework), and random peer and practice assessments to determine whether there are any gaps in a health practitioner's practice. With few exceptions, information obtained as part of a QA process cannot be used in a court or regulatory proceeding, so practitioners can discuss issues without fear that the information may be used against them (Health Professions Procedural Code, 1991, s. 83.1; Steinecke, 2014, 9:50).

Seven years earlier, in 2002, Dr. Y underwent peer and practice assessment arranged by the CPSO's QA committee. The committee did so upon learning that Dr. Y had been performing liposuction procedures. After completing the QA process, Dr. Y was permitted to continue performing cosmetic surgery. Dr. Y wanted to rely on this approval in her 2009 disciplinary hearing.

Based on the law, the discipline committee would not allow her to do so (*Yazdanfar (Re)*, [2009] O.C.P.S.D. No. 32).

Challenge to the Constitutionality of a Regulation

In Ontario, physicians cannot advertise using "false, misleading or deceptive" information. They also cannot use patient testimonials or any "comparative or superlative statements" in their advertisements (Ontario Regulation 114/94, 1991, s. 6).

One of the allegations against Dr. Y was that she engaged in professional misconduct by virtue of the advertisements on her clinic's website. These advertisements included misleading patient testimonials and the use of excessive praise. In one testimonial, a patient called Dr. Y "the best doctor." In another, a patient said she would not want "anyone else to touch her." Other patients talked about the success of their tummy tucks and labioplasties, even though Dr. Y did not perform these procedures.

In April 2010, Dr. Y brought another motion before the CPSO's discipline committee, challenging the constitutionality of the CPSO's advertising regulation. She claimed that it unjustifiably infringed on her right to freedom of expression under Canada's Constitution.

Dr. Y failed on this motion as well. In its decision, the CPSO stated that "advertising by way of testimonials and superlatives is not what the public has come to expect of the medical profession, and in this context does not foster good decision making by patients" (*Yazdanfar (Re)*, [2011] O.C.P.S.D. No. 9, para. 48).

Discipline Hearing and Findings

In July 2009, almost 2 years after the death of the young mother, Dr. Y's discipline hearing started. Over the course of 68 days, the CPSO's discipline committee heard from more than 50 wit-