SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Heather Allison Larton (CPSO# 70062)
(the Respondent)

INTRODUCTION

The Respondent provided care to the Complainant at a university health clinic while the Complainant was a university student. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's conduct. Specifically, the Respondent failed to send a form for them to be approved by OHIP for gender affirming top surgery (double mastectomy), though the request was first made three years ago.

According to the Complainant, after the initial request, they had multiple appointments with the Respondent during which they asked about the status of the referral and each time the Respondent said that she had followed up with OHIP but had not heard back, and that OHIP was taking a long time or was delayed because of the COVID-19 pandemic.

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of March 6, 2024. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to providing timely responses to patient requests, accurately documenting referrals, re-referring when it comes to light that a referral has not occurred, recognizing the vulnerability of/impact on the patient, and the importance of ensuring functioning email and voicemail systems to enable contact by the College and responding promptly to inquiries by the College.

COMMITTEE'S ANALYSIS

When a College Investigator spoke with the Respondent by telephone about the referral, the Respondent advised that she had sent it to OHIP, but that she would nevertheless resubmit it. However, when the College Investigator followed up with the Respondent a few weeks later, the Respondent confirmed that she had not resubmitted it to OHIP. The Complainant agreed to withdraw their complaint given the Respondent's commitment to resubmit it. However, another month passed and the Complainant reported that they contacted the clinic and spoke with the Respondent's nurse who informed them that the Respondent did not resubmit the referral to OHIP; and that given this information, they wished to proceed with their complaint against the Respondent.

The College then made multiple attempts to notify the Respondent of the complaint by telephone to the Respondent's phone number registered with the College, by telephone to the health clinic, by email to the Respondent's email address registered with the College and by mail to the Respondent's home and clinic addresses. However, the Respondent did not respond to any of the College's correspondence.

A College Investigator attended the Respondent's office, at which time the Respondent advised that the inbox of her e-mail account registered with the College was full, and that her email account through the university had been deactivated and needed to be set up again. She acknowledged receiving correspondence from the College by mail to her practice address.

That same day, the College investigator hand delivered a letter which included inquiries related to the complaint, and requesting the Respondent provide an alternate method of communication. The Respondent did not provide a response to the complaint, nor did she respond to the College's inquiries.

While the Committee recognized that the Respondent was not obligated to provide a response to the complaint, it noted that as a member of a self-regulating profession, the Respondent is expected to respond to any inquiries that she may receive from the College to ensure the best quality of patient care. Further, she is expected to be accessible to the College, including ensuring that she provides her contact information to the College, including any changes to it, and ensuring functioning email and voicemail systems.

Based on the information before it, it was unclear to the Committee whether the Respondent sent the OHIP referral for gender affirming top surgery when first requested three years before the College complaint or followed up during that time. The Committee noted however that, if the Respondent sent the referral as she indicated, she failed to document this in the medical record, and this contrary to College policy on medical record documentation.

Regardless of whether the Respondent sent the original referral, the Respondent acknowledged during her telephone call with the College investigator that she did not resubmit the referral after the complaint and the College investigator had advised that OHIP had not received it. In the Committee's view, this demonstrated a disregard towards the vulnerability of the Complainant and the impact the delay has had on them.

The Committee noted a similar prior College complaint in 2010 which was referred to the College's Discipline Committee and resulted in Discipline finding as well as a

reprimand, supervision and a reassessment. As similar concerns had again been identified in this case, the Committee was of the view that a significant disposition was warranted. However, the Committee noted that the two cases were distinguishable in that the 2010 case involved the Respondent obstructing the patient by refusing to provide information that the patient could not get elsewhere. In this case, the Respondent was not the only physician that could have fulfilled the Complainant's request in that the Complainant could have gone elsewhere for a referral.

Taking all these factors together, the Committee determined that it was appropriate to caution the Respondent.