NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Sammy Vaidyanathan, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity, the name or any information that would identify patients referred to orally or in exhibits at the hearing, and the name or any information that would identify the person identified as “Nurse A” in these proceedings, under subsection 45(3) of the Health Professions Procedural Code (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

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

DISCIPLINE COMMITTEE
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Citation: *College of Physicians and Surgeons of Ontario v. Vaidyanathan*, 2021 ONCPSD 1
Date: January 4, 2021

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Sammy Vaidyanathan

ORDER AND REASONS

Panel: Mr. Pierre Giroux (Chair)
Dr. Eric Stanton
Mr. Mehdi Kanji
Dr. Joanne Nicholson
Dr. Paul Hendry

Heard: July 13 and September 23, 2020

Appearances:

Ms. Emily Graham, for the College
Ms. Keary Grace and Mr. Hakim Kassam, for Dr. Sammy Vaidyanathan
Ms. Kimberly Potter, Independent Legal Counsel to the Discipline Committee

Introduction

[1] The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario ("the College") heard this matter via videoconference on July 13, 2020 and September 23, 2020. At the conclusion of the hearing, the Committee found that Dr. Vaidyanathan committed an act of professional misconduct and reserved its finding with respect to penalty and costs.

The Allegations

[2] The Notice of Hearing alleged that Dr. Vaidyanathan committed an act of professional misconduct:

i. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*("O. Reg. 856/93"), in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and

ii. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/83), in that he has failed to maintain the standard of practice of the profession.

[3] The Notice of Hearing further alleged that Dr. Vaidyanathan is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "Code").

Response to the allegations

[4] Dr. Vaidyanathan admitted to committing an act of professional misconduct under paragraph 1(1)(33) of O. Reg. 856/93 and under paragraph 1(1)(2) of O. Reg. 856/93.

[5] The College withdrew the allegation of professional misconduct under subsection 52(1) of the Code, i.e., incompetence.

The facts

[6] The following facts were set out in an Agreed Statement of Facts and Admission (Liability) which was filed as an exhibit and presented to the Committee:

Background

1. Dr. Vaidyanathan is 40 years old. He practices emergency medicine, and also practices in walk-in/episodic care clinics outside of a hospital setting. He obtained his certificate of registration authorizing independent practice from the College in 2010.

File #7216295

Treatment of Self and OHIP Billing for Treatment of Self; Obtaining treatment while on shift

2. In the course of a separate investigation, the College obtained Dr. Vaidyanathan's OHIP claims for the period between May 2010 and May 2017. The OHIP data, attached at Tab 1 [to the Agreed Statement of Facts and Admission (Liability)], indicated that Dr. Vaidyanathan billed his own OHIP number 10 times for providing care or treatment to himself, over 9 service dates – two OHIP billings related to the same service date, February 26, 2011.

3. Hospital charts obtained by the College indicate that on 10 occasions between February 2011 and September 2016, Dr. Vaidyanathan provided himself with medical care and/or treatment while he was on shift in the emergency departments of the Humber River Regional Hospital or the Niagara Health System.

4. Dr. Vaidyanathan's self-treatment did not comply with the College's policy on Physician Treatment of Self, Family Members, or Others Close to Them, attached at Tab 2 [to the Agreed Statement of Facts and Admission (Liability)]. None of the treatment was provided in an emergency situation when another qualified health-care professional was not readily available.

February 26, 2011

5. Dr. Vaidyanathan was on shift in the emergency department of Humber River Regional Hospital, Church Site on February 26, 2011. While he was on shift, Dr. Vaidyanathan treated himself for "fever/body pain". The hospital chart, and Dr. Vaidyanathan's transcription of his handwritten entries, are attached at Tabs 3 and 4 [to the Agreed Statement of Facts and Admission (Liability)].

6. Dr. Vaidyanathan registered himself at 3:19 am, and claimed to assess himself at 3:21 am. Dr. Vaidyanathan recorded that he had fever, chills, arthralgia, myalgia and sore throat. He prescribed himself Tamiflu, which was administered at 3:20 am. At 3:23 am, he ordered blood work for himself and entered the orders under his own name, including for a complete blood count, routine chemistry, culture and sensitivity, and a malaria screen. Dr. Vaidyanathan claimed to reassess himself at 6:10 am, including his own respiratory and cardiovascular function, and recorded that he had no abdominal pain. He discharged himself at 7:00 am, recording a self-diagnosis of influenza-like illness.

7. During the investigation, Dr. Vaidyanathan asserted that his care and treatment on February 26, 2011, had been directed by another physician whose name appears in the chart, Dr. David Moscovitz, and that the orders in the EMR had not been made by Dr. Vaidyanathan. This was inaccurate and misleading. Dr. Moscovitz has no recollection of being involved in Dr. Vaidyanathan's care, and he cannot account for how his name appears as a consulting internist on Dr. Vaidyanathan's chart. Dr. Moskovitz explained that if he had been involved, he would have dictated a consult note, and billed OHIP. Neither of those things occurred. While Dr. Moscovitz hypothesized that he may have been asked to order bloodwork for Dr. Vaidyanathan as a favour, he clarified that it would not typically have been his practice to do so. Typically, he explained that he would do a proper consultation and render an opinion or impression. The physician's orders in the EMR were made by Dr. Vaidyanathan.

<u>September 3, 2011</u>

8. Dr. Vaidyanathan was on shift in the emergency department at the Humber River Regional Hospital, Finch Site on September 3, 2011. While he was on shift, Dr. Vaidyanathan treated himself for an injury to his left hand. The hospital chart, and Dr. Vaidyanathan's transcription of his handwritten entries, are attached at Tabs 5 and 6 [to the Agreed Statement of Facts and Admission (Liability)].

9. Dr. Vaidyanathan registered himself at 2:22 pm, and claimed to assess himself at 2:27 pm. Dr. Vaidyanathan recorded his symptoms, and at 2:26 pm ordered that an x-ray be taken of his left hand. Dr. Vaidyanathan later discharged himself, recording "hand contusion" as his self-diagnosis.

10. On the emergency record, Dr. Aaron Orkin is recorded as the “ER Registration Doctor”. Dr. Orkin was not involved in Dr. Vaidyanathan’s care or treatment.

December 4, 2011

11. Dr. Vaidyanathan was on shift in the emergency department at the Humber River Regional Hospital, Finch Site, on December 4, 2011. While he was on shift, Dr. Vaidyanathan treated himself for a head lesion. The hospital chart, and Dr. Vaidyanathan’s transcription of his handwritten entries, are attached at Tabs 7 and 8 [to the Agreed Statement of Facts and Admission (Liability)].

12. Dr. Vaidyanathan registered himself at 4:14 pm, and claimed to assess himself at 4:00 pm. Dr. Vaidyanathan recorded that he had a chronic lesion on his scalp, and referred himself to plastic surgery for a consult. A plastic surgeon sutured Dr. Vaidyanathan’s scalp lesion in the emergency department. Dr. Vaidyanathan discharged himself at 5:15 pm, recording “lesion NYD” as his self-diagnosis. Dr. Vaidyanathan’s scalp lesion was not urgent, and did not require emergency treatment.

13. In the hospital chart, the name of another physician, Dr. Meera Jayarajan, is recorded. Dr. Jayarajan did not assess or treat Dr. Vaidyanathan, and was not involved in his care.

October 22, 2012

14. Dr. Vaidyanathan was on shift in the emergency department of the Humber River Regional Hospital, Finch Site, on October 22, 2012. While he was on shift, Dr. Vaidyanathan treated himself. Under “reason for visit”, Dr. Vaidyanathan indicated “wants repeat bloodwork”. The hospital chart, and Dr. Vaidyanathan’s transcription of his handwritten entries, are attached at Tabs 9 and 10 [to the Agreed Statement of Facts and Admission (Liability)].

15. Dr. Vaidyanathan registered himself at 2:14 am, and claimed to assess himself at 2:20 am. Dr. Vaidyanathan recorded that he had been seen the previous day regarding intermittent fevers, and wrote that the “med on call suggested repeat blood work”. Despite the reference to “med on call”, no physician other than Dr. Vaidyanathan provided any care or treatment to Dr. Vaidyanathan on that date. Dr. Vaidyanathan ordered blood work for himself, and recorded the results. Dr. Vaidyanathan discharged himself at 5:35 am, recording a self-diagnosis of “ill-defined condition”.

March 4, 2014

16. Dr. Vaidyanathan was on shift in the emergency department of the Humber River Regional Hospital, Finch Site on March 4, 2014. While he was on shift, Dr. Vaidyanathan treated himself for left foot pain. The hospital chart, and Dr. Vaidyanathan's transcription of his handwritten entries, are attached at Tabs 11 and 12 [to the Agreed Statement of Facts and Admission (Liability)].

17. Dr. Vaidyanathan registered himself at 4:47 am, and claimed to assess himself at 5:00 am. Dr. Vaidyanathan recorded his symptoms, and at 4:51 am ordered that an x-ray be taken of his left foot. Dr. Vaidyanathan discharged himself at 6:41 am, and recorded a self-diagnosis of "sprain foot".

August 18, 2015

18. Dr. Vaidyanathan was on shift in the emergency department of the Humber River Regional Hospital, Finch Site on August 18, 2015. While he was on shift, Dr. Vaidyanathan treated himself. Under "reason for visit", Dr. Vaidyanathan indicated "for blood works". The hospital chart, and Dr. Vaidyanathan's transcription of his handwritten entries, are attached at Tabs 13 and 14 [to the Agreed Statement of Facts and Admission (Liability)].

19. Dr. Vaidyanathan registered himself at 5:51 am, and claimed to assess himself at 5:55 am. Dr. Vaidyanathan indicated that he had "no medical issue", and ordered a number of laboratory investigations, including tests for Hepatitis A, B and C; HIV; chlamydia; and gonorrhea. Dr. Vaidyanathan discharged himself at 7:00 am, recording "well adult" as his self-diagnosis.

August 27, 2015

20. Dr. Vaidyanathan was on shift in the emergency department of the Humber River Regional Hospital, Finch Site on August 27, 2015. While he was on shift, Dr. Vaidyanathan treated himself. Under "reason for visit", Dr. Vaidyanathan indicated "medical advice". The hospital chart, and Dr. Vaidyanathan's transcription of his handwritten entries, are attached at Tabs 15 and 16 [to the Agreed Statement of Facts and Admission (Liability)].

21. Dr. Vaidyanathan registered himself at 2:05 am, and claimed to assess himself at 2:00 am. Dr. Vaidyanathan recorded that he had no clinical symptoms other than arthralgia/myalgia, and ordered blood

work for himself, including for total iron binding capacity (“TIBC”), ferritin, thyroid stimulating hormone (“TSH”), T4, T3, Vitamin B12, and iron. Dr. Vaidyanathan discharged himself at 2:50 am, recorded “ill-defined condition” as his self-diagnosis.

December 5, 2015

22. Dr. Vaidyanathan was on shift in the emergency department at the Humber River Regional Hospital, Wilson Site on December 5, 2015. While he was on shift, Dr. Vaidyanathan treated himself for a “left foot injury”. The hospital chart, and Dr. Vaidyanathan’s transcription of his handwritten entries, are attached at Tabs 17 and 18 [to the Agreed Statement of Facts and Admission (Liability)].

23. Dr. Vaidyanathan registered himself at 5:46 am, and claimed to assess himself at 5:52 am. Dr. Vaidyanathan recorded his symptoms, ordered an x-ray of his left foot/ankle, and prescribed himself Naproxen 500mg po x 1. Dr. Vaidyanathan discharged himself at 7:34 am, recording “foot sprain” as his self-diagnosis.

24. On the emergency record, Dr. Ahmed Mian is recorded as the “ER Registration Doctor”. Dr. Mian did not assess or treat Dr. Vaidyanathan, and was not involved in Dr. Vaidyanathan’s care or treatment.

January 20, 2016

25. Dr. Vaidyanathan was on shift in the emergency department at the Niagara Health System, Welland Site on January 20, 2016. While he was on shift, Dr. Vaidyanathan treated himself, indicating “barium swallow” as the “reason for visit”. The hospital chart, and Dr. Vaidyanathan’s transcription of his handwritten entries, are attached at Tabs 19 and 20 [to the Agreed Statement of Facts and Admission (Liability)].

26. Dr. Vaidyanathan registered himself at 7:09 am, and claimed to assess himself at 7:00 am. Dr. Vaidyanathan recorded that he was suffering from epigastric pain, and ordered a barium swallow for himself. Dr. Vaidyanathan discharged himself at 9:00 am, recording post-operative complications (“post op cx”) as his self-diagnosis.

27. In the hospital chart, the name of another physician, Dr. Wouter Oelofse, is recorded. Dr. Oelofse did not assess or treat Dr. Vaidyanathan, and was not involved in his care.

September 21, 2016

28. Dr. Vaidyanathan was on shift in the emergency department at the Niagara Health System, Greater Niagara General site on September 21, 2016. While he was on shift, Dr. Vaidyanathan treated himself for "face pain". The hospital chart, and Dr. Vaidyanathan's transcription of his handwritten entries, are attached at Tabs 21 and 22 [to the Agreed Statement of Facts and Admission (Liability)].

29. Dr. Vaidyanathan registered himself at 4:01 am, and claimed to assess himself at 4:00 am. He recorded that he had been struck in the face four days earlier, and that he had pain in the nasal region and nasal swelling. He ordered a CT scan of his facial bones, a nebulizer, and an oral corticosteroid, and referred himself to an ear, nose and throat specialist for drainage of a septal abscess and nasal packing. Dr. Vaidyanathan discharged himself at 9:00 am, recording "nasal contusion" as his diagnosis.

30. In engaging in the conduct described at paragraphs 2 to 29, Dr. Vaidyanathan engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Behaviour at Humber River Hospital

31. The College's investigation into Dr. Vaidyanathan's conduct at Humber River Hospital revealed that on several occasions, Dr. Vaidyanathan engaged in inappropriate and unprofessional behaviour and communications with colleagues, staff and hospital administration, as follows.

<u>Use of Stretcher/Mobile Computer</u>

32. In the morning of June 19, 2015, Dr. Vaidyanathan was on shift in the emergency department of Humber River Hospital, Finch Site. During a break, Dr. Vaidyanathan occupied a stretcher intended for patient use in an acute care area of the emergency department containing 10 other patient stretchers. There was a patient in the acute care stretcher next to Dr. Vaidyanathan, with a curtain separating them. Dr. Vaidyanathan slept on the acute care stretcher, and watched a YouTube video on a mobile computer intended for use in patient care. When he was finished his break, the emergency department nursing staff asked Dr. Vaidyanathan to clean up after himself. Dr. Vaidyanathan told them to "get housekeeping to do it". Photographs of the state in which Dr. Vaidyanathan left the stretcher, and the

YouTube video he was watching, are attached at Tab 23 [to the Agreed Statement of Facts and Admission (Liability)].

33. The Humber River Hospital, Finch Site has a Doctor's Lounge, which has large couches and is available for physician use during breaks.

Communication re: Laceration Trays

34. In September 2015, the Humber River Hospital emergency department implemented the use of new laceration trays. On September 4, 2015, the Manager of the Finch Site emergency department circulated an email to staff advising that this new product was now available on the supply carts at both sites.

35. On September 6, 2015, Dr. Vaidyanathan responded to this email, copying the entire emergency department, as follows:

> "The new tray is garbage. The needle driver cannot hold a 6.0. It's too large and meant for a med student to practice. Garbage. I had to put 5.0 in just so the needle and forceps could touch the needle. Absolutely garbage. It's a suture tray for a med student that practices on a pig foot. This is not patient care redefined. It's patient care one (sic.) the cheap. Ask a plastics guy if he would touch that crap."

36. On September 6, 2015, a Clinical Service Manager replied to Dr. Vaidyanathan, indicating that the new laceration trays had been trialed by some of his peers and had been selected based on their feedback. Dr. Vaidyanathan responded, copying others including the then-Chief/Medical Director of Emergency, "Have you ever treated anyone? Your option is useless".

37. The emails regarding Dr. Vaidyanathan's communication with respect to the new laceration trays are attached at Tab 24 [to the Agreed Statement of Facts and Admission (Liability)].

Communications with Nurse A

38. In 2014, Dr. Vaidyanathan and a nurse at Humber River Hospital ("Nurse A"), engaged in a romantic relationship. Thereafter, Dr. Vaidyanathan and Nurse A continued to share a close personal friendship until their relationship began to deteriorate. As attached at Tab 25 [to the Agreed Statement of Facts and Admission (Liability)], Dr. Vaidyanathan and Nurse A exchanged a series of text messages, including text messages from Dr. Vaidyanathan to Nurse A that Dr. Vaidyanathan acknowledges were inappropriate and unprofessional.

39. For instance, during the night shift, a dispute arose between Dr. Vaidyanathan and Nurse A regarding the treatment of a patient in the emergency department. Dr. Vaidyanathan was the duty doctor on shift. During a time when Dr. Vaidyanathan was not present in the emergency department, but was in a different area of the hospital, Nurse A involved another physician in the patient's care ("Dr. X"), who ordered a CT scan. Dr. Vaidyanathan disagreed with the ordering of a CT scan for this patient, and was of the opinion that it could have put the patient at risk due to his chronically low blood pressure. Dr. Vaidyanathan felt that Nurse A should have gone to him with her concerns as he was more familiar with the patient's history, and that she deliberately involved a less knowledgeable physician in order to "show him up" for being late for his shift. Following this incident, Dr. Vaidyanathan sent Nurse A a series of [inappropriate and unprofessional] text messages. [Text messages omitted.]

40. In the course of their personal relationship, Dr. Vaidyanathan had given Nurse A a set of keys, and a parking pass. A dispute arose between them regarding the return of these items, during which Dr. Vaidyanathan sent Nurse A a series of [inappropriate and unprofessional] text messages. [Text messages omitted.]

41. In 2015, Dr. Vaidyanathan contacted Nurse A by text message, requesting to speak with her. He requested that she acknowledge her role in the deterioration of their relationship and that she apologize to him. During this conversation, Dr. Vaidyanathan yelled at Nurse A and admonished her for raising their dispute with hospital administration.

42. Dr. Vaidyanathan's conduct described in paragraphs 31 to 41 was inconsistent with the professional obligations articulated in the College's policy on Physician Behaviour in the Professional Environment (attached at Tab 26 [to the Agreed Statement of Facts and Admission (Liability)]), which set out expectations including that:

    a. physicians are expected to act in a courteous, dignified and civil manner towards their patients, their colleagues and others involved in the provision of health care. Disruptive physician behaviour can interfere with quality health care delivery;

    b. physicians have a responsibility to the medical profession to behave in a professional and appropriate manner; and

    c. disruptive behaviour by physicians can include profane, disrespectful, insulting, demeaning or abusive language;

inappropriate rudeness; passing severe judgment or censuring colleagues in front of other staff; outbursts of anger; and behaviour other would describe as bullying.

43. In engaging in the conduct described at paragraphs 31 to 42, Dr. Vaidyanathan engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Incomplete and Inaccurate Information on Annual Renewals & Questionnaire

44. In the course of the College's investigation, Dr. Vaidyanathan was required to complete a Physician Practice Questionnaire, which provides investigators and the ICRC with information about the physician's practice, including the list of hospitals with which the physician is affiliated.

45. Dr. Vaidyanathan submitted his Physician Practice Questionnaire on September 28, 2017, attached at Tab 27 [to the Agreed Statement of Facts and Admission (Liability)], and identified he had privileges at four hospitals:

    a. Brampton Civic (i.e. William Osler Health System);

    b. Humber River Regional Hospital;

    c. Joseph Brant Hospital; and

    d. St. Catharines General Hospital (i.e. Niagara Health System).

46. Dr. Vaidyanathan had not previously disclosed his affiliation with these hospitals to the College.

47. Furthermore, on his 2018 Annual Renewal, attached at Tab 28 [to the Agreed Statement of Facts and Admission (Liability)], Dr. Vaidyanathan indicated that he had privileges at a fifth hospital, namely Campbellford Memorial Hospital, which he had not previously disclosed to the College.

48. The College made inquiries as to when Dr. Vaidyanathan had obtained privileges at William Osler Health System, Joseph Brant Hospital, Niagara Health System, and Campbellford Memorial Hospital. As set out below, those inquiries revealed that on the 2016 Annual Renewal, 2017 Annual Renewal, and 2017 Physician Practice Questionnaire, Dr. Vaidyanathan provided incomplete and/or inaccurate information to the College regarding his hospital privileges.

2016 Annual Renewal

49. Dr. Vaidyanathan completed his 2016 Annual Renewal (attached at Tab 29 [to the Agreed Statement of Facts and Admission (Liability)]) on April 15, 2016. He was asked: “Confirm or update your Ontario Hospital Privileges or Appointments (does not include honorary appointments)”. Dr. Vaidyanathan indicated only “Humber River Regional Hospital”.

50. As of April 15, 2016, in addition to having privileges at Humber River Regional Hospital, Dr. Vaidyanathan also had privileges at the following hospitals, which he did not disclose to the College:

    a. Niagara Health System: he had been granted temporary privileges on October 9, 2015, and was appointed to Locum Tenens staff effective November 24, 2015 for a period of one year, to November 23, 2016;

    b. Campbellford Memorial Hospital: he had been appointed to the professional staff in the Term category on October 8, 2015;

    c. Joseph Brant Hospital: between October 10, 2015 and January 2, 2016, Dr. Vaidyanathan was granted privileges to work in the emergency department on eight separate occasions, for 14 shifts. His next shift was on April 15, 2016, three days after he completed his 2016 Annual Renewal.

2017 Annual Renewal

51. Dr. Vaidyanathan completed his 2017 Annual Renewal (attached at Tab 30 [to the Agreed Statement of Facts and Admission (Liability)]) on May 2, 2017. He was asked: “Confirm or update your Ontario Hospital Privileges or Appointments (does not include honorary appointments)”. Dr. Vaidyanathan indicated only “Humber River Regional Hospital”.

52. As of May 2, 2017, Dr. Vaidyanathan had privileges at the following hospitals which he did not disclose to the College:

    a. Campbellford Memorial Hospital: since October 2015;

    b. William Osler Health System: Dr. Vaidyanathan had been granted temporary privileges, on November 16, 2016 until January 31, 2017, then on February 1, 2017 until May 31, 2017, and again on June 1, 2017 until December 31, 2017;

c. Joseph Brant Hospital: Dr. Vaidyanathan had been granted Courtesy staff privileges as of November 30, 2016;

d. Niagara Health System: Dr. Vaidyanathan had an appointment as Term Staff, which had been extended on January 2017 for another year to January 24, 2018.

2017 Physician Practice Questionnaire

53. When Dr. Vaidyanathan submitted his Physician Practice Questionnaire on September 28, 2017 (attached at Tab 27 [to the Agreed Statement of Facts and Admission (Liability)]), he indicated that he had privileges at four hospitals. As of September 28, 2017, Dr. Vaidyanathan also had privileges at a fifth hospital, Campbellford Memorial Hospital, which he had held since 2015 as set out above, and which he did not disclose to the College.

54. In engaging in the conduct described at paragraphs 44 to 53, Dr. Vaidyanathan engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Investigation – File #1104860

55. In October 2018, the College received a letter from Dr. Margaret Dean, a family physician, attached at Tab 31 [to the Agreed Statement of Facts and Admission (Liability)], raising concerns about Dr. Vaidyanathan's narcotics prescribing to one of their mutual patients. Following the receipt of this letter, investigators were appointed to investigate whether Dr. Vaidyanathan, in his family medicine practice and in his family medicine/emergency medicine practice, has engaged in professional misconduct and/or is incompetent.

56. Two experts were retained to review 31 of Dr. Vaidyanathan's patient charts including the patient about whom a concern had been raised by Dr. Dean: 16 from his emergency medicine practice, and 15 from his walk-in practice.

Opinion re: emergency medicine practice

57. Dr. Pierre Mikhail provided an opinion with respect to Dr. Vaidyanathan's care and treatment of patients in his emergency medicine practice. His reports are attached at Tabs 32 and 33 [to the Agreed Statement of Facts and Admission (Liability)].

58. With respect to Chart #2 in Dr. Mikhail's report, the College subsequently clarified that one of the prescriptions for which Dr. Mikhail criticized Dr. Vaidyanathan, dated December 14, 2016, had in fact been written by a different physician, as attached at Tab 34 [to the Agreed Statement of Facts and Admission (Liability)]. The prescription had been incorrectly attributed to Dr. Vaidyanathan in the NMS data.

59. As Dr. Mikhail opined, and taking into account the information at paragraph 58 above with respect to Chart #2, Dr. Vaidyanathan failed to meet the standard of practice of the profession in emergency medicine (9/16 charts); displayed a lack of knowledge, skill and judgment (9/16 charts); and his clinical practice exposed patients to potential harm (7/16 charts) as set out in the reports of Dr. Mikhail, whose conclusions included the following:

    a. Illegibility: Dr. Mikhail could not read Dr. Vaidyanathan's handwritten charts, which were illegible;

    b. Inadequate documentation of assessments: The majority of the documented assessments were disorganized, lacked pertinent positive and negative historical features, and had scant physical exams documented. Persistently poor documentation of both historical and physical exam features was evident in most of the charts;

    c. Inadequate documentation of prescriptions: For the majority of the charts, the only information regarding narcotic prescriptions, or prescriptions of any kind, was set out in a spreadsheet provided by the Ministry of Health and Long-Term Care's Narcotics Monitoring System ("NMS"). In the majority of cases in which a prescription was given to the patient, the chart did not mention a prescription; and

    d. Prescribing without indication and in excessive amounts: Opioids were prescribed in the majority of the ER charts reviewed. In most cases, they were prescribed without a coherent indication, and in amounts that could pose risk to the patient and in some cases the public.

60. For example:

    a. In Chart #11, the patient's "Reason for Visit" to the ER in June 2016 was "Medication request". Dr. Vaidyanathan recorded that the patient was taking Methotrexate, Naproxen and Celebrex. There was no indication of why a patient who lived

approximately 2.5 hours away from Niagara Health was attending at its ER for her medication, or why she could not obtain them from her usual physician. Dr. Vaidyanathan took no history other than “Hx chronic pain”. He recorded “Dx chronic pain”, and “Rx MS Contin Morphine”. The history was inadequate, and Dr. Vaidyanathan did not document any physical examination, the rationale for prescribing narcotics, nor the quantities prescribed. This prescribing of narcotics was reckless. Dr. Vaidyanathan failed to recognize the effects of unwarranted narcotics on this patient, and the population at large. The care provided exposed the patient and the population at large to risk, because of the risk of both adverse narcotic effects to patient and diversion;

b. In Chart #5, the patient attended the ER in October 2016 with a purulent lesion on his hand. On that date, Dr. Vaidyanathan prescribed the patient 40 Oxycocet tablets and 30 x 1mg Lorazepam tablets. These prescriptions were not documented on the chart, and the ER note did not document a rationale for a benzodiazepine prescription. The failure to document narcotic prescriptions and the provision of both narcotics and benzodiazepines to a patient who seemed to have an abscess was irresponsible and unnecessary, and exposed the patient to risk of harm;

c. In Chart #14, a patient with known cystic fibrosis attended the ER in February 2017 with shortness of breath. Dr. Vaidyanathan’s physical examination was inadequate. Under “o/e” (“on examination”), he recorded “short of breath, dyspneic, non toxic”. Only “non toxic” is a physical finding. The others are features of a history a physician would take. No explanation was given for the lack of a physical exam. Dr. Vaidyanathan took an insufficient history and documented an inadequate exam, with no chest auscultation. Given that infectious exacerbations are common in cystic fibrosis and require antibiotics, this was not excusable. Very often the physical exam findings in cystic fibrosis patients warrant a chest x-ray, which also was not done. Dr. Vaidyanathan also prescribed intravenous Dilaudid, as well as 15 x 2mg Dilaudid tablets. Narcotics are not generally an accepted efficacious treatment for dyspnea. While Dr. Vaidyanathan’s explanation for this prescription in the interview with Dr. Mikhail was reasonable,

namely, that the patient was palliative, awaiting a lung transplant, and experiencing an acute anxiety attack, he failed to record this rationale in the chart; and

d. In Chart #7, a patient presented to the ER in October 2018 because she was informed her calcium was elevated. She was also a palliative breast cancer patient, who was already on Fentanyl 50mcg patches. Dr. Vaidyanathan prescribed her 5 additional Fentanyl patches, and 200 x 1 mg Hydromorphone tablets. He did not record the quantity of Fentanyl patches prescribed, and did not document the Hydromorphone prescription at all. Dr. Vaidyanathan did not document any pain assessment, or any rationale for prescribing analgesics. The patient also had a palliative care physician who could provide these for her, if warranted. Dr. Vaidyanathan offered he had no reasonable explanation of why he provided so many narcotics to a patient that had a palliative care physician.

Opinion re: walk-in practice

61. Dr. Jan Ahuja provided an opinion with respect to Dr. Vaidyanathan's care and treatment of patients in his walk-in practice. His reports are attached at Tabs 35 and 36 [to the Agreed Statement of Facts and Admission (Liability)].

62. As Dr. Ahuja opined, Dr. Vaidyanathan failed to meet the standard of practice of the profession in his walk-in practice (15/15 charts); displayed a lack of knowledge in patient assessment (6/15 charts); displayed a lack of skill in patient assessment (14/15 charts); displayed a lack of judgment in prescribing opioids (13/15 charts) and in prescribing benzodiazepines (7/15 charts); and his clinical practice exposed patients to potential harm (14/15 charts), as set out in the report of Dr. Ahuja, whose conclusions included the following:

    a. <u>Chart note organization</u>: Dr. Vaidyanathan did not record entries according to SOAP, and often the elements of the history and physical were entangled;

    b. <u>Failure to record adequate detail</u>: For most visits, Dr. Vaidyanathan's records of treatment lacked adequate detail:

        i. the Subjective entries, when present, lacked detail as to the onset, duration, quality and associated symptoms of the chief complaint;

ii. the Objective assessments rarely included vital signs such as temperature, pulse, or blood pressure, and rarely documented a full assessment of the physical findings pertaining to the chief complaint;

iii. the Assessment was often not documented specifically; and

iv. the Plan rarely included advice to the patient as to how to manage the problem aside from a drug prescription, without documentation of side effects of such drugs or suggestions regarding follow-up of the condition;

c. Failure to record adequate detail specifically with respect to pain conditions: Many of Dr. Vaidyanathan's patients had longstanding issues with chronic pain, and were being treated with narcotic analgesics. While Dr. Vaidyanathan documented that the patients suffered from chronic pain, he rarely described their past histories, current symptoms or the medications being used for pain control. Even on the first visit with the patient, he rarely documented a physical examination, and when he did, it was lacking in sufficient detail to appreciate the nature of the problem. For example:

i. in Chart #11 (visit June 2016), Dr. Vaidyanathan prescribed Percocet, without recording the quantity prescribed or directions as to use, without recording the patient's history of current problems, only a brief and incomplete physical exam, and no assessment;

ii. in Chart #8, (visit June 2016), Dr. Vaidyanathan prescribed Tecnal C[1] ½ tid for 2 months to a patient without recording the reason for the patient's visit or current symptoms, and recording an examination of only "normal ROM";

iii. in Chart #1 (visit August 2017) Dr. Vaidyanathan recorded only that the patient had a "history of a car accident, lost his GP", and did not record a diagnosis. He nonetheless prescribed Diazepam 5mg and Oxycocet (5/325);

[1] contains 4 medications: acetylsalicylic acid, butalbital, caffeine, and codeine

iv. in Chart #2, (visit May 2018), Dr. Vaidyanathan recorded “pt. of Dr. Zelig” and “chronic opioid user”, but did not record the patient’s history of problems, reasons for opioid use, or current symptoms. He nonetheless prescribed Fentanyl 75mcg/h patch and Oxycodone 80mg;

v. in Chart #4, (visit May 2018), Dr. Vaidyanathan recorded “pt. of Dr. Zelig with chronic hip/back pain on long-term meds”, but did not record the patient’s history of current complaints or a physical examination. He nonetheless prescribed Oxycodone CR 80 and Percocet;

d. Chronic pain management: In a number of cases, Dr. Vaidyanathan’s management of chronic pain patients was concerning. For example:

i. in Chart #8 (visit December 2017), it was noted in the history that the patient’s wife had raised concerns regarding her husband’s abuse of narcotics. Following this, the wife sent a letter to Dr. Vaidyanathan dated November 20, 2017 detailing the patient stealing her Dexedrine and Tylenol #3; his erratic and dangerous behaviour; and requesting Dr. Vaidyanathan take action. Dr. Vaidyanathan noted that he received the letter, and recorded that “the patient’s account was somewhat different but plausible” and “suspect may be using PRN meds more often, yet no sign of abuse”. This demonstrated poor judgment and placed the patient at potential ongoing risk. In the EMR, during a visit to another physician at the same clinic, entries were made in October 2018 concerning a letter from the patient’s wife dated September 13, 2018 which detailed her further concerns regarding her husband’s addiction to pain medication. She requested that Dr. Vaidyanathan initiate a withdrawal plan. During the interview, Dr. Vaidyanathan stated that he had never seen the letter, despite that it was specifically addressed to him;

ii. in Chart #5, in a patient with chronic mechanical back pain, Dr. Vaidyanathan wrote a prescription for a supply of 4 months of Percocet in September 2018 despite having attempted to taper the dosage of Percocet over

the previous two years. In the interview, Dr. Vaidyanathan stated that he was going on leave and did not wish to leave the patient without medication. He agreed that it would have been preferable to have another physician at the clinic assume management and continue the narcotic taper;

e. In several cases, Dr. Vaidyanathan's choice of medications was questionable. For example:

   i. in Chart #7 (visit November 2016), the patient complained of "bloating, gaseous, nausea…" as well as dental pain. Although no diagnosis was offered, Dr. Vaidyanathan prescribed Clindamycin 300 mg tid. Clindamycin is recommended qid rather than tid. It is not clear why Penicillin was not used instead. Clindamycin is often associated with gastrointestinal side effects, and this patient already had gastrointestinal symptoms;

   ii. in Chart #10 (visit November 2016), the patient with joint pains was prescribed Celebrex, a non-steroidal anti-inflammatory ("NSAID"), despite already taking Naproxen, another NSAID;

   iii. in Chart #12 (visit September 2017), Dr. Vaidyanathan prescribed Hycodan, a narcotic cough syrup, to a patient already on two narcotics and benzodiazepines;

   iv. in Chart #6 (visit February 2018), Dr. Vaidyanathan treated the patient's cough with Koffex DM, a narcotic, despite the patient already taking two narcotics, Oxycodone and Percocet;

   v. in Chart #15 (visit April 2018), the patient requested a B12 shot and one was administered by Dr. Vaidyanathan, despite a normal B12 level done 8 months earlier and recorded in the EMR. When questioned during the interview with Dr. Ahuja, Dr. Vaidyanathan stated, "I think he said, 'It's time for my B12 shot', and I probably didn't think twice when he came in and said, 'Here's my B12, can you put this in my arm for me?' I probably didn't even think about it as he's saying, 'This is time for my B12 shot';

f. Failure to record justification for prescription: In several patients, Dr. Vaidyanathan prescribed a medication without adequately describing the problem or documenting a diagnosis. For example:

    i. in Chart #6 (visit May 2017), Dr. Vaidyanathan prescribed Pantoloc, a medication used for the prevention or treatment of ulcers or for gastroesophageal reflux, without any assessment that the patient had gastrointestinal complaints;

    ii. in Chart #1 (visit January 2018), Dr. Vaidyanathan prescribed hydrocortisone, a topical cream used to treat itching and irritation, without an adequate description of a rash on the patient's hands, or a diagnosis of eczema;

g. Failure to record samples: Dr. Vaidyanathan gave patients samples of drugs without recording them. For example:

    i. in Chart #12 (visit June 2017), Dr. Vaidyanathan gave the patient a sample of an allergy medication that was not recorded in the EMR;

    ii. in Chart #6 (visit June 2018), Dr. Vaidyanathan's plan for management of bronchitis was "antibiotics/prednisone/Symbicort", yet the only prescription found in the EMR was for prednisone. Dr. Vaidyanathan gave the patient samples of Zithromax and Symbicort that he had in the office, but failed to record these in the record of treatment;

h. Failure to follow-up: In several patients, Dr. Vaidyanathan failed to adequately follow-up on patient complaints, and investigations he had ordered. For example:

    i. in Chart #7 (visit January 2017), the patient apparently had "cysts" and the plan noted by Dr. Vaidyanathan was "…will reassess next week for potential I&D of lesion". However, the patient was not seen the following week, and Dr. Vaidyanathan made no mention of this issue during the patient's subsequent visit (in February 2017);

    ii. in Chart #6 (visit March 2018), the patient complained of vaginal irritation. Dr. Vaidyanathan did not record a further history, he did not note an examination of the

area, he did not offer a diagnosis, and did not mention a plan. He ordered lab work, the results of which were "insufficient urine for GC/CT; urine culture neg; swab+ BV". The chart from the patient's next visit (April 2018) made no mention of these lab findings; there was no treatment of the positive result and no repeat of urine testing for a sexually transmitted disease. Further documents included two consults to specialists for the vaginal issue, yet there were no results of these consults in the records.

63. In engaging in the conduct described at paragraphs 55 to 62, Dr. Vaidyanathan failed to maintain the standard of practice of the profession.

PART II – ADMISSION

64. Dr. Vaidyanathan admits the facts at paragraphs 1 to 63 above, and admits that, based on these facts, he engaged in professional misconduct:

    a. under paragraph 1(1)33 of Ontario Regulation 856/[9]3, made under the Medicine Act, 1991, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and

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

Finding

[7] The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission (Liability). Having regard to these facts, the Committee accepted Dr. Vaidyanathan's admission and found that he committed an act of professional misconduct in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and has failed to maintain the standard of practice of the profession.

Penalty and reasons for penalty

[8] The following facts were set out in an Agreed Statement of Facts (Penalty) which was filed as an exhibit and presented to the Committee:

> File #7216295
>
> *Treatment of Self and OHIP Billing for Treatment of Self; Obtaining treatment while on shift*
>
> 1. In May 2020, seven months after these allegations were referred to the Discipline Committee, Dr. Vaidyanathan confirmed that he had repaid OHIP for the ten billings he submitted with respect to the care and treatment he provided to himself in the emergency departments of Humber River Hospital and Niagara Health between 2011 and 2016.
>
> *Humber River Hospital Investigation regarding Communications with Nurse A*
>
> 2. Humber River Hospital retained an independent workplace investigator to investigate Dr. Vaidyanathan's conduct towards Nurse A. In a report attached at Tab 1 [to the Agreed Statement of Facts (Penalty)], the investigator concluded:
>
>> I find that Dr. Vaidyanathan's conduct did breach Humber River Hospital's *Anti-Harassment & Anti-Discrimination Policy*, *Violence and Harassment in the Workplace Policy*, *Code of Conduct*, and *Medical-Dental Staff Code of Conduct*, as well as the definition of Workplace Harassment under the *Occupational Health and Safety Act* with regards to some of the allegations made against him.
>
> 3. In November and December 2016, Dr. Vaidyanathan appeared before Humber River Hospital's Medical Advisory Committee ("MAC") in connection with his conduct towards Nurse A. At those meetings, the MAC recommended that Dr. Vaidyanathan work no more than 4 night shifts each month; that a letter of reprimand be placed in Dr. Vaidyanathan's file; and that he be referred to the Physician Health Program ("PHP") of the Ontario Medical Association for an assessment. Dr. Vaidyanathan's personnel file from Humber River Hospital does not contain a letter of reprimand related to his conduct towards Nurse A.
>
> 4. In February 2017, Dr. Vaidyanathan was referred to the PHP by Humber River Hospital, as recommended by the hospital's MAC. Dr. Vaidyanathan has remained engaged with in the PHP since that time.

In April 2019, Dr. Vaidyanathan entered into a 5-year monitoring contract with the PHP for substance use disorder. Dr. Vaidyanathan's substance use disorder was not the cause of the misconduct at issue in this case. Through his monitoring contract, Dr. Vaidyanathan agreed to workplace monitoring, to assist in monitoring his behaviour in the workplace. Dr. Vaidyanathan's workplace monitors have reported no concerns.

Dr. Vaidyanathan's Prior History

December 2011 – ICRC Decision – File #81781

5. On December 14, 2011, the ICRC considered a complaint relating to Dr. Vaidyanathan's care in the emergency department of an insulin-dependent diabetic patient with swollen, red feet in February 2011. A copy of the December 2011 ICRC decision is attached at Tab 2 [to the Agreed Statement of Facts (Penalty)].
6. The Committee was troubled by Dr. Vaidyanathan's approach to this case. Dr. Vaidyanathan diagnosed gout, prescribed Indomethacin, and advised the patient to return if her foot got worse. However, the diagnosis was likely more suggestive of cellulitis, especially in an insulin-dependent female diabetic at high risk for foot infections. Diabetic foot infections generally need aggressive, early treatment to give the patient the best chance of cure.
7. The ICRC counseled Dr. Vaidyanathan about his approach to the management of a diabetic patient with a foot infection.

January 2016 – ICRC Decision – File #97948

8. On January 13, 2016, the ICRC considered a complaint relating to Dr. Vaidyanathan's care and conduct of an obese, diabetic patient who attended in the emergency department in April 2015 for a recurrent groin abscess. A copy of the January 2016 ICRC decision is attached at Tab 3 [to the Agreed Statement of Facts (Penalty)].
9. One of the Committee's concerns was that Dr. Vaidyanathan's charting was rather sparse, and did not indicate that he took into account the patient's history, such as past infections, her previous engagements with CCAC home care, her weight, or her Type 2 diabetes. It was also concerned that, with respect to follow-up arrangements, Dr. Vaidyanathan left packing in the wound and did not arrange for home care. Given the patient's difficulty mobilizing and the

fact that she lived alone, a referral to the CCAC for continued wound care would have been appropriate.

10. The ICRC advised Dr. Vaidyanathan to ensure proper draping and privacy, maintain proper documentation, including documenting a complete history, and to order CCAC for ongoing wound care.

July 2019 – ICRC Decision – File #1100642

11. On July 19, 2019, the ICRC considered an investigation into Dr. Vaidyanathan's emergency medicine practice. A copy of the July 2019 ICRC decision in File #1100642 is attached at Tab 4 [to the Agreed Statement of Facts (Penalty)].

12. An expert retained by the College opined that in 16 out of 27 charts reviewed, Dr. Vaidyanathan failed to meet the standard of care for an emergency physician. Specifically, his repeated pattern of inadequate assessments in both the history and physical examination, inadequate reassessments, inadequate discharge instructions, and inadequate follow-up arrangements, would reflect an overall practice which was below the standard of care and was likely to expose his patients to harm or injury. The expert noted poor and illegible records, inadequate physical examinations and histories, inadequate reassessments, inadequate discharge instructions and inadequate follow-up plans. As a result, the Committee was concerned that Dr. Vaidyanathan had decreased skills in a wide range of emergency cases.

13. In light of an undertaking entered into by Dr. Vaidyanathan on July 31, 2019, pursuant to which he agreed to engage in professional education, clinical supervision and a reassessment, attached at Tab 5 [to the Agreed Statement of Facts (Penalty)] and described below, the ICRC took no further action.

July 2019 – ICRC Decision – File #1101073

14. On July 19, 2019, the ICRC considered a complaint regarding Dr. Vaidyanathan's care and treatment of a patient who died the day after being assessed in the emergency department by Dr. Vaidyanathan and discharged. A copy of the July 2019 ICRC decision in File #1101073 is attached at Tab 6 [to the Agreed Statement of Facts (Penalty)].

15. The Committee was of the view Dr. Vaidyanathan's assessment was not sufficiently thorough, his clinical work-up was poor, and his record-keeping was inadequate. An expert retained by the College opined

that Dr. Vaidyanathan fell below the standard of practice of the profession in his care and treatment of the patient. His assessment of the patient was “woefully inadequate”. Specifically, his history, examination of the patient and investigations were all inadequate. The expert opined that Dr. Vaidyanathan demonstrated a lack of skill in doing an incomplete assessment with potentially serious medical complaints, and a lack of judgement by discharging the patient without a more comprehensive assessment. In the expert’s opinion, Dr. Vaidyanathan’s assessment was so inadequate that his clinical practice could expose, and was likely to expose, patients to harm or injury because of his lack of thoroughness.

16. In light of an undertaking entered into by Dr. Vaidyanathan on July 31, 2019, pursuant to which he agreed to engage in professional education, clinical supervision and a reassessment, attached at Tab 5 [to the Agreed Statement of Facts (Penalty)]and described below, the ICRC took no further action.

17. Dr. Vaidyanathan has no prior history before the Discipline Committee.

July 2019 – Undertaking

18. In his July 31, 2019 undertaking, Dr. Vaidyanathan undertook to:

    a. practise under the guidance of a Clinical Supervisor acceptable to the College for 12 months, as follows:

        i. high-level supervision for a minimum of 2 months and a minimum of 20 shifts, during which the Clinical Supervisor shall: (1) review Dr. Vaidyanathan’s assessment including history taking and physical examinations, treatment, management of test results, discharge instructions and follow-up plan for each patient he treats in each shift, before the end of each shift; and (2) perform direct observation of his in-person assessments of two patients per shift;

        ii. moderate-level supervision for a minimum of 2 months, during which the Clinical Supervisor shall meet with Dr. Vaidyanathan once every 2 weeks to review a minimum of 20 charts; and

        iii. low-level supervision for a maximum of 8 months, during which Dr. Vaidyanathan shall meet with his Clinical

Supervisor once per month to review a minimum of 20 charts;

b. engage in professional education in medical record-keeping, test results management and professional obligations and human rights:

    i. a review and written summary of the following College policies: Medical Record, Test Results Management, Professional Obligations and Human Rights, and Ontario's Routine Immunization Schedule;

    ii. the CMPA's two e-learning modules on medical-record keeping; and

    iii. the University of Toronto's Medical Record-Keeping course;

c. have his practice reassessed within six months of the end of the period of Clinical Supervision.

19. On November 27, 2019, Dr. Vaidyanathan attended the University of Toronto's Medical Record-Keeping course. His certificate of completion and learner assessment are attached at Tab 7 [to the Agreed Statement of Facts (Penalty)].

20. On December 9, 2019, Dr. Vaidyanathan submitted his certificates of completion for the two CMPA e-modules on medical-record keeping. They are attached at Tab 8 [to the Agreed Statement of Facts (Penalty)].

21. Dr. Vaidyanathan's review and written summary of the required policies and the immunization schedule are attached at Tab 9 [to the Agreed Statement of Facts (Penalty)]. On December 10, 2019, as attached at Tab 10 [to the Agreed Statement of Facts (Penalty)], the College advised Dr. Vaidyanathan that he had successfully completed them.

22. Dr. David Provan, Dr. Paul Jacobson, Dr. Meera Jayarajan and Dr. Aneesh Chhabra were approved as Dr. Vaidyanathan's clinical supervisors. Between January 17 and March 18, 2020, Dr. Vaidyanathan practiced under high-level supervision. Between March 18, 2020 and June 1, 2020, Dr. Vaidyanathan practiced under moderate-level supervision. He is currently practicing under low-level supervision.

23. Dr. Vaidyanathan's clinical supervisors' reports to date are attached as follows:

    a. March 6, 2020, covering the period from January 17 to February 15, 2020 (Tab 11 [to the Agreed Statement of Facts (Penalty)]);

    b. March 23, 2020, covering the period from February 19 to March 18, 2020 (Tab 12 [to the Agreed Statement of Facts (Penalty)]);

    c. April 28, 2020, covering the period March 22 to April 18, 2020 (Tab 13 [to the Agreed Statement of Facts (Penalty)]); and

    d. May 31, 2020, covering the period April 19 to May 16, 2020 (Tab 14 [to the Agreed Statement of Facts (Penalty)]); and

    e. July 3, 2020, covering June 2020 (Tab 15 [to the Agreed Statement of Facts (Penalty)]).

24. Letters regarding Dr. Vaidyanathan's return to supervised practice from Dr. Leon Rivlin, Chief of Emergency Medicine at Humber River Hospital, dated April 28, 2020, and May 28, 2020, are attached at Tabs 16 and 17 [to the Agreed Statement of Facts (Penalty)].

Undertaking in Lieu of interim Order

25. On February 3, 2020, as attached at Tab 18 [to the Agreed Statement of Facts (Penalty)], Dr. Vaidyanathan entered into an interim undertaking in lieu of an Order under s. 25.4 of the Health Professions Procedural Code. It applies to Dr. Vaidyanathan's office-based (i.e. out-of-hospital) practice, such as all family practices, walk-in clinics, and cosmetics clinics at which he may practice.

26. The undertaking provides for clinical supervision of all prescriptions for Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances, and Monitored Drugs in his office-based practice. To date, Dr. Vaidyanathan has not prescribed any Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances, and Monitored Drugs in his office-based practice since February 3, 2020.

Other courses

27. On January 21, February 18, and March 25, 2020, Dr. Vaidyanathan attended the University of Toronto's Safer Opioid Prescribing Webinar Series. His certificate of completion is attached at Tab 19 [to the Agreed Statement of Facts (Penalty)].

28. On June 5, 2020, Dr. Vaidyanathan attended the Challenging Cases in Opioid Use and Misuse Virtual Workshop. A letter confirming that he attended is attached at Tab 20 [to the Agreed Statement of Facts (Penalty)]. In order to successfully complete the workshop, Dr. Vaidyanathan is also required to complete two practice application exercises, in July and August 2020.

[9] Following the July 13, 2020 hearing, the Committee requested a further hearing to clarify certain aspects of the parties' submissions with respect to the appropriate penalty. The further hearing was held on September 23, 2020. The following facts were set out in a Supplementary Agreed Statement of Facts (Penalty), which was filed as an exhibit at the hearing and presented to the Committee:

July 2019 – Undertaking

1. On August 25, 2020, the College Compliance Case Manager requested Dr. Vaidyanathan's clinical supervisors to ensure that five charts out of the twenty charts reviewed each month are for patients to whom Dr. Vaidyanathan prescribed one or more of: Narcotic Drugs, Narcotic Preparations; Controlled Drugs Benzodiazepines and Other Targeted Substances, and/or Monitored Drugs. The e-mail from the College's Compliance Case Manager is attached at Tab 1 [of the Supplementary Agreed Statement of Facts (Penalty)].
2. Further to Dr. Vaidyanathan's July 31, 2019 undertaking, his clinical supervisor's report for the month of August 2020 is attached at Tab 2 [of the Supplementary Agreed Statement of Facts (Penalty)].
3. The parties have agreed that the reassessment of Dr. Vaidyanathan's emergency medicine practice pursuant to his July 31, 2019 undertaking will include a review of hospital charts in which Dr. Vaidyanathan prescribed one or more of: Narcotic Drugs, Narcotic Preparations; Controlled Drugs Benzodiazepines and Other Targeted Substances, and/or Monitored Drugs.

Letter from Dr. Rivlin

4. A letter from Dr. Leon Rivlin, Chief of Emergency Medicine at Humber River Hospital dated September 17, 2020 regarding the timing of the commencement of the suspension of Dr. Vaidyanathan's certificate of registration in light of the COVID-19 pandemic is attached at Tab 3 [of the Supplementary Agreed Statement of Facts (Penalty)].

Safer Opioid Prescribing Series

5. The program description and program outline for the Safer Opioid Prescribing Webinar Series attended by Dr. Vaidyanathan in January, February and March 2020 (see Agreed Statement of Facts (Penalty), Exhibit 3, paragraph 27 and Tab 19 thereof) is attached at Tab 4 [of the Supplementary Agreed Statement of Facts (Penalty)].
6. The program description and program outline for the Challenging Cases in Opioid Use and Misuse Virtual Workshop attended by Dr. Vaidyanathan in June 2020 (see Agreed Statement of Facts (Penalty), Exhibit 3, paragraph 28 and Tab 20 thereof) is attached at Tab 5 [of the Supplementary Agreed Statement of Facts (Penalty)].

Dr. Vaidyanathan's Out-of-Hospital Practice

7. Dr. Vaidyanathan has two out-of-hospital practice locations, both of which are cosmetic clinics. This is currently the totality of his out-of-hospital practice. At both locations, Dr. Vaidyanathan is the Medical Director, and he either performs or delegates the performance of cosmetic injections. Dr. Vaidyanathan does not prescribe opioids to patients at the cosmetic clinics. Dr. Vaidyanathan intends to return to these practice locations after the suspension of his certificate of registration, subject to demand for his services at that time.
8. In and prior to March 2020, Dr. Vaidyanathan also practiced at two walk-in clinics. He has not practiced in a walk-in clinic since March 2020. He does not intend to either of these walk-in clinics after the suspension of his certificate of registration.

Submissions on penalty

[10] While counsel for the College and counsel for Dr. Vaidyanathan submitted an Agreed Statement of Facts and Admission (Liability), an Agreed Statement of Facts (Penalty), and a Supplementary Agreed Statement of Facts (Penalty), the parties had differing views on what would be an appropriate penalty Order. The penalties proposed by the parties are set out below.

<u>Penalty Sought by College</u>

[11] The College sought an Order:

a. requiring Dr. Vaidyanathan to appear before the panel to be reprimanded;

b. directing the Registrar to suspend Dr. Vaidyanathan's certificate of registration for twelve (12) months, commencing on the later of: (a) December 31, 2020 at 12:01 a.m. or (b) thirty days after the date of this Order;

c. imposing terms, conditions and limitations on Dr. Vaidyanathan's certificate of registration, including requirements that he:

   i. comply with the College Policy "Closing a Medical Practice";

   ii. participate in and successfully complete, within six (6) months of the date of this Order, individualized instruction in ethics satisfactory to the College, with an instructor approved by the College, who shall provide a summative report to the College including his or her conclusion about whether Dr. Vaidyanathan successfully completed the instruction; and

   iii. be prohibited from issuing new prescriptions or renewing existing prescriptions for or administering Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances, and Monitored Drugs in his out-of-hospital practice.

d. requiring that Dr. Vaidyanathan pay costs to the College in the amount of $10,370 within ninety days of the Order.

Penalty Sought by Member

[12] The Member sought an Order:

a. requiring Dr. Vaidyanathan to appear before the panel to be reprimanded;

b. directing the Registrar to suspend Dr. Vaidyanathan's certificate of registration for six (6) months, commencing on the later of: (a) December 31, 2020 at 12:01 a.m. or (b) thirty days after the date of this Order;

c. imposing terms, conditions and limitations on Dr. Vaidyanathan's certificate of registration, including requirements that he:

i. participate in and successfully complete, within six (6) months of the date of this Order, individualized instruction in ethics satisfactory to the College, with an instructor approved by the College, who shall provide a summative report to the College including his or her conclusion about whether Dr. Vaidyanathan successfully completed the instruction; and

ii. be prohibited from issuing new prescriptions or renewing existing prescriptions for or administering Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances, and Monitored Drugs in his out-of-hospital practice unless and until he provides 15 days' notice to the College, at which time he will enter into an Undertaking with an appropriate individualized education plan, clinical supervision, and a reassessment, approved by the ICRC. This restriction will not apply to his hospital based, emergency medicine practice.

[13] The parties agree that Dr. Vaidyanathan should appear before the panel to be reprimanded, be subject to a suspension of some duration, complete instruction in ethics, and that his prescribing of controlled substances out-of-hospital (but not in his emergency department practice) should either be prohibited or be subject to certain conditions. The parties disagree as to the length of an appropriate suspension and the nature of the prescribing restrictions out-of-hospital. Further, counsel for Dr. Vaidyanathan submitted that the penalty should not include the penalty term proposed by the College that Dr. Vaidyanathan comply with the terms of the "Closing a Medical Practice" policy.

Penalty and reasons for penalty

[14] To determine an appropriate penalty, the Committee considered the nature of the misconduct set out in the jointly filed Agreed Statement of Facts and Admission (Liability), the Agreed Statement of Facts (Penalty), the Supplementary Agreed Statement of Facts (Penalty), and other documents filed. The Committee also

considered aggravating and mitigating factors on penalty and reviewed prior cases of this Committee submitted by the parties.

[15] The Committee was also guided by the well-recognized penalty principles. The first and foremost principle is protection of the public. Further, the penalty must convey the profession's disapproval and denunciation of the misconduct, assure the integrity of the profession, and maintain public confidence in the profession and in the College's ability to regulate the profession in public interest. The penalty should provide specific deterrence to the member and general deterrence to the entire profession. Where appropriate, the penalty should also provide for the rehabilitation of the member.

[16] The Committee weighed the above principles, keeping in mind the facts and circumstances of the case, to arrive at its decision on penalty.

Aggravating Factors

[17] The Committee considered the following to be aggravating factors in this case:

a. The misconduct leading to the finding made by this Committee began very early on in Dr. Vaidyanathan's career, and has been persistent and wide-ranging throughout;

b. The misconduct permeated Dr. Vaidyanathan's professional life in his relationships with the College and his interpersonal relationships in the workplace at Humber River Hospital (HRH);

c. Dr Vaidyanathan abused his authority and power;

d. Dr. Vaidyanathan acted in his own self-interest and prioritized his needs over those of his patients;

e. The misuse of public resources was a recurrent issue;

f. Dr. Vaidyanathan's actions demonstrate a pattern of deceit. In particular, he attributed his self-treatment to other physicians and knowingly and inappropriately billed OHIP for same. Further, he failed to report his

privileges at several hospitals to the College. Dr. Vaidyanathan's behaviour was deliberate, and indicative of a sense of arrogance and disregard for his professional obligations;

g. The independent practice reviews document Dr. Vaidyanathan's lack of judgement in his delivery of patient care, which is pervasive over years of practice. These patient care concerns include his narcotic prescribing, record keeping and ability to manage complications of chronic illness such as substance use disorder and cystic fibrosis;

h. Dr. Vaidyanathan has a history of investigations by ICRC between 2011 and 2019. Some of the misconduct at issue in this proceeding relating to patient care was of the same nature as that which was the subject of those ICRC investigations, and for which he was required to educate himself.

Mitigating Factors

[18] The Committee considered the following to be mitigating factors in this case:

a. This is Dr. Vaidyanathan's first time before the Discipline Committee;

b. Dr. Vaidyanathan admitted his misconduct, demonstrating insight and accountability, thereby saving the College the expense and time of a lengthy, contested hearing;

c. Dr. Vaidyanathan has paid back OHIP for his self-treatment billings;

d. Dr. Vaidyanathan voluntarily took steps to address concerns regarding his prescribing practice by participating in coursework including the University of Toronto's *Safer Opioid Prescribing Webinar Series* and the *Challenging Cases in Opioid Use and Misuse Virtual Workshop*. This shows that Dr. Vaidyanathan may have some insight regarding his clinical deficiencies and seeks to improve;

e. Dr. Vaidyanathan enrolled with the Physician Health Program (PHP) in April 2019, demonstrating his overall commitment to personal growth and rehabilitation.

[19] The Committee is of the view that the aggravating factors firmly outweigh the mitigating factors in this case. In coming to this conclusion, the Committee considered the decision in *CPSO v. Fenton,* 2017 ONCPSD 16 which states the following at page 21:

> The Committee accepts that Dr. Fenton may have gained an insight from acknowledging his misconduct and settling the matter outside a contested hearing and that he has no prior disciplinary history. However, faced with the breadth and seriousness of the professional misconduct, such mitigating factors do not carry significant weight.

[20] As in *Fenton*, the Committee is of the view that the mitigating factors do not carry significant weight when considered against the aggravating factors set out above.

Prior Cases

[21] Both College counsel and counsel for Dr. Vaidyanathan submitted Books of Authorities with prior cases of this Committee. These included 11 cases from Dr. Vaidyanathan and 24 cases from the College.

[22] Select cases submitted to and considered by the Committee relate to the following:

- self-treatment or treatment of family members (*CPSO v. Raddatz*, 2020 ONCPSD 27 and *CPSO v. Irvine*, 2011 ONCPSD 39);
- inappropriate billings (*CPSO v. Opper*, 2015 ONCPSD 15);
- unprofessional communications (*CPSO v. Waddell*, 2020 ONCPSD 9 and *CPSO v. Podell*, 2017 ONCPSD 4);
- failure to report to the College (*CPSO v. Varenbut*, 2015 ONCPSD 40);
- failure to maintain the standard of practice (*CPSO v. Irwin*, 2018 ONCPSD 36 and *CPSO v. Houshmand*, 2020 ONCPSD 16); and
- inappropriate narcotic prescribing (*CPSO v. Esmond*, 2016 ONCPSD 4; *CPSO v. Matheson*, 2017 ONCPSD 32; *CPSO v. Fenton*, 2017 ONCPSD

16; *CPSO v. Humatov*, 2019 ONCPSD 42; and *CPSO v. Pasternak*, 2018 ONCPSD 49).

[23] Although prior cases of the Committee are not binding as precedent, the Committee accepts that as a principle of fairness, like cases should be treated alike. The Committee is cognisant that each case must be decided on its own set of unique facts and circumstances. The Committee recognizes, however, that prior cases involving conduct of a similar nature may serve as a guide as to an appropriate range of penalties.

[24] The most serious penalties imposed in the cases provided were: a six-month suspension (*Raddatz* (joint-submission) and *Fenton*); clinical supervision for 12-months (*Pasternak* (joint-submission), *Houshmand* and *Fenton*) a six-month restriction on the member's surgical practice (*Irwin*); and a prohibition against prescribing narcotics and/or other controlled substances (*Esmond and Matheson*).

Analysis

[25] Both parties propose, and the Committee agrees, that the Order should include a reprimand, instruction in ethics, and the payment of costs by Dr. Vaidyanathan. Where the parties disagree, however, is regarding the length of the suspension, the inclusion of the penalty term that Dr. Vaidyanathan comply with the College's policy on "Closing a Medical Practice", and the nature of the restriction on Dr. Vaidyanathan's prescribing of controlled substances in his out-of-hospital practice.

[26] As detailed below, the Committee: (a) agrees with the College's submission that Dr. Vaidyanathan's certificate of registration should be suspended for 12 months; (b) agrees with Dr. Vaidyanathan's submission that there is no need to impose a term in the penalty Order that he comply with the College's policy on "Closing a Medical Practice"; (c) agrees with the College that Dr. Vaidyanathan should be prohibited from prescribing controlled substances in his out-of-hospital practice;

and (d) disagrees with both parties that there should be no prohibition on Dr. Vaidyanathan's prescribing controlled substances in his emergency department practice. In respect of the last, the Committee finds that the only restriction that would adequately protect the public is to prohibit Dr. Vaidyanathan from prescribing, renewing or administering controlled substances in both his out-of-hospital and emergency practice. Each of these areas is addressed in turn below.

I. Length of Suspension

[27] The Committee agrees with the College that a twelve-month suspension is appropriate in this case. Counsel for Dr. Vaidyanathan submitted that a six-month suspension would suffice as there are no similar cases that resulted in a twelve-month suspension. None of the cases provided by the parties, however, involved a physician whose misconduct approached the frequency, duration or scope of that found in this case.

[28] Dr. Vaidyanathan has committed numerous types of misconduct during his nine-year career. Central to his misbehaviour is a persistent lack of judgement exemplified by: his frequent self-treatment and billing of OHIP for these services; the falsification of hospital records; his lack of professionalism in the work environment; his failure to provide complete and accurate information to his regulatory body; and the many examples of lack of judgment in his delivery of patient care over years of practice.

[29] Dr. Vaidyanathan's misconduct demonstrates a blatant disregard towards his professional obligations in many respects.

a) Self-treatment and OHIP billing

[30] Dr. Vaidyanathan demonstrated a significant lack of integrity and poor judgement by billing OHIP ten times for his self-treatment over five years, and falsifying hospital documents to indicate that other physicians were treating him. He used emergency room resources, including laboratory tests and x-rays, for his own

self-treatment at the expense of other patients. By allocating himself these resources, Dr. Vaidyanathan avoided the necessary objective review by another physician to determine whether the testing and treatments were appropriate and necessary.

[31] Dr. Vaidyanathan paid back OHIP for his self-treatment billings only after he was notified of his appearance before the Discipline Committee.

b) Unprofessional Behaviour

[32] Dr. Vaidyanathan repeatedly demonstrated extremely unprofessional behaviour in the work environment and in his communications with his fellow healthcare professionals. His misconduct included abusive and demeaning conduct towards female colleagues who were subordinate to him.

[33] The Committee was particularly alarmed by Dr. Vaidyanathan's harassment of Nurse A, which included aggressive and intimidating language in texts about personal matters. This culminated in Nurse A's formal complaint to the HRH administration, an investigation, and the establishment of an institutional formal safety plan to protect Nurse A.

[34] Dr. Vaidyanathan also misused hospital resources by occupying a patient's bed in an acute care area requiring a housekeeper to clean the area after him.

[35] The Committee acknowledges that since Dr. Vaidyanathan has entered into the PHP in April, 2019, his supervisors have not reported any concerns with his behavior towards his colleagues. However, the serious nature of his behavioral transgressions merit a serious sanction.

c) Incomplete and Inaccurate information to the College

[36] Dr. Vaidyanathan repeatedly provided incomplete and inaccurate information to the College about his hospital privileges. His failure to report is indicative of a contempt for the College's authority, raises serious concerns about Dr.

Vaidyathan's governability, and mirrors his unprofessional conduct in the workplace.

d) Clinical Care

[37] The investigations into Dr. Vaidyanathan's practice, as outlined in the Agreed Statement of Facts and Admission (Liability), reveal multiple failures to meet the standard of practice. Two assessors (Dr. Mikhail and Dr. Ahuja) highlighted issues relating to his medical record keeping and patient assessments in the narcotics prescribing context. In his emergency practice, Dr. Mikhail found that in nine out of sixteen charts, Dr. Vaidyanathan "displayed a lack of knowledge, skill and judgement", and in seven out of sixteen charts, "his clinical practice exposed patients to potential harm". Regarding his out-of-hospital practice, Dr. Ahuja indicated that Dr. Vaidyanathan "displayed a lack of skill in patient assessment" and "his clinical practice exposed patients to potential harm" in fourteen out of fifteen charts.

[38] The Committee is also concerned by Dr. Vaidyanathan's history before the ICRC. The Committee recognizes that it is not to fashion a penalty in respect of the conduct that was the subject of matters before the ICRC; however, in determining the appropriate Order, the Committee must take into account Dr. Vaidyanathan's history, including prior opportunities for remediation.

[39] Dr. Vaidyanathan was the subject of three prior complaints to the ICRC, one of which followed the treatment of a patient who died the day after Dr. Vaidyanathan assessed the patient, and an investigation into his emergency medicine practice.

[40] In respect of the investigation, the assessor noted that "in sixteen out of twenty-seven charts, Dr. Vaidyanathan failed to meet the standard of care for an emergency physician" and that his practice "is likely to expose his patients to harm or injury". The examples were "wide-ranging, including (but not limited to) treatment of shortness of breath, head injuries, management of a Form 1,

management of fever in sickle cell anemia, assessment of a decreased level of consciousness, seizure…and fibular fracture management." The assessor noted that information from hospital files indicated "a series of complaints that are fairly extensive with repeated themes (such as missed diagnoses, communication issues with other staff and patients, and poor medical records) over several years at a number of different hospitals".

e) Decision on Length of Suspension

[41] The Committee was cognizant that the penalty should reflect the duration, severity, and frequency of the individual's misconduct. On assessment of all the evidence before it, the Committee concluded that a twelve-month suspension was a just and appropriate penalty that is proportional to the conduct established by the facts and circumstances of the case.

[42] A twelve-month suspension will protect the public and maintain public confidence in the system of self-regulation. Further, the penalty will act as a very strong specific deterrent to Dr. Vaidyanathan and general deterrent to the entire profession that the Committee will not tolerate the nature, breadth and duration of misconduct found here.

II. Inclusion of Requirement that Dr. Vaidyanathan Comply with College Policy

[43] The Committee agrees with counsel for Dr. Vaidyanathan that it is not necessary for the Order to include the requirement that Dr. Vaidyanathan comply with the College Policy on *Closing a Medical Practice.*

[44] In *CPSO v. Raddatz,* 2020 ONCPSD 27, the Committee found that it was "not appropriate to direct in its penalty order that Dr. Raddatz be required to comply with the "Closing a Medical Practice" policy. The Committee states at page 15:

> Although the Committee has not been consistent in including such a provision in the past, it accepts that there should be a concern addressed that rises above the need for every physician to have proper regard to all College policies.

> In this instance, the Committee is not persuaded that Dr. Raddatz's disregard for the College's "Physician Treatment of Self, Family Members, or Others Close to Them" policy, while deliberate and repeated, gives rise to significant concern that she would fail to comply with the "Closing a Medical Practice" policy or other practice-related policies.

[45] Having adopted the reasoning in *Raddatz*, the Committee finds that there is insufficient evidence to warrant the inclusion of the penalty term that Dr. Vaidyanathan comply with the College's policy on *Closing a Medical Practice.*

III. Controlled Substance Prescribing

[46] While the College and Dr. Vaidyanathan do not agree on the limitations that should be placed on Dr. Vaidyanathan's prescribing of controlled substances, they agree that this Committee should not place any restrictions on Dr. Vaidyanathan's prescribing in his emergency department practice. The parties' position is that restrictions on Dr. Vaidyanathan's prescribing of controlled substances in his emergency department practice is unnecessary as a result of the undertaking Dr. Vaidyanathan entered into in July 2019.

[47] With respect to this jointly proposed aspect of the penalty, the parties submit that the Committee should not depart from the joint proposal unless it would bring the administration of justice into disrepute or is otherwise not in the public interest (*R. v. Anthony-Cook,* 2016 SCC 43).

[48] On review of the evidence, the Committee determined that a full prohibition on the prescribing of controlled substances, regardless of the practice location, is necessary to protect the public. The Committee is of this view based on the serious issues identified pertaining to Dr. Vaidyanathan's clinical judgment, the lack of evidence regarding the safety of Dr. Vaidyanathan's narcotic prescribing, and prior decisions of this Committee.

a) *Dr. Vaidyanathan's Clinical Judgment re. Controlled Substance Prescribing*

[49] The independent practice reviews document Dr. Vaidyanathan's lack of judgment in his delivery of patient care, including in his controlled substance prescribing, both in his emergency department and out-of-hospital practices. These reviews indicated that Dr. Vaidyanathan's judgement and knowledge regarding narcotics prescribing were equally and highly problematic in the two practice locales.

[50] Dr. Vaidyanathan's cavalier approach to the prescribing of controlled substances was reckless, and demonstrated problems with his medication choice, and prescribed quantities and duration of controlled substances, both in the emergency department and out-of-hospital. The assessors involved in reviewing Dr. Vaidyanathan's prescribing of controlled substances agreed that the care provided by Dr. Vaidyanathan did not meet the standard of practice.

[51] Dr. Mikhail's assessment of Dr. Vaidyanathan's emergency department practice revealed a lack of knowledge, skill and judgement in nine of fifteen charts. The documented incidents included a "reckless" prescribing of narcotics and a "fail[ure] to recognize the effects of unwarranted narcotics on a patient, and the population at large." He found, "In the majority of the charts opioids are prescribed, but in most of these instances are prescribed without a coherent indication and in amounts that could pose risk to the patient and in some cases the public", and that he had "significant concerns for [Dr. Vaidyanathan's] reckless prescription of opioids and in some cases, sedative agents".

[52] Dr Ahuja's assessment of Dr. Vaidyanathan's out-of-hospital practice revealed a lack of judgement in prescribing opioids in thirteen of fifteen charts in his walk-in practice with many examples of prescribing narcotics without providing adequate explanations for the type, dose, frequency and durations used. Dr. Vaidyanathan ignored previous histories of narcotic use, failed to assess patients prior to prescribing narcotics, and prescribed other controlled substances without adequately determining what other substances the patients were taking which might result in additive effects. He failed to recognize a substance use disorder even when it was brought to his attention, and he failed to take steps to ensure

that his prescribing practices would not result in substance use disorders in other patients. These clinical deficiencies are particularly striking to the Committee given the increased physician and general public awareness regarding the overuse of narcotics and the opioid crisis.

[53] The Committee is extremely concerned about the breadth of clinical gaps and below standard care identified in Dr. Vaidyanathan's practice relating to: controlled substance prescribing in general, but narcotics most frequently; record keeping; management of complications of chronic illness such as substance use disorder and cystic fibrosis; management of infections; and transitions in care and patient follow-up. In the Committee's view, these practice deficiencies provide the potential of risk of harm to patients.

b) Current Supervision re. Controlled Substances Prescribing In-Hospital

[54] Both parties submitted that any restrictions imposed on Dr. Vaidyanathan's prescribing of controlled substances should be limited to his out-of-hospital practice. The parties' view is that Dr. Vaidyanathan's emergency department practice is already under supervision, in accordance with his July 2019 undertaking, and that this is sufficient to address the prescribing deficiencies identified in-hospital by Dr. Mikhail. The Committee strongly disagrees with this view.

[55] The clinical supervision resulting from the July 2019 undertaking is in response to a complaint about Dr. Vaidyanathan's patient management in the emergency department. It focused on medical record keeping and clinical assessments and did not deal with the prescribing of controlled substances. The Individualized Education Plan (IEP) contained in the July 2019 undertaking did not include any education on prescribing narcotics, although later Dr. Vaidyanathan voluntarily took two courses to address this gap in 2020. Since controlled substance prescribing was not specified in the July 2019 undertaking, none of the initial supervisor reports during the periods of high and medium supervision observed

or commented on controlled substance prescribing, but rather focussed on record keeping and patient assessment.

[56] Dr. Vaidyanathan was under low supervision at the time of this hearing. His supervisor meets with him once per month to review twenty charts. While the written comments by his supervisors indicate improvement regarding some aspects of his practice, the reports lack the detail needed to establish any substantive change in his clinical knowledge and judgement as it pertains to controlled substance prescribing. The recorded evaluations were very general and did not provide convincing detail to indicate that the significant lapses identified by Dr. Mikhail have been addressed.

[57] Further, while his supervisor commented that "[f]rom an opioid perspective, I think Dr. Vaidyanathan's prescription practices are in keeping with the standard of practice", this assessment was based on a review of only five out of twenty-five charts which related to prescribing of controlled substances. Only four of the five reports indicated that controlled substances were prescribed. The four reports are extremely brief and included only one line mentioning that controlled substances were prescribed, and were used appropriately, but no other detail is provided.

[58] The Committee acknowledges that Dr. Vaidyanathan has demonstrated some rehabilitation in his practice and in his conduct. In the reports available to date, Dr. Vaidyanathan's supervisors have commented on significant improvements in his practice in the areas of medical record keeping, charting, determining a differential diagnosis and appropriate disposition in the emergency department. His Department Chief at HRH has reported no recent concerns with his conduct. However, based on the limited information in the supervisor's report in respect of Dr. Vaidyanathan's prescribing of controlled substances, the Committee is not reassured that Dr. Vaidyanathan can prescribe controlled substances safely in either his emergency department practice, or his out-of-hospital practice. There is insufficient evidence to support the submission that the emergency department

provides adequate safeguards, and that the supervision has resulted in Dr. Vaidyanathan's remediation, particularly in regard to his judgment in prescribing controlled substances. The Committee had persisting doubts about his ability to improve his judgement or clinical knowledge based on the current remediation strategy.

c) Prior Cases of this Committee

[59] The Committee notes that in the majority of prior cases reviewed by the Committee where narcotic prescribing was at issue, the resultant penalty was a general prohibition on controlled substance prescribing, regardless of practice locale.

[60] The College provided the Committee with two cases in which prescribing prohibitions were imposed in an out-of-hospital location only: *CPSO v. Chan*, 2018 ONCPSD 24 and *CPSO v. Gill*, 2016 ONCPSD 49. The penalty orders permitted Dr. Chan and Dr. Gill to prescribe in-hospital where their prescribing could be monitored, since prescriptions had to be filled through hospital pharmacies. These cases pertained to misconduct that was either self and/or family narcotic prescribing and did not involve the physicians' ability to safely prescribe narcotics to other patients, or their judgement and general provision of clinical care. For the reasons set out above, the Committee finds those cases to be distinguishable from this case.

d) Decision on Controlled Substance Prescribing

[61] The Committee has determined that the only way to protect patients and the public is if Dr. Vaidyanathan is subject to a general prohibition on prescribing controlled substances, regardless of location. The Committee feels strongly that anything short of this would be contrary to the public interest and bring the administration of justice into disrepute. The public would question why Dr. Vaidyanathan was able to continue to prescribe controlled substances with his longstanding record of deceit, displayed lack of clinical judgement, and failure to

maintain the standard of practice. The Committee is also concerned about Dr. Vaidyanathan's governability. Glaring gaps in Dr. Vaidyanathan's standard of practice remained after he appeared before ICRC as a result of several patient complaints.

[62] The Committee sees no justification to limit the prohibition of his controlled substance prescribing to just his out-of-hospital practice. The Committee does not agree with the parties that the supervision he is currently undertaking in the emergency department will serve as adequate remedy for his misconduct. Management of patients in an emergency department is similar to that in an out-of-hospital practice. Patients treated in the emergency room are often managed and sent home with a prescription without any oversight by other healthcare professionals. As a result, the Committee is not convinced that an emergency department would be any different than an unsupervised out-of-hospital locale with respect to Dr. Vaidyanathan's controlled substance prescribing. A broad prohibition on prescribing controlled substances (i.e. both in-hospital and out-of-hospital) is required to ensure the public is protected.

Conclusion

[63] It is important that the profession hold the public's trust. To accomplish this, penalties should be commensurate with the seriousness, frequency and intentions of those whose behaviour and practice fall outside of accepted standards of the profession.

[64] Throughout his relatively brief career, Dr. Vaidyanathan has displayed a persistent and shocking lack of judgement, integrity and professionalism. Dr. Vaidyanathan has also shown contempt for the rules that govern the profession. His behaviour has been deceitful and self-serving with apparent disregard for the patients he is treating. His management of patients has fallen below the standard of practice including his prescribing of controlled substances. In light of these findings, a proportionate penalty is a severe one.

[65] The public reprimand, twelve-month suspension of Dr. Vaidyanathan's certificate of registration, requirement that Dr. Vaidyanathan successfully complete an ethics course before he returns to practice, and a general prohibition against prescribing controlled substances are serious penalties that serve to denounce his misconduct. They will maintain the integrity of the profession and the public's confidence in the College's ability to regulate the profession in the public interest by demonstrating that the College continues to hold physicians accountable and to a very high standard. They also serve both as a specific deterrent to Dr. Vaidyanathan against engaging in such misconduct in the future, and as a general deterrent to the profession.

Order

[66] The Discipline Committee orders:

1. Dr. Vaidyanathan to attend before the panel to be reprimanded.

2. The Registrar to suspend Dr. Vaidyanathan's certificate of registration for a period of twelve (12) months, commencing thirty (30) days after the date of this Order.

3. The Discipline Committee directs the Registrar to place the following terms, conditions and limitations on Dr. Vaidyanathan's certificate of registration:

    a. Dr. Vaidyanathan shall participate in and successfully complete, within six (6) months of the date of this Order, individualized instruction in medical ethics satisfactory to the College, with an instructor approved by the College, who shall provide a summative report to the College including his or her conclusion about whether Dr. Vaidyanathan successfully completed the instruction;

    b. Dr. Vaidyanathan shall not issue new prescriptions or renew existing prescriptions for or administer any of the following substances:

i. Narcotic Drugs (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);

ii. Narcotic Preparations (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);

iii. Controlled Drugs (from Part G of the Food and Drug Regulations under the *Food and Drugs Act*, S.C., 1985, c. F-27);

iv. Benzodiazepines and Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act*., S.C., 1996, c. 19);

(A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached hereto as Schedule “A”; and links to the current regulatory lists are attached hereto as Schedule “B”)

v. Monitored Drugs (as defined under the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22, with a link to the current regulatory list attached hereto as Schedule “C”); and as amended from time to time;

c. Dr. Vaidyanathan shall post a sign in his practice locations, in a clearly visible and secure location, that states as follows:

IMPORTANT NOTICE

Dr. Vaidyanathan must not prescribe or administer any of the following:

- Narcotic Drugs
- Narcotic Preparations
- Controlled Drugs
- Benzodiazepines and Other Targeted Substances
- Monitored Drugs

Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca

d. Dr. Vaidyanathan shall post a certified translation(s) in any language(s) in which he provides services, of the sign described in paragraph 3(c) above in all waiting rooms, examination rooms and consulting rooms, in all of his Practice Locations, in a clearly visible and secure location.

e. Dr. Vaidyanathan shall provide the certified translation(s) described in paragraph 3(c) above, to the College within thirty (30) days of this Order.

f. Should Dr. Vaidyanathan elect to provide services in any other language(s), he must notify the College prior to providing any such services.

g. Dr. Vaidyanathan shall provide to the College the certified translation(s) described in paragraph 3(e) prior to beginning to provide services in the language(s) described in paragraph 3(f).

h. Dr. Vaidyanathan shall consent to the College providing any Chief(s) of Staff or a colleague with similar responsibilities, such as a medical director, at any location where he practises ("Chief(s) of Staff") with any information the College has that led to this Order and/or any information arising from the monitoring of his compliance with this Order.

i. Dr. Vaidyanathan shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within five (5) days of this Order and shall inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.

j. Dr. Vaidyanathan shall cooperate with unannounced inspections of his Practice Location(s) and patient charts by a College representative(s)

for the purpose of monitoring and enforcing his compliance with the terms of the Order.

k. Dr. Vaidyanathan shall consent to the College making enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System implemented under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22, as amended ("NMS"), and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of the Order and any terms, conditions or limitations on Dr. Vaidyanathan's certificate of registration; and

l. Dr. Vaidyanathan shall be responsible for any and all costs associated with implementing the terms of the Order.

4. The Discipline Committee orders Dr. Vaidyanathan to pay costs to the College in the amount of $10,370.00 within ninety (90) days from the date of this Order.

Correction Notice:

The text of the Order in the original 'Order and Reasons' dated January 4, 2021 was corrected on January 5, 2021 by amending the wording of the "Important Notice" at paragraph [66]3c.

SCHEDULE "A"

Summary of Narcotic and Controlled Drug Regulations taken from the Compendium of Pharmaceuticals and Specialties (CPS)

Narcotic and Controlled Drug Regulations

Office of Controlled Substances, Health Canada
Date of Revision: November 2019

Table 1 summarizes the requirements for prescribing, dispensing and record-keeping for narcotics, controlled drugs, benzodiazepines and other targeted substances. This document is not intended to be a comprehensive review of the topic. The reader is therefore encouraged to seek additional and confirmatory information (e.g., Controlled Drugs and Substances Act, Narcotic Control Regulations, Food and Drug Regulations parts G and J, Benzodiazepines and Other Targeted Substances Regulations, New Classes of Practitioners Regulations and the Regulations Amending Certain Regulations to Access of Restricted Drugs).

Unauthorized forms of cocaine continue to be regulated as a "restricted drug" under Part J of the *Food and Drug Regulations*. Cocaine that meets one of the following criteria continues to be regulated as a "narcotic" under the *Narcotic Control Regulations*:

- A drug in dosage form, that has a Drug Identification Number (DIN) assigned to it under the *Food and Drug Regulations* (i.e., market authorized); or,
- A drug in dosage form authorized for sale for a clinical trial; or,
- A drug compounded by a pharmacist in accordance with or in anticipation of the receiving of a written prescription from a practitioner with timeliness.

Table 1: Narcotic and controlled Drugs, Benzodiazepines and Other Targeted Substances:

Summary of Requirements:

Classification and Description	Legal Requirements
Narcotic Drugs[a] • 1 narcotic (e.g., codeine, hydromorphone, ketamine, morphine) • 1 narcotic + 1 active non-narcotic ingredient (e.g., Novahistex DH, Tylenol No. 4) • All narcotics for parenteral use (e.g., fentanyl, pethidine)	• Written prescription required. • Verbal prescriptions not permitted. • Refills not permitted. • Written prescriptions may be prescribed to be dispensed in divided portions (part-fills). • For part-fills, copies of prescriptions should be made in reference to the original prescription. Indicate on the original prescription: the new prescription number, the date of the part-fill, the quantity dispensed and the pharmacist's initials.[b]

• All products containing hydrocodone, oxycodone, methadone or pentazocine • Dextropropoxyphene (e.g., Darvon-N, 642) • Nabilone (i.e., Cesamet)	• Transfers not permitted. • Record and retain all documents pertaining to all transactions for a period of at least 2 years, in a manner that permits an audit. • Report any loss or theft of narcotic drugs within 10 days after the discovery date to the Office of Controlled Substances at the address indicated on the forms.
Narcotic Preparations[a] • Verbal prescription narcotics: 1 narcotic + 2 or more active non-narcotic ingredients in a recognized therapeutic dose (e.g., Fiorinal- C¼, Fiorinal-C½,, Robitussin AC, 282, 292, Tylenol No. 2, Tylenol No. 3) • Exempted codeine compounds: contain codeine up to 8 mg/solid dosage form or 20 mg/30 mL liquid + 2 or more active non- narcotic ingredients (e.g., Atasol-8)	• Written or verbal prescriptions permitted. • Refills not permitted. • Written or verbal prescriptions may be prescribed to be dispensed in divided portions (part-fills). • For part-fills, copies of prescriptions should be made in reference to the original prescription. Indicate on the original prescription: the new prescription number, the date of the part-fill, the quantity dispensed and the pharmacist's initials.[b] • Transfers not permitted. • Exempted codeine compounds when dispensed pursuant to a prescription follow the same regulations as for verbal prescription narcotics. • Record and retain all documents pertaining to all transactions for a period of at least 2 years, in a manner that permits an audit. • Report any loss or theft of narcotic drugs within 10 days after the discovery date to the Office of Controlled Substances at the address indicated on the forms.
Controlled Drugs[a] • Part I Amphetamines (e.g., Dexedrine, Adderall XR) Methylphenidate (e.g., Biphentin, Concerta, Ritalin) Pentobarbital Preparations: 1 controlled drug + 1 or more active noncontrolled ingredient(s) in a recognized therapeutic dose	• Written or verbal prescriptions permitted. • Refills not permitted for verbal prescriptions. • Refills permitted for written prescriptions if the prescriber has indicated in writing the number of refills and dates for, or intervals between, refills • Written or verbal prescriptions may be prescribed to be dispensed in divided portions (part-fills) • For refills and part-fills, copies of prescriptions should be made in reference to the original prescription. Indicate on the original prescription: the new prescription number, the date of the repeat or part-fill, the quantity dispensed and the pharmacist's initials.[b]

	• Transfers not permitted. • Record and retain all documents pertaining to all transactions for a period of at least 2 years, in a manner that permits an audit. • Report any loss or theft of controlled drugs within 10 days after the discovery date to the Office of Controlled Substances at the address indicated on the forms.
Controlled Drugs[a] • Part II Barbiturates (e.g., phenobarbital) Butorphanol Nalbuphine (e.g., Nubain Injection) Preparations: 1 controlled drug + 1 or more active noncontrolled ingredient(s) in a recognized therapeutic dose (e.g., Fiorinal	• Written or verbal prescriptions permitted. • Refills permitted for written or verbal prescriptions if the prescriber has authorized in writing or verbally (at the time of issuance) the number of refills and dates for, or intervals between, refills. • Written or verbal prescriptions may be prescribed to be dispensed in divided portions (part-fills). • For refills and part-fills, copies of prescriptions should be made in reference to the original prescription. Indicate on the original prescription: the new prescription number, the date of the repeat or part-fill, the quantity dispensed and the pharmacist's initials.[b] • Transfers not permitted. • Record and retain all documents pertaining to all transactions for a period of at least 2 years, in a manner that permits an audit. • Report any loss or theft of controlled drugs within 10 days after the discovery date to the Office of Controlled Substances at the address indicated on the forms.
Controlled Drugs[a] Part III Anabolic steroids including: Testosterone (e.g., Androderm) Testosterone cypionate (e.g., Depo-Testosterone) Testosterone undecanoate (e.g., Andriol)	• Written or verbal prescriptions permitted. • Refills permitted for written or verbal prescriptions if the prescriber has authorized in writing or verbally (at the time of issuance) the number of refills and dates for, or intervals between, refills. • Written or verbal prescriptions may be prescribed to be dispensed in divided portions (part-fills). • For refills and part-fills, copies of prescriptions should be made in reference to the original prescription. Indicate on the original prescription: the new prescription number, the date of the

	repeat or part-fill, the quantity dispensed and the pharmacist's initials.[b] • Transfers not permitted. • Record and retain all documents pertaining to all transactions for a period of at least 2 years, in a manner that permits an audit. • Report the loss or theft of controlled drugs within 10 days after the discovery date to the Office of Controlled Substances at the address indicated on the forms.
Benzodiazepines and Other Targeted Substances[a] Alprazolam Bromazepam Chlordiazepoxide Clobazam Diazepam Ethchlorvynol Lorazepam Oxazepam Temazepam Triazolam	• Written or verbal prescriptions permitted. • Refills for written or verbal prescriptions permitted if indicated by prescriber and less than 1 year has elapsed since the day the prescription was issued by the practitioner. • Part-fill permitted as per prescriber's instructions. • For refills or part-fills of prescriptions, record the following information: date of the repeat or part-fill, prescription number, quantity dispensed and the pharmacist's initials. • Transfer of prescriptions permitted except for a prescription that has been already transferred. • Record and retain all documents pertaining to all transactions for a period of at least 2 years, in a manner that permits an audit. • Report any loss or theft of benzodiazepines and other targeted substances within 10 days after the discovery date to the Office of Controlled Substances at the address indicated on the forms.
Meprobamate	

[a] The products noted are examples only.

[b] If the software used in the pharmacy allows at a minimum the effective monitoring between part-fills (quantity, date, prescription number), and the original order to allow verification and prevent the risk or potential risks of fraud, reference copies do not need to be made.

SCHEDULE "B"

Current regulatory lists

- **Narcotic Drugs and Preparations**

(from the Schedule to the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act,* S.C., 1996, c. 19)

Available at: https://laws-lois.justice.gc.ca/eng/Regulations/C.R.C.,_c._1041/

- **Controlled Drugs**

(from the Schedule to Part G of the Food and Drug Regulations made under the *Food and Drugs Act,* R.S.C., 1985, c. F-27)

Available at: https://laws-lois.justice.gc.ca/eng/regulations/c.r.c.,_c._870/

- **Benzodiazepines/Other Targeted Substances**

(from Schedules 1 and 2 to the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act,* S.C., 1996, c. 19)

Available at: https://laws-lois.justice.gc.ca/eng/regulations/sor-2000-217/

SCHEDULE "C"
List of monitored drugs

From section 2 of Ontario Regulation 381/11 made under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22)

Available at:
http://www.health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Sammy Vaidyanathan

The Tribunal delivered the following Reprimand
by videoconference on Tuesday, October 19, 2021.

*****NOT AN OFFICIAL TRANSCRIPT*****

Dr. Vaidyanathan:

When an individual receives their certificate of registration to practice medicine in the Province of Ontario, the underlying expectation and, in fact, the essence of being a physician is to use one's knowledge, skill, judgement and experience to reduce suffering and improve their patient's lives.

This can only be accomplished by practicing conscientiously with integrity and engaging in continuous medical education to remain current and, as a result, serve your patients well.

The Agreed Statement of Facts on Liability presented to this panel was both disturbing and disheartening.

You have been shown to exhibit a pattern of behavior that is self-centered, unethical, abusive, deceptive, inappropriate and unprofessional.

Furthermore, both your emergency medicine practice and your walk-in practice have been found to be wanting and failed to meet the standard of practice.

You have displayed a lack of knowledge, skill, and judgement in the treatment of your patients, including inappropriate opioid prescribing, that could pose a risk to your patients.

You also have a prior history with the CPSO with respect to the treatment of patients that resulted in counselling, advice, and undertakings, including supervision, professional education and obligations in regard to record keeping, and human rights.

We note, however, you have no prior history with this Committee.

Your behaviour has not only brought disgrace to yourself but the profession as a whole. This cannot and indeed will not be tolerated.

The question now remains --- are you remediable?

You must seriously consider how you wish to practice medicine in the future. Our January 4, 2021 decision ensures that the interest of the public is protected and, as well, will act as a general deterrent to the physicians practising in Ontario.

It is now up to you.

In the time ahead your regulator will follow your progress with interest. We expect you to adhere to the terms, conditions and limitations imposed upon you.

We sincerely hope that you have learned from this experience and will not appear before this panel again. You are now dismissed.