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

Dr. Peter Gerard James Young (CPSO #69293)
(the Respondent)

INTRODUCTION

The Patient saw the Respondent for a face and neck lift. Following the procedure, the Patient noticed an ulcerated wound on the left side of the neck. The Patient was unhappy with the results of the procedure, requested a refund and brought her concerns about the Respondent to the College.

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of December 19, 2025.

The Committee required the Respondent to appear before a Panel of the Committee to be cautioned regarding disclosure of harmful incidents to patients, appropriate billing practices and medical record keeping.

The Committee also accepted an undertaking from the Respondent and directed its concerns about the Respondent's billing practices to the General Manager of OHIP.

COMMITTEE'S ANALYSIS

Disclosure of Harm

In his response, the Respondent appears to make light of a significant intraoperative complication (cautery burn) resulting in skin necrosis and a large wound on the Patient's neck. The Patient questioned the Respondent several times about it, thinking it was related to the drain site, which he dismissed stating that the drain was behind her neck. He mentioned a possible burn or dressing related injury in a casual way, and there is no documentation of this in the medical record. The Committee found it quite concerning that a serious adverse event did not result in the prompt disclosure to the Patient nor clear documentation, as is required.

Medical Record Keeping

The Committee observed that the Respondent's operating room and post-operative follow-up notes are either missing or contain multiple errors making the documentation unreadable at times.

Billing Practices

The Patient stated that she did not receive an official receipt as she had paid cash for the procedure to be exempt from paying HST. The Respondent acknowledged that he does offer this discounted option to his patients to make his pricing competitive in comparison to other surgeons. The Committee noted that this conduct is not only inappropriate, but it also circumvents mandatory tax requirements, diminishes transparency, and undermines compliance with applicable law. Further, instead of an official receipt, a document marked "Quote" was provided, which does not seem to bear the Patient's name. It is unclear what documentation was given to the Patient, if any.

According to the OHIP report, the Respondent billed OHIP for five instances of "Debridement of wound(s) and/or ulcer(s) extending into subcutaneous tissue" (Fee Code Z080A). These are not supported by documentation as having been performed. The Committee directed staff to notify the General Manager of OHIP of the Respondent's OHIP billing practices for consideration.

CONCLUSION

Therefore, in addition to accepting the Respondent's undertaking, the Committee required the Respondent to appear before a Panel of the Committee to be cautioned as outlined above.

This is a summary of the Committee's decision as it relates to the caution disposition.