NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Yau this is notice that the Discipline Committee ordered that no person shall publish or broadcast the name or any information that could disclose the identity of the patients referred to orally or in the exhibits filed at the hearing 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… 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.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Yau, 2017 ONCPSD 20

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. PATRICK WING NIN YAU

PANEL MEMBERS: **DR. ERIC STANTON (Chair)**
MR. ARTHUR RONALD
DR. JAMES WATTERS
MR. PIERRE GIROUX
DR. PEETER POLDRE

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS ELIZABETH WIDNER

COUNSEL FOR DR. YAU:

MR. ERIC PELLEGRINO

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS JENNIFER MCALEER

Hearing Date: April 12, 2017
Decision Date: April 12, 2017
Release of Written Reasons: May 16, 2017

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on April 12, 2017. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct in that he failed to maintain standard of practice of the profession and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Patrick Wing Nin Yau committed an act of professional misconduct:

1. under paragraph 1(1)2 of O Reg. 856/93 in that he has failed to maintain the standard of practice of the profession.

The Notice of Hearing also alleged that Dr. Yau is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Yau entered a plea of no contest to allegation 1, in that he has failed to maintain the standard of practice of the profession. Counsel for the College withdrew the allegation of incompetence.

THE FACTS

The following facts were set out in the Statement of Uncontested Facts which was filed as an exhibit:

PART I – FACTS

A. Overview

1. Dr. Patrick Yau ("Dr. Yau") is a 48 year old general surgeon practising medicine in Toronto, Ontario. He received his certificate of registration authorizing independent practice in Ontario in 1998. Dr. Yau has held privileges at Scarborough General Hospital since 1999.

2. At all relevant times, Dr. Yau was practising general surgery, including bariatric surgery at the Prince Arthur Surgical Centre Inc., an Out of Hospital Premise ("OHP"), located in Toronto, Ontario, which offered weight loss surgical procedures, including adjustable laparoscopic gastric banding developed by Slimband Inc. (the "Clinic"). At all times relevant to the case of Patient B, set out below, Dr. Yau held the position of medical director of the Clinic.

3. Dr. Yau does not currently hold the position of medical director at any OHP. The Clinic ceased operations as of March 22, 2017 and is no longer part of the College's OHP program.

B. Patient A

3. Patient A attended at the Clinic for bariatric surgery with Dr. Yau in November 2013.

4. Prior to meeting Dr. Yau in 2013, Patient A had already had two previous bariatric surgeries. The first surgery, a vertical banded gastroplasty, took place in 1980. Four years later, Patient A underwent a second surgery to convert the vertical banded gastroplasty into a gastric bypass. At the time of the initial surgery, Patient A had a Body Mass Index ("BMI") of 41 and was morbidly obese.

5. In November 2013, Dr. Yau conducted a telephone consultation with Patient A, who resided in another province. In advance of this consultation, Patient A completed a questionnaire indicating that she hoped to reduce her BMI to 21. There is no note by Dr. Yau regarding BMI at that consultation.

6. Four days later in November 2013, Patient A participated in a telephone pre-surgical consultation with a Clinic nurse. Based on her self-reported weight and height, Patient A's BMI was noted to be 26.

7. On the day of surgery about a week later, Patient A was weighed by Clinic staff and her weight was recorded as being 10 lbs. less than the weight she self-reported during the telephone pre-surgical consultation. Her BMI was recorded as being 24.9, which is considered to be in the normal range. Patient A provided her consent for the gastric banding surgery.

8. Dr. Yau attempted surgery on Patient A. The surgery could not be completed due to difficulties encountered during the surgery, namely many dense adhesions that made dissection difficult. A tiny perforation was diagnosed and surgically repaired. The surgery was aborted, a drain was placed and the patient was sent to the Scarborough Hospital for observation. She was ultimately discharged home without complications.

9. The College retained Dr. Steven Miller, general surgeon, who provided an opinion to the College, dated October 6, 2016. Dr. Miller is a fellow of the Royal College of Surgeons (Canada) who practises at the Hôpital Pierre-Boucher in Longueil, Québec. He has particular expertise in bariatric surgery, lap-band procedures and laparoscopy.

10. In Dr. Miller's opinion, Dr. Yau fell below the standard of practice of the profession in deciding to perform surgery on Patient A. Dr. Miller's opinion is as follows:

    - There was no indication to proceed with bariatric surgery, including gastric banding, for this patient, given her normal BMI;

- Dr. Yau's decision to proceed with surgery exposed the patient to potential harm or injury, particularly given the risk that the patient's well-functioning gastric bypass could be damaged during surgery.

11. Dr. Yau agreed during the interview conducted by Dr. Miller that there was no indication to perform the surgery on Patient A and that there was a risk of harm to the patient in performing the surgery.

12. Dr. Yau advised the College during its investigation that he missed the BMI noted as 24.9 on a computerized printout from an assessment done the day of surgery, and inadvertently proceeded with the surgery based on the initial numbers.

13. Dr. Yau has confirmed since the care provided to Patient A he has, on his own initiative, implemented a number of changes to his practice, including improved documentation of patient discussions and indications for surgery, dictation of pre-operative notes and scrutinization of all patient's vitals including morphological values, BMI, height and weight on the surgery day.

C. Patient B

14. Patient B was a middle-aged patient from another province. He attended at the Clinic in Toronto for a laparoscopic gastric banding procedure in January, 2012, to assist him in losing weight. In addition to obesity, Patient B suffered from Type 1 Diabetes and hypertension, both of which were medically controlled.

15. Following surgery, Patient B stayed overnight in the Clinic. Nurses in the Clinic monitored Patient B during the night and documented abnormal and high glycemic results. Dr. Yau was not on the premises overnight and was not notified of Patient B's elevated results, nor did he see Patient B prior to his discharge. At the time of discharge from the Clinic, Patient B's blood sugar and glucose levels were not verified or recorded by the Clinic nurse.

16. Patient B was discharged the following morning, and boarded a flight home to another province. He disembarked, checked into a hotel and was found deceased the following morning. The provincial Medical Examiner attributed the cause of death to bacterial meningitis and noted that diabetic ketoacidosis was a significant condition contributing to his death. Patient B's mother complained to the College regarding the care her son received at the Clinic.

17. At the time, the Clinic's Discharge Protocol only required that diabetic patients be advised upon discharge if he or she tested "outside of parameters".

18. The College retained Dr. Pierre Garneau to provide an opinion regarding Patient B. Dr. Garneau is a general surgeon and director of the bariatric surgery clinic at Sacré-Coeur Hospital in Montreal.

19. In Dr. Garneau's opinion, dated October 6, 2013, Dr. Yau fell below the standard of practice of the profession in his role as medical director of the Clinic, in failing to ensure that an appropriate policy was in place at the Clinic for the post-operative management and discharge of diabetic patients.

PART II: PLEA OF NO CONTEST

20. Dr. Yau does not contest the facts contained in paragraphs 1 to 19 above, and does not contest, for the purposes of College proceedings, that the conduct described constitutes a failure to maintain the standard of practice of the profession, contrary to paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*.

FINDING

Rule 3.02 of the Discipline Committee's Rules of Procedure regarding a plea of no contest states as follows:

3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:

(a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
(b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
(c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

The Committee accepts as correct all of the facts set out in the Statement of Uncontested Facts. Having regard to these facts, the Committee accepts Dr. Yau's admission and finds that he committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession.

ADDITIONAL EVIDENCE REGARDING PENALTY

A Book of Cautions was entered as an exhibit. It included four cautions issued to Dr. Yau by the Inquiries Complaints and Reports Committee (ICRC) of the College between February 15, 2013 and October 11, 2013.

Caution #1

In June 2010, Patient X filed a complaint with the College regarding the care she received from Dr. Yau and two other physicians. This complaint was related to a surgical removal of a suspected lipoma. The ICRC considered the complaint in July 2011 and cautioned Dr. Yau in person regarding the need for pre-operative marking of the surgical site and documentation of such and on obtaining informed consent.

The Health Professions Appeal and Review Board (HPARB) subsequently directed the ICRC to reconsider its decision with respect to Dr. Yau.

On February 15, 2013, following the HPARB direction, the ICRC reviewed its prior decision and determined that Dr. Yau must attend the College to be cautioned in person with respect to his failure to follow the pre-surgical checklist and to mark the site of surgery, his failure to obtain informed consent before proceeding to the second surgery, as well as his inadequate disclosure and management of an adverse surgical event.

Caution #2

In May 2012, the College received a complaint from Patient Y regarding the care and conduct of Dr. Yau. The College retained an independent expert who opined that Dr. Yau failed to meet the standard of care, in that he performed the laparoscopic adjustable gastric band (LAGB) surgery on Patient Y when the surgery was not indicated for the patient. On October 11, 2013, the ICRC noted the concerns about Dr. Yau's process of obtaining consent as well as his professional communications with patients and ordered a caution in person with respect to an appropriate individualized consent process, on documentation of the consent discussion, and on expedient management of patient complications.

Caution #3

In February 2012, the College received a complaint from Patient Z. Patient Z had previously undergone a surgery performed by another surgeon in 2005.In January 2012, Dr. Yau performed a diagnostic laparoscopy on Patient Z, removed the existing band, repaired a hernia and placed a new band. The ICRC issued a written caution to Dr. Yau regarding the need for the appropriate post-operative care and follow-up and on the requirement for comprehensive documentation.

Caution #4

In October 2012, following the complaints of Dr. Yau's patients, the ICRC approved the Registrar's appointment of an investigator under section 75(1)(a) of the Code to examine Dr. Yau's practice. On October 11, 2013, upon consideration of the investigator's report on the

review of Dr. Yau's 25 patient charts, the ICRC determined that Dr. Yau be cautioned in person with respect to the pre-operative consent discussion, pre-operative screening, use of templates, post-operative follow-up with patients, and on professional communication. The ICRC also required Dr. Yau to complete a Specified Continuing Education or Remediation Program (SCERP) to deal with the many issues of concern regarding his care of patients.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Yau made a joint submission as to the appropriate penalty and costs order.

The proposed penalty and costs order includes a three-month suspension of Dr. Yau's certificate of registration, commencing on May 13, 2017, a public reprimand, the requirement to pay costs to the College in the amount of $5,000.00, and imposition of the following terms, conditions and limitations on Dr. Yau's certificate of registration:

(i) Dr. Yau will not perform the revision surgery referred to as 'band over bypass' outside of a hospital setting;
(ii) Dr. Yau will meet in-person with patients who reside in the GTA for a pre-surgical consultation in respect of gastric banding on a day that is prior to surgery and will document the consultation. For patients that reside outside the GTA, Dr. Yau will conduct a telephone consolation on a day that is prior to surgery day and will document the consultation; and
(iii) Dr. Yau will not act as a Medical Director of an Out-of-Hospital Premise for a period of one (1) year.

In considering the proposed penalty order, the Committee was mindful of the well-established principles applicable to the administration of penalty. The principles include public protection, maintenance of public confidence in the profession and the ability of the College to govern effectively the profession in the public interest, specific deterrence and general deterrence of the members of the profession, and the opportunity for member rehabilitation.

Both aggravating and mitigating factors must be considered. The penalty must be proportionate to the misconduct. The Committee also notes that while previous cases may be considered as a guide in determining the appropriate penalty, each individual case is unique and there are challenges associated with comparing cases.

Further, the Committee is aware of the recent Supreme Court of Canada decision in *R. v. Anthony-Cook*, 2016 SCC 43, which re-affirms that a joint submission on penalty should be accepted by the Committee, unless the penalty proposed by the joint submission would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

The Committee accepts the proposed penalty and finds that it is proportional to the misconduct in this matter. The reasons for its decision are set out below.

ANALYSIS

The nature of the misconduct

The Committee is concerned about serious deficiencies related to the standard of Dr. Yau's surgical practice. In the case of Patient A, Dr. Yau performed surgery on the patient, for which there was no indication, thus exposing the patient to potential harm or injury. In the case of Patient B, a diabetic patient died post-operatively following discharge from the clinic at which Dr. Yau served as a medical director. As a medical director of the clinic, Dr. Yau failed to maintain the standard of practice of the profession, in that he failed to ensure that the clinic had an appropriate policy in place for the post-operative management of diabetic patients.

Aggravating factors

Although this was Dr. Yau's first appearance before the Discipline Committee, his history of cautions from the ICRC was considered as an aggravating factor. These cautions, as detailed above, involved a wide array of practice issues that included Dr. Yau's personal communication

abilities as well as many vital process matters in the operation of the clinic that were his responsibility as a medical director. These included disclosure and management of an adverse surgical event, the pre-operative consent discussion, pre-operative screening, use of templates, and post-operative follow-up with patients.

The Committee concurred with the decision in *CPSO v. Krishnalingam* (2016), in which case the Discipline Committee considering the 1996 ICRC caution of Dr. Krishnalingam regarding similar misconduct, stated at page 9:

> The Committee is aware of the limited use which can be made of previous cautions based on allegations that have not been proven in disciplinary proceedings. There is, however, precedent for the Discipline Committee considering prior complaints and cautions as an aggravating factor. In *CPSO v. Chung* (2014), the Committee found "striking similarity" between the substance of the previous complaints and the findings, which it made in the matter before it.

With respect to Dr. Yau, the Committee notes the similarities between the ICRC cautions previously issued to Dr. Yau and the key elements of inadequate care provided by Dr. Yau to Patients A and B. Specifically, the case of Patient A is similar to the case of Patient Y (the ICRC caution #2), in that there was no indication for surgery for either of those patients. The case of Patient B, where there was no policy at the clinic regarding post-operative management and discharge of diabetic patients, is similar to the case of Patient Z (ICRC caution #3) and the observations of the College-appointed investigator regarding the clinic's lack of post-operative processes (ICRC caution #4).

Mitigating factors

The Committee is in agreement that Dr. Yau's actions in settlement of this matter by pleading no contest should be considered as a mitigating factor. This saved expert witnesses from having to testify and saved the College the expense of a contested hearing. Further, as noted earlier, this

was the first time that Dr. Yau has come before the Discipline Committee. The Committee also notes that Dr. Yau cooperated fully with the College's investigation, was forthcoming with the College-appointed medical inspector, demonstrated insight and made improvements to a variety of his clinic's processes. In addition, he completed the SCERPs prescribed by the ICRC.

Case Law

The case law cited below illustrates a range of appropriate penalties and is consistent with the penalty order proposed by the parties for Dr. Yau.

In *CPSO v. Aziz* (2014), Dr. Aziz fell below the standard of practice of the profession in his management of two patients in the Emergency Department. As an aggravating factor, he failed to cooperate with the College's investigation and breached his undertaking related to clinical supervision. The penalty in that matter was a three-month suspension of Dr. Aziz's certificate of registration, a public reprimand, imposition of a period of clinical supervision, and the order to pay hearing costs.

In *CPSO v. Botros* (2016), Dr. Botros fell below the standard of practice of the profession in his care of two sleep apnea patients. Dr. Botros had a previous discipline history. The penalty in that matter was a four-month suspension of Dr. Botros' certificate of registration, a public reprimand, the requirement to complete a course in ethics, a fine, and the order to pay hearing costs.

Conclusion

The Committee is satisfied that the penalty proposed by the parties represents the appropriate sanction given all of the circumstances in this matter.

Having regard to Dr. Yau's misconduct described above, the Committee agrees that a three-month suspension of Dr. Yau's certificate of registration will denounce Dr. Yau's misconduct and will serve as a specific deterrent to him. The suspension of his certificate of registration will also serve as a general deterrent to other members of the profession.

The reprimand delivered in this matter allows the Committee to directly address Dr. Yau and to express its condemnation of his misconduct. The reprimand, in addition to suspension of his certificate of registration, should further serve as a specific deterrent to Dr. Yau, and its publication in the public register will also serve as a general deterrent to the members of the profession.

A public reprimand and suspension of Dr. Yau's certificate of registration convey to the public that the Committee does not tolerate such misconduct and demonstrate that the College, as a self-governing professional body, holds physicians accountable.

Public protection is achieved by the terms, conditions, and limitations of the order. The Committee orders that all future 'band over bypass' surgery be performed by Dr. Yau in a hospital setting. It is expected that Dr. Yau will improve his pre-operative processes by meeting with patients on a day prior to surgery. Those consultations will be documented properly. Finally, Dr. Yau is prohibited from acting as a medical director of any Out-of-Hospital Premise for a period of one year.

The Committee finds the order that Dr. Yau pay costs to the College of a one-day hearing is appropriate, fair, and reasonable in the circumstances.

ORDER

The Committee stated its finding in paragraph 1of its written order of April 12, 2017. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. The Registrar suspend Dr. Yau's certificate of registration for a period of three (3) months effective May 13, 2017, at 12:01 a.m.

3. The Registrar impose the following terms, conditions and limitations on Dr. Yau's Certificate of Registration:

(i) Dr. Yau will not perform the revision surgery referred to as band over bypass outside of a hospital setting;

(ii) Dr. Yau will meet in-person with patients who reside in the GTA for a pre-surgical consultation in respect of gastric banding on a day that is prior to surgery and will document the consultation. For patients that reside outside the GTA, Dr. Yau will conduct a telephone consolation on a day that is prior to surgery day and will document the consultation; and

(iii) Dr. Yau will not act as a Medical Director of an Out-of-Hospital Premise for a period of one (1) year.

4. Dr. Yau attend before the Committee to be reprimanded.

5. Dr. Yau pay costs to the College in the amount of $5,000.00 within thirty (30) days of the date this Order becomes final.

At the conclusion of the hearing, Dr. Yau waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND
Delivered April 12, 2017
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. PATRICK WING NIN YAU

Dr. Yau, it is always unfortunate when a member of our profession appears before this Committee. You have been found to have committed an act of professional misconduct, by failing to maintain the Standard of Practice of the profession.

Your falling below the Standard of Care in two cases, including the death of a patient soon after procedure, are of deep concern to the Committee, as it should be to you. This is because of the negative impact that the sub-standard care does have on the health and confidence of our patients. Your actions have not only disgraced yourself, but the profession as a whole.

Patients place great trust in their physician, that they will receive the Standard of Care that they deserve. You have violated that trust, and as a result put your patients in harm's way. This cannot, and indeed will not, be tolerated or condoned by the public or the profession as a whole.

The Committee is reassured that you've already engaged in a remediation plan, and is hoped that you will learn from this experience, and you will never appear before this Committee again.