

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Brett Lennox Ferdinand, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients under ss.45(3) of the Code.

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

93(1) Every person who contravenes an order made under section 45 or 47 is guilty of an offence and on conviction is liable to a fine of not more than \$10,000 for a first offence and not more than \$20,000 for a subsequent offence.

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

IN THE MATTER OF a Hearing directed
by the Complaints Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) of the *Health Professional 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. BRETT LENNOX FERDINAND

PANEL MEMBERS:

DR. J. SCHILLNGER (CHAIR)
DR. C. J. CLAPPERTON
J. DHAWAN
DR. P. HORSHAM
D. MACKINNON

Hearing Date: April 11, 2005
Decision/Release Date: April 11, 2005

Publication Ban

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on April 11, 2005. At the conclusion of the hearing, the Committee delivered its decision and order in writing. The Committee found that Dr. Brett Lennox Ferdinand committed an act of professional misconduct. The Committee also found that Dr. Ferdinand is incompetent. The Committee put in place an order requiring additional training, assessment and supervised practice under a number of restrictive terms, conditions and limitations on Dr. Ferdinand's certificate of registration. The Committee indicated that its written reasons for its decision and order would follow.

PUBLICATION BAN

The Discipline Committee made an order pursuant to subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, prohibiting the publication or broadcast of the name of the patients, or any information that could disclose the name or identities of the patients.

ALLEGATIONS

The Notice of Hearing alleged that Dr. Brett Lennox Ferdinand committed an act of professional misconduct:

- (1) under paragraph 1(1)33 of Ontario Regulation 856/93 of the *Medicine Act, 1991*, ("O. Reg. 856/93") in that he committed acts or omissions relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Ferdinand is incompetent as defined by subsection 52(1) of the Code, in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients of a nature or to an extent that demonstrates that he is unfit to continue practise or that his practise should be restricted.

RESPONSE TO THE ALLEGATIONS

Dr. Ferdinand admitted the allegations as set out in the Notice of Hearing.

EVIDENCE

The following Agreed Statement of Fact was presented to the Committee and filed as Exhibit 2.

Agreed Statement of Fact

Part I - History of the Case

1. Dr. Brett Lennox Ferdinand (Dr. Ferdinand) is a member of the College of Physicians and Surgeons of Ontario (the College) and was first registered at the College in January 1999. He received his M.D. from McGill in 1993 and his specialty qualification in 1998.
2. He began his practice in two small towns in Ontario practising General surgery in 1999. He was appointed associate staff surgeon at General Hospital in 1999. Dr. Ferdinand's privileges were not renewed in late 1999 or early 2000. After that time he moved to another small town where he began practising general surgery. He also practised in Quebec.
3. Dr. Ferdinand's practice came under review by the College of Physicians and Surgeons of Ontario in 2002 as a result of a report prepared for General Hospital by Dr. Z in November 1999. Effective August 9, 2002, the Executive Committee imposed restrictions on Dr. Ferdinand's certificate, and specifically restricted him from performing all surgery except for:
 - (a) as a surgical assistant;
 - (b) endoscopies; and
 - (c) minor office or out-patient procedures that require at most local anaesthesia.
4. Under section 75(c) of the Health Professions Procedural Code, Dr. Y provided a report to

the Complaints Committee.

Part II - Incompetence

5. As noted in Dr. Y's report, Dr. Ferdinand's surgical skill, knowledge and accessibility appear to fall within an acceptable standard. However, his communication skills, surgical judgement, insight and credibility were deficient in the opinion of Dr. Y. The specific facts relied upon to support the opinion of Dr. Y are set out below.
6. Out of 20 patient charts from the General Hospital in which problems had been identified, Dr. Y had queries or found problems with the care in the following fourteen cases:
 - i) Patient B: Dr. Ferdinand performed a laparoscopic cholecystectomy. No stones were found in the specimen. There was no preoperative work-up noted although there may have been a preoperative work up in the office chart. As a result one cannot know the indications for operating.
 - ii) Patient L: This was a laparoscopic Nissen fundoplication with complications of a perforated stomach and herniation of stomach into chest. The initial OR note does not mention any problem but notes from the administrator report that Dr. Ferdinand had trouble with the retractor and imply that Dr. Ferdinand had not arranged to have the proper equipment for this procedure. Dr. Y has concerns about the care administered and about inadequate documentation.
 - iii) Patient B: Incarcerated inguinal hernia with sigmoid colon, abdominal abscess, hernia repair, sigmoid resection and primary anastomosis. Post-operatively chronic drainage and wound infection. Concern is poor documentation in OR note. It was not possible to tell what was done and how hernia was repaired.
 - iv) Patient D: Dr. Ferdinand did a supraclavicular node exploration when Dr. Y was of the opinion that a needle biopsy would have sufficed for clinically positive nodes postmastectomy. Pathology showed metastatic cancer.

- v) Patients C & D: In two cases reviewed by Dr. Y laparoscopy converted to open Nissen because of bleeding and poor visibility. While this is not a problem if it is an isolated occurrence, it raises concerns when it happens with any frequency.
 - vi) Patient K: When a patient with spontaneous necrotizing fascitis of one breast asks Dr. Ferdinand to remove the other breast in the hope of relieving her neck pain, he does so. This should not have been done without consulting a rheumatologist, since the patient had rheumatoid arthritis.
 - vii) Patient P: Dr. Ferdinand treated a 64 year old with enterovesical fistula by resection of sigmoid and small bowel. Although CT scan was done there was no preoperative colonoscopy or definitive imaging of the intestine to look for site of the fistula or pathologic cause. Dr. Y's opinion is that there should have been definitive imaging to identify the location of the fistula and that the decision to repair the fistula rather than resect the bowel was below the standard.
7. Out of twenty-five cases picked randomly from Dr. Ferdinand's office, fifteen appeared acceptable and ten led to the following concerns or queries:
- i) Patient L: A difficult laparoscopic cholecystectomy led to a small bowel fistula which closed on TPN. The concern was that while the care was acceptable, the operation was conducted very quickly. Dr. Y noted very fast operations in other cases that also ended with complications.
 - ii) Patient P: Laparotomy for small bowel obstruction in a Crohns patient. Dr. Ferdinand found gallstones and so did an incidental cholecystectomy. The patient developed a bile leak from duct of Luschka, subphrenic abscess and multiple abdominal abscesses. Although it is possible to justify cholecystectomy to avoid future trouble, in this case it was an aggressive approach and led to complications.
 - iii) Patient M: Groin hernia with gangrene of the bowel, small bowel resection. Two days after surgery, the patient developed small bowel obstruction secondary to 'volvulus adherent to the

new SB anastomosis.’ Patient went back to operating room, aspirated at induction and died. Dr. Y cannot think of a cause for an obstruction so soon after surgery without some technical cause. The cause is not well described in the OR note. Therefore, Dr. Y questions both the care and the documentation in this case.

- iv) Patient H: Lap Nissen and cholecystectomy. The cholecystectomy was done for gallstones and right upper quadrant pain but there was no clear evidence of biliary colic or acute cholecystitis.
 - v) Patient B: Twenty -one year old patient with a mobile breast nodule. The diagnosis on examination was fibro adenoma or cyst. Dr. Ferdinand gave the patient the option of excision and the patient requested this. Dr. Ferdinand removed it and the diagnosis was fibro adenoma. The concern of Dr. Y was that Dr. Ferdinand did not first perform needle biopsy. If it had been a cyst it would have disappeared. Subsequently, the same patient had abdominal pain, diarrhea and weight loss. Dr. Ferdinand did a colonoscopy and OGD. He said the OGD was to rule out GERD although her only symptom was a bit of heartburn. Although the care was acceptable, this case again showed that Dr. Ferdinand was aggressive in moving to surgery.
 - vi) Patient B: This patient suffered right upper quadrant pain. Dr. Ferdinand’s note says that the ultrasound was negative and ‘will get HIDA, and if HIDA positive will do cholecystectomy for chronic cholecystitis’. The HIDA was positive and Dr. Ferdinand did a laparoscopic cholecystectomy. Pathology report showed chronic inflammatory cells, chronic cholecystitis. Dr. Y’s opinion is that this was an overly liberal indication for cholecystectomy.
8. Dr. Y reviewed the two cases which were the subject of complaints to the College of Physicians and Surgeons. In one of the cases, Dr. Ferdinand did not adequately communicate with the family of the patient with respect to the management of postoperative complications. Dr. Y was of the opinion that Dr. Ferdinand’s management of these cases did not fall below the standard of care.
 9. Dr. Y reviewed fifteen charts chosen randomly from General Hospital 2. The care in these

cases did not fall below the standard. In two cases, set out below, documentation fell below the standard:

- i) Patient G: The patient developed a bile leak following a cholecystectomy and was sent home with a drain. The bile leak and drain were not mentioned in the final note. The documentation did not meet the standard of the profession.
 - ii) Patient G: This was a 45 year old patient referred for gallstones, three month history of pain and weight loss. Dr Ferdinand wrote a plan for a laparoscopic Cholecystectomy as soon as possible. He properly repeated the ultrasound which was negative. He did an OGD which showed a large gastric ulcer. This was treated with Losec. It was H pylori positive but no note is made of treating it with antibiotics. He either did not use or did not document the use of antibiotics.
10. The Regional Coroner, Dr. X noted 11 cases about which he had concerns. One case, upon review, did not involve Dr. Ferdinand. In seven cases Dr. Y had no concerns. Dr. Y had concerns in the following three cases:
- i) On or about May 6, 2002, Dr. Ferdinand performed a conversion of a previous gastrectomy to a Roux-Y configuration on a patient, Mr. B (the patient), at General Hospital 2. At the time that the surgery was performed, the patient was 82 years old, did not have any disease and was not on any medication.

The surgery is an elective procedure and was performed due to the patient's complaint of post-prandial epigastric pain. The operating time during surgery was approximately 50 minutes. Postoperatively and during the night, the patient became hypotensive, experienced diaphoresis, and his dressings became soaked with blood.

During the night between the hours of 03:00 - 04:00, one of the nurses involved in Mr. B.'s care recalls that she contacted Dr. Ferdinand and notified him of the patient's condition. In particular, she recalls telling Dr. Ferdinand that Mr. B.'s blood pressure was dropping. At or around this time, Dr. Ferdinand ordered that the patient receive fluid bolus intravenously but

did not attend the patient at this time.

In the early morning hours on or about May 7, 2002, the patient went into cardiac arrest and died. A Code was called and time of death was reported at 05:50. Dr. Ferdinand did attend the patient during the cardiac arrest resuscitation and was present when the patient died.

On the death certificate, which was completed on May 7, 2002, Dr. Ferdinand designated the cause of death as “aspiration pneumonitis”.

When the patient’s family members were notified of the death, Dr. Ferdinand also communicated to them that one possible cause of death was “aspiration pneumonitis”. On the discharge summary report, which was dictated on or about May 28, 2002, Dr. Ferdinand provided that the cause of death was “aspiration pneumonitis”.

Subsequently, Dr. X, Coroner for the region, performed an autopsy on the patient and determined that the patient had approximately two litres of blood in his abdomen. In his opinion, the cause of death was “hemoperitoneum, 2150 ml associated with mesenteric laceration”.

Dr. Y is of the opinion that the operation in this case was conducted very quickly. Dr. Ferdinand failed to attend the patient in postoperative haemorrhagic shock despite notification and clear indication from clinical signs. There was an inappropriate designation of the cause of death in designating the cause as aspiration in the chart and on the death certificate. The discharge summary, dictated after autopsy, is misleading in referring selectively to Dr. Ferdinand’s actions.

Dr. Y is of the opinion that Dr. Ferdinand’s care of this patient fell below the standard of care. Dr. Ferdinand should have attended the patient postoperatively. Also, Dr. Ferdinand’s discharge summary was misleading.

- ii) Patient S was an 81 year old woman with chronic narcotic dependency and depression. She presented in the emergency room with severe abdominal pain. The preoperative consult note

documents weight loss, crying despite 100 mg. Demerol, on fentanyl, thin, HR 88, T 36.2. Preoperative progress note says: “Discussed case with patient and 2 daughters. No clinical change, labs repeated, films impressive [x-ray reports, in French, said ileus or early obstruction], patient says pain is 10/10, I explained risks and benefits of surgery, observation. She wishes to proceed with OR, family agrees.” According to Dr. Ferdinand’s final note, the daughters had never seen the patient in so much pain before. Dr. Ferdinand operated on the basis of possible ischemic gut.

She was taken to the operating room approximately two hours after Dr. Ferdinand first saw her in the emergency room. At laparotomy, no abnormality was found.

Progress note for the OR just says laparotomy.

The patient was in the OR for only 20 minutes despite the fact that Dr. Ferdinand took down adhesions.

The patient died post operatively after recovering surgically according to the final note. The final note does not say how or why she died. The post operative note on day three said increased glucose and WBC, query source of sepsis. The notes after that time are not clear on clinical status and many just say ‘status quo’. Postop note for day 17 says patient in withdrawal [from narcotics].

Dr. Y’s concerns are:

- i) Poor documentation;
- ii) OR was exceptionally fast;
- iii) Patient was taken to OR very soon after presentation in ER, was a known narcotic dependent with chronic abdominal pain without free air or intestinal wall thickening or any sign to suggest ischemia; Blood gases were apparently not drawn. It would have been preferable to observe the patient for at least several more hours.

Dr. Y is of the opinion that Dr. Ferdinand’s care of this patient fell below the standard of

care. The decision to operate was precipitous and undertaken without any attempt at expectant management and the operation was done very quickly.

- iii) Patient T was an 87 year old male with a past history of diabetes, COPD, cerebrovascular disease and coronary artery disease. He presented at the emergency room with abdominal pain, amylase 3500 (normal 100), LFT's normal, negative CT scan in Ottawa. Dr. Ferdinand's conclusion in the consult note was "Pancreatitis vs Bowel obstruction>perf/ischemia." On the second day after presentation Dr. Ferdinand noted that the patient might need a laparotomy for "BO tomorrow." Dr. Ferdinand also noted, "patient's condition is not improving despite NG in position (Rx) and working well. Fleets given produced some stool as expected but no gas pr. Patient still c/o abd pain...amy decreasing to 612 but WBC up to 24.3 with left shift, increased lipase but CT normal and this is not the usual evolution of pancreatitis (also given previous chole, LFT's are normal, no hx of etho)...low grade fever...??septic process...AXR still dilated loops +/-diffuse." Two days later Dr. Ferdinand took the patient to the operating room. The indication for operating was not clear and his OR note says "The whole picture was not clear." Laparotomy showed no abnormality except a "clearly inflamed left colon with some chronic changes in the sigmoid..." Dr. Ferdinand resected the rectosigmoid with colostomy. The pathology report showed multiple diverticula with chronic diverticulitis, focal acute peritonitis in that there was a "single focal area, approximately 2x 1.5 cm. of fibrinopurulent exudate." There is no progress note on the operation. Postoperatively the patient suffered a myocardial infarction and died.

Dr. Y's opinion is that:

Dr. Ferdinand stated that this is not the usual course for pancreatitis but in fact it is the usual course although a CT scan at this point would usually be abnormal. Dr. Ferdinand noted the past cholecystectomy as suggesting that gallstone pancreatitis was unlikely. In fact a previous cholecystectomy shows the patient had gallstone disease and supports gallstones as a cause.

Dr. Ferdinand took an elderly patient to the operating room without a clear reason. An

operation should not be the default therapy in an 87 year old patient with pancreatitis. Treatment for pancreatitis should be supportive. He should have obtained a second opinion before operating for unclear reasons in a poor risk patient.

Dr. Ferdinand's progress note on day two of the patient's admission included a comment that the patient was "otherwise in good health." This was not true. The patient had diabetes, coronary artery disease, lung disease and cerebrovascular disease.

Dr. Ferdinand's decision to remove the sigmoid colon and give a colostomy was overly aggressive.

There was no progress note on the operation.

Dr. Y is of the opinion that Dr. Ferdinand's care of this patient fell below the standard of care.

Part III - Dr. Y's Conclusions

11. Dr. Y is of the opinion that these cases demonstrate a pattern of proceeding precipitously to surgery with questionable indications, reluctance to utilize expectant management and reluctance to obtain second opinions when indications are unclear. The rush to surgery puts the patient at risk for complications. The documentation is frequently incomplete and leads to uncertainty around the reasons for the operations and for the complications. This pattern is the basis for Dr. Y's overall conclusion that Dr. Ferdinand is incompetent in the sense that he shows a lack of judgement of a nature that demonstrates that Dr. Ferdinand's practice should be restricted.

Part IV - Failure to Comply with Restriction on his Practice

12. On or about July 1, 2002, Dr. Ferdinand attended a post-operative surgical patient at General Hospital and General Hospital 2. Dr. Ferdinand ordered a transfusion for this patient, without reviewing the patient's plan of care with another surgeon on staff. Dr. Ferdinand

then left General Hospital 2 to attend his practice at another hospital. Dr. Ferdinand did not inform the surgeon on call of his intervention before leaving General Hospital 2 on the day in question. The surgeon on call was in transit from another hospital at the time. The transfusion was, in Dr. Ferdinand's opinion, urgent. It was a symptomatic anemia patient.

13. At the relevant time, General Hospital 2 had placed restrictions on Dr. Ferdinand's practice including:

In respect of the postoperative care of your patients, another surgeon on staff shall have authority to review the care being provided to your patients and, where necessary, direct the care and treatment of that patient.

Part IV - Conclusion

14. Dr. Y was of the opinion, as noted above, that Dr. Ferdinand's communication skills, surgical judgement, insight and credibility fell below an acceptable standard of care. He found that Dr. Ferdinand has a history of proceeding precipitously to surgery with questionable indications, which puts his patients at risk of complications. In addition, Dr. Ferdinand has shown reluctance to utilize expectant management and has shown reluctance to obtain second opinions when indications are unclear. Dr. Ferdinand's record-keeping is deficient and on one occasion misleading. Dr. Ferdinand also failed to comply with restrictions imposed on his practice at General Hospital 2 & General Hospital.
15. Based on the facts set out above, Dr. Ferdinand's judgment is deficient. As a result, Dr. Ferdinand should continue to have restrictions imposed on his practice.

FINDINGS AND DECISION

The Committee accepted as true all of the facts set out in the Agreed Statement of Fact. Having regard to these facts, the Committee accepted Dr. Ferdinand's admission and found that he committed an act of professional misconduct under O. Reg. 856/93 in that he committed acts or omissions relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The

Committee also found Dr. Ferdinand to be incompetent pursuant to s.52(1) of the Code.

PENALTY AND REASONS THEREFOR

The Committee was presented with a joint draft proposal for penalty. The law is clear that the Committee must accept a joint submission on penalty unless its acceptance would bring the administration of justice into disrepute. The Committee obtained clarification from the parties on different aspects of the proposed order with the added requirement that Dr. Ferdinand successfully complete College courses in Record Keeping and Communications. The Panel accepted the Joint Proposal for penalty with the revisions made to it by the parties.

In reviewing the joint submission for penalty, the Committee considered the evidence that had been agreed upon by both parties and led to the finding. Communication skills, surgical judgement, insight and credibility were deficient in the opinion of the College expert reviewing the case and were accepted by Dr. Ferdinand. The plan as presented in the joint proposal will enable Dr. Ferdinand to address those concerns with a year of traineeship, similar to a surgical residency. Following successful completion of that phase, his work will be carefully monitored for another three years and he will not be allowed to do surgery unless he consults with another surgeon beforehand. Built into the proposal are contingencies for failure in his training or failure to abide by the plan. In the Committee's view, the strict requirements will eliminate any risk Dr. Ferdinand poses to the public in the short term while allowing for follow-up for any ongoing difficulties in the long term. Not only will the public be protected but, if Dr. Ferdinand is able to correct the deficiencies he demonstrated, he would eventually be able to return to a full surgical practice. If not, there is provision under the Order for further assessment and training, with the possible ultimate sanction of revocation in the event of a breach of any of the terms, conditions or limitations in the Order.

In support of the jointly proposed penalty order, there was filed with the Committee strongly supportive letters from a former Chief of Staff at the hospital where he practised and from the Chief Executive Officer and Patient Care Coordinator of that hospital. There was also filed in evidence the expert report of Dr. W who supported a remedial order with the possibility of a return to full surgical practice if Dr. Ferdinand successfully addresses the concerns raised about him.

The Committee notes the following concerns that must be addressed if Dr. Ferdinand is to be returned to full surgical practice. Dr. Ferdinand did not attend a patient when told about his dropping blood pressure and other signs suggestive of hemorrhagic shock. It was not clear from the material provided why he neglected to properly assess and treat this patient, who subsequently died. The lack of care and compassion he showed for this patient are of serious concern. In other cases, he aggressively and cavalierly pursued surgery as a first approach rather than considering that less invasive alternatives were more appropriate. While the deficiencies Dr. Ferdinand demonstrated fall under the general area of judgement, the Committee is not clear why this is so. The Committee expects that the training and subsequent monitoring period will allow for those supervising him to examine the nature of the underlying difficulties and provide an opportunity to address them in an environment that is safe and appropriate.

ORDER

The Discipline Committee ordered and directed that the following terms, conditions and limitations be imposed on Dr. Ferdinand's certificate of registration:

1) Nature

Dr. Ferdinand may only practice surgery in accordance with the supervisory and other provisions in the rest of the Order.

2) Objectives

The objective of the Traineeship and practice experience authorized by this Order is to assist Dr. Ferdinand to improve and/or obtain the requisite skills necessary to practice in Ontario, in particular, those skills related to insight, decision-making and professional judgment.

3) Duration

Up until July 1, 2005, Dr. Ferdinand is specifically restricted from performing all surgery except:

- (a) as a surgical assistant;

- (b) endoscopies (except laparoscopies); and
- (c) minor office or out-patient procedures that require at most local anaesthesia

After July 1, 2005, Dr. Ferdinand may only practice as part of the Traineeship described below, or under the supervision provisions following the Traineeship. The one full year of clinical traineeship (hereinafter the “Traineeship”) authorized by this Order must be completed by Dr. Ferdinand by June 30th, 2007.

4) Structure

1. For the one-year Traineeship portion of this Order, Dr. Ferdinand may only practice in a public hospital with a teaching affiliation with a Canadian Medical School under the supervision of that university’s residency training program in general surgery, such program to be approved by the College;
2. During the one full year Traineeship, the following terms, conditions and limitation shall be imposed on Dr. Ferdinand’s certificate of registration:
 - (a) Dr. Ferdinand is only permitted to practice under the supervision of active staff general surgeons of the hospital according to the principles of graded responsibility set out by the Royal College of Physicians and Surgeons of Canada. He cannot be the primary surgeon in any case and is precluded from providing any primary surgical care including any post-operative care without such oversight;
 - (b) Dr. Ferdinand is not permitted to have admitting privileges at any health facility;
 - (c) Dr. Ferdinand is not permitted to operate on a patient unless the decision to operate has been approved by the staff surgeon in any case.
3. Following the successful completion of the Traineeship as evidenced by the supervisor’s report to the Director of Professional Enhancement at the College, the following terms, conditions and limitations shall be imposed on Dr. Ferdinand’s certificate of registration:

- (a) For a period of at least two years, following the Traineeship, Dr. Ferdinand shall be assisted by another surgeon licensed to practice in Ontario during any surgery or operation except endoscopies (excluding laparoscopies) and minor office or out-patient procedures that require at most local anaesthesia;
 - (b) For a period of at least three years, following the Traineeship, Dr. Ferdinand shall not make any decision to operate in any case without such decision having received prior approval from another surgeon licensed to practice in Ontario.
4. Dr. Ferdinand's practice will be reviewed on an ongoing basis, at Dr. Ferdinand's expense, by a certified surgeon agreeable to Dr. Ferdinand and acceptable to the Registrar.
5. Supervision Methods
- 1. The supervisor for the period following the Traineeship need not be the person who supervises during the Traineeship. There shall however be a supervisor approved by the College during the duration of this Order;
 - 2. During the term of this Order, the supervisor will review every two weeks a random sample of a reasonable number of cases in which Dr. Ferdinand was involved in any surgical intervention;
 - 3. The random sample of cases will be representative of Dr. Ferdinand's whole scope of practice;
 - 4. The review of the cases will consist of considering all clinical information pertinent to the patient, a review of Dr. Ferdinand's report and other work product, and a discussion with Dr. Ferdinand of the case;
 - 5. Each review will include attention to Dr. Ferdinand's assessment, problem-solving, professional judgment, documentation and follow-up recommendations, as well as a mortality and morbidity review of Dr. Ferdinand's patients;

6. Dr. Ferdinand shall not start the next two weeks' work until the review of his prior two weeks' work has been completed;
7. If the supervisor is unable to perform the review at the end of any two week period, the supervisor will seek an extension from the Director of Professional Enhancement;
8. The supervisor will promptly inform the Director of Professional Enhancement of any circumstances indicating the Dr. Ferdinand is not practising in accordance with the standards of surgery in Ontario;
9. Shortly before the end of the Traineeship period and once a year thereafter, the supervisor will report in detail to the Director of Professional Enhancement and indicate the degree to which Dr. Ferdinand's practice is in accordance with the standards of surgery in Ontario and provide observations in support of the conclusion.

6) Contingencies

1. If Dr. Ferdinand completes the Traineeship and subsequent 3-year practice experience required by this Order to the satisfaction of the Director of Professional Enhancement, all terms, conditions and limitation will be removed from his certificate of registration without any further appearance before this Committee.
2. If the terms, conditions and limitations imposed upon Dr. Ferdinand's certificate of registration are not removed under 6(1) but Dr. Ferdinand completes the authorized Traineeship and practice experience to the satisfaction of the Discipline Committee, the Committee upon application may remove all terms, conditions and limitations from his certificate of registration, unless the Committee reasonably concludes that another period of transitional practice experience is warranted.
3. If, on application to the Committee, the Committee forms the opinion that Dr. Ferdinand is not progressing satisfactorily, or that different methods of supervision are necessary to

accomplish the objectives of the practice experience, the Committee may amend the terms, conditions and limitation imposed on his certificate of registration.

4. If the supervisor is of the opinion that Dr. Ferdinand's performance is placing his patients at risk, the supervisor will notify Dr. Ferdinand and the Director of Professional Enhancement and Dr. Ferdinand will immediately stop practising.
5. If Dr. Ferdinand loses his hospital privileges or is suspended from the public hospital, he will immediately notify the Director of Professional Enhancement.
6. If on application, the Committee forms the opinion that Dr. Ferdinand is not practising in accordance with the standards of surgery in Ontario, the Committee may imposed such further terms, conditions and limitations on Dr. Ferdinand's certificate of registration as the Committee considers necessary to serve and protect the public interest.
7. If on application, the Committee determines that there has been a breach of any of the terms, conditions and limitation in this Order, it will take whatever steps it considers advisable in the interest of the public, including the revocation of Dr. Ferdinand's certificate of registration.
- 7) Other Conditions

The following must occur prior to the commencement of the one-year Traineeship program:

1. A certified surgeon agreeable to Dr. Ferdinand and acceptable to the Registrar will be designated as the supervisor for the purposes of this Order;
2. Dr. Ferdinand will authorize the College to inform, and the College shall inform, the head of the medical school residency training program and any other supervisor of Dr. Ferdinand, of his full professional history known to the College, including the decision and reasons of the Discipline Committee in this matter;

3. Dr. Ferdinand will inform any public hospital in which Dr. Ferdinand is practising of all such professional history during the period 1999 through present;
 4. Dr. Ferdinand and the supervisor will execute a document indicating that each has read, understood and agreed to abide by this Order and by its terms, conditions and limitations;
 5. The supervisor will execute a document indicating his/her undertaking to comply with the requests, directions or other obligations on his/her part mentioned in this Order.
- 8) Courses

Dr. Ferdinand shall take at his own expense and successfully complete the record keeping and communications courses offered by the College within two years of the date of this order.

- 9) The Discipline Committee directs the results of this proceeding to be included in the Register.

The Committee is of the view that this Order as to penalty with its retraining, assessment, and phased and supervised re-entry provisions addresses the need for public protection in this case.