NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Fatemeh Roya Yar, 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 subsection 45(3) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

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.

Indexed as Yar (Re)

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

IN THE MATTER OF a Hearing directed by the Executive Committee of the College of Physicians and Surgeons of Ontario, pursuant to Section 36(2) of the ***Health Professions Procedural Code***, being Schedule 2 to 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. FATEMEH ROYA YAR

PANEL MEMBERS: P. BEECHAM (CHAIR)
DR. O. KOFMAN
J. DHAWAN
DR. J. DOHERTY

Hearing Dates: **September 19-23, 2005**
November 7-11, 2005
December 12-15, 2005

Decision/ Release Date: **March 17, 2006**

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 September 19 to 23, November 7 to 11 and December 12 to 15, 2005. At the conclusion of the hearing, the Committee reserved its decision.

PUBLICATION BAN

On September 19, 2005, 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 subsection 45(3) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Fatemeh Roya Yar committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93") in that she has failed to meet the standard of practice of the profession; and,

2. under paragraph 1(1)(33) of O. Reg. 856/93 in that she committed acts or omissions relevant to the practice of medicine that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

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

RESPONSE TO THE ALLEGATIONS

Dr. Yar denied the allegations as set out in the Notice of Hearing.

EVIDENCE

Overview of the Issues

At the conclusion of the hearing, the College sought a finding only with respect to the allegations relating to Dr. Yar's practice of emergency medicine, as follows:

1. Dr. Yar, in ordering thrombolytics for two (2) patients, namely, patient A and patient B, failed to meet the standard of practice and was incompetent. The two (2) cases have similarities but differ in many significant respects and will, therefore, be considered separately.

2. Dr. Yar has poor communication skills, compromising her relationships and interactions with patients, family members of patients, co-workers and colleagues, and that she is insufficiently receptive to feedback. This allegation is based on a review of nine (9) specifically selected charts of patients who have been under Dr. Yar's care as well as interviews with various healthcare personnel. This allegation is asserted to constitute a failure to meet the standard of practice, disgraceful, dishonourable or unprofessional conduct and/or incompetence.

The onus is on the College to prove these allegations to the Bernstein standard of clear and convincing based on cogent evidence. Dr. Yar specifically denies ordering thrombolytics in both of these cases.

Initially, the allegations dealt with during the hearing included incompetence with regard to Dr. Yar's care relating to cardiac issues other than the use of thrombolytics. In addition, the initial allegations referred to Dr. Yar's lack of skill and knowledge in intubation. The College chose not to pursue these other cardiac and intubation issues

after extensive evidence had been presented at the hearing including multiple witnesses, multiple patient charts and documents particularly with respect to intubation. However, reference will be made to some of this evidence from these cases as it pertains to Dr. Yar's communication skills and allegations with respect thereto.

The background and circumstances that led to Dr. Yar's discipline hearing are relevant. Dr. Yar has practised as a family physician in a small town in Ontario (population approximately 14,000) since 2002. She was born in Iran and studied medicine and ophthalmology in India until 1991. Subsequently, she had further ophthalmology training in England.

She came to Canada in 1993. From 1997 to 2001, she had further medical training in emergency medicine, internal medicine and family medicine in hospitals affiliated with the University of Toronto. She is 43 years old, married to a physician and has two children.

Her activities in her community consisted of family medicine and an emergency room rotation at the hospital, which has a total of thirty-three active and chronic beds. There were no regular on-site specialists for back up.

Dr. Yar had a dispute with the local hospital administration regarding her office lease and she was evicted from her office. She moved to her husband's office. Her hospital privileges were suspended on September 2, 2004 primarily because of care concerns with regard to her handling of patients as well as communication issues. It is Dr. Yar's belief that she was targeted by the hospital administration.

The Executive Committee of the College of Physician and Surgeons of Ontario was informed of these concerns and arranged for further investigation under section 75(a) of the Regulated Health Professions Act ("RHPA"). The results of this investigation lead to the current allegations and resultant discipline hearing.

Summary of the Evidence

The Committee heard the testimony of Dr. Z and Dr. Y who were both experts called by the College in family and emergency medicine. In addition, the witnesses for the College included Dr. X and five nurses, all of whom had worked at the hospital. The witnesses called by the defence included Dr. W, Dr. V, Dr. U, Dr. T, Dr. S, Dr. R, Dr. Q, Dr. P and Dr. Yar (Dr. S was the only cardiologist called by either side to give expert testimony). In addition, Dr. Yar's office secretary, Ms. C, was a supportive witness called by the defence.

Various exhibits were filed including clinical records, documents, multiple reports and other relevant communications. With regard to patient B, for whom it was alleged that Dr. Yar had ordered or considered ordering thrombolytics without adequate criteria, both College experts as well as defence experts agreed that there was no indication for the use of thrombolytics. It was essentially agreed that, if she had ordered thrombolytics in that case, even if they were not given, Dr. Yar fell below the standard of practice of the profession and demonstrated a lack of judgment. While ordering thrombolytics would fall below the standard of practice, defence witnesses considered that failure in itself was insufficient to indicate incompetence.

Similarly, the College and defence experts agreed that, in the case of patient A, there was no indication for the use of thrombolytics, ordering them would be inappropriate and below the expected standard of practice and would show a lack of judgment. The question in this case was acknowledged to be hypothetical. Dr. S, the sole cardiologist to testify as an expert, was not aware of any "off label" use (i.e. a use other than for those conditions specifically approved) of thrombolytics, which conflicted with the suggestion of Dr. Yar and Dr. W that there was such a use.

Essentially, Dr. Yar denied ordering thrombolytics in either of these two cases although she acknowledged that she considered using them in patient B and wrote a confusing

conditional order that caused concern with the nursing staff who were involved with his care.

The summarized evidence pertaining to the allegations of Dr. Yar's poor communication skills is specifically related to nine (9) selected patient charts, as well as the testimony from the various nurses and physicians who were either directly involved or gave evidence and opinions with regard to this matter.

The two (2) cases relevant to the use of thrombolytics were included in the communication issues as well. The case of patient B in particular illustrated a significant communication ambiguity.

There was unanimous agreement that good communication is essential for quality care. The College and defence witnesses confirmed, and Dr. Yar acknowledged, this fact. Both College experts, following their review of the patient charts and interview with Dr. Yar, concluded that Dr. Yar had at times a communication problem with patients, nursing staff and colleagues. While Dr. Yar generally denies the allegations with respect to poor communication skills, she concedes that, in some situations, her communications have been incomplete, inappropriate, misunderstood and upsetting. She recognized the need for improvement in this area.

The Evidence

Issue 1 - Thrombolytics:

a) Patient B

The Committee heard the evidence of Nurse D and Nurse E as well as Dr. Y, Dr. Z, Dr. X, Dr. S, Dr. Q, Dr. W and Dr. Yar. The reports of Dr. Y, Dr. Z, Dr. S, Dr. Q and Dr. W were filed as exhibits.

This 54-year-old man presented to the emergency of the hospital in July, 2004. He had a history of multiple episodes of chest pain with exertion. The initial ECG was normal.

Because of a suspicion of acute coronary artery syndrome, Dr. Yar admitted him to the hospital. She initiated a cardiac diagnostic and treatment protocol including enzymes, a nitropatch, subcutaneous heparin, metoprolol and plavix. During his brief admission, he was noted to have a wide complex tachycardia, which, at that time, was diagnosed as ventricular tachycardia. Dr. S, in his expert testimony, disagreed with this interpretation.

Dr. Yar's interpretation of the arrhythmia, in conjunction with patient B's clinical presentation, was a likely clot and led to her discussion with the nurses and Dr. X and ultimately to the conditional order for the administration of TNK, a thrombolytic. Dr. Yar denied ordering TNK. She testified that she was merely considering its use despite the fact that the accepted criteria were not present.

The accepted criteria for the use of thrombolytics include ECG changes showing an elevated ST segment or a new left bundle branch block together with symptoms. These changes were never present in the ECG. All of the evidence presented, including that of Dr. S, clearly and categorically indicated that there were no criteria for the administration of thrombolytics present in this case.

The nursing notes, written by Nurse D, indicated that Dr. Yar called, "spoke to Dr. X and then to me. Requested start t-PA" (a thrombolytic). Dr. X testified that he informed Dr. Yar that thrombolytics should not be given as there were no criteria present. He did not document the telephone conversation with Dr. Yar. Dr. Yar indicated to him that she was on her way to the hospital.

Dr. X testified that he was not surprised by Dr. Yar's request for thrombolytics as she had made a similar request in a previous patient, patient A, six weeks earlier where the appropriate criteria were not present. Following that incident, Dr. X testified that he had informed Dr. O, Chief of Emergency, of the request. With regard to the case of patient B, Dr. X testified that he called Dr. O and said "Here we go again". Dr. X also testified that, several weeks later in mid August, he emailed the hospital administrator with regard to

Dr. Yar's request for the administration of thrombolytics to patient B. Shortly thereafter, the evidence indicated that Dr. Yar's hospital privileges were suspended.

Nurse D testified that she called Nurse E, the nursing supervisor, who came to the floor. According to the testimony of Nurse D, when Dr. Yar arrived at the nursing station, she inquired as to whether thrombolytics had been given and was told it had not been given. Dr. Yar said she was ordering TNK. Nurse D also testified that Nurse E told Dr. Yar there was no ST elevation and the nurses were concerned. Nurse D testified that Dr. Yar reiterated that, because of ventricular tachycardia and that a clot was likely, patient B definitely needed TNK. Dr. Yar was very upset and annoyed as judged by the way she spoke. According to Nurse D, Dr. Yar did not care about the criteria.

Dr. Yar, in her testimony and in her interview with Dr. Y as referenced in his report, Exhibit 11, referred to research in an "article" that supported the use of thrombolytics in other cardiac disorders. This article or information was never presented as evidence and its contents remain unknown.

Dr. Yar's notes with regard to these events indicate that she discussed giving TNK with the nurses. The notes refer to the fact that strict criteria do not exist. She thought that ventricular tachycardia was the result of ischemia of myocardial infarction, but "she won't give it [thrombolytics] as the nurses are uncomfortable giving it". The order sheet dated July 1, 2004 written by Dr. Yar noted, "TNK as per protocol if there is any ABN [abnormal] ECG ō SX" [with symptoms].

Dr. S regarded this written order as problematic if the intent was to order a thrombolytic without personally making the decision based on a review of the ECG. As he testified, "one does not order a thrombolytic for an abnormal electrocardiogram". Dr. S, in his testimony and in his report (Exhibit 32), also stated that, with a mortality rate of one percent, the decision to administer a thrombolytic should be based on the ST segment criterion (or the presence of left bundle branch block). The administration of a thrombolytic in this case was not indicated.

Drs. Q, W, Z and Y essentially agreed that thrombolytics were not indicated in this patient based on the established criteria. Dr. W referred to the "off label" use of thrombolytics but Dr. S had never heard of its use in this manner.

Dr. S testified that he has seen a wide spectrum of individuals in five or six cases, including a cardiologist, give thrombolytics inappropriately based on various factors including ECG interpretation. In response to a question from the Committee, he testified that in no case was there a report to the College. He couldn't recall anything that followed because nothing untoward occurred. It was the general consensus that orders for thrombolytics over the phone would be inappropriate.

FINDINGS AND DECISION

Issue 1a) - Patient B

The issue is whether or not Dr. Yar ordered thrombolytics for patient B either by phone or by written order. Dr. Yar denies the phone order and indicated that she was thinking out loud. She testified that she would not use thrombolytics in this case. According to the report submitted by Dr. Y, when asked what the criteria for thrombolytics were, Dr. Yar answered correctly. She thought it was an option for this patient based on some research evidence that she testified she had seen but that were never put into evidence before the Committee.

Dr. Yar acknowledged that the written order is ambiguous and not an appropriate order. Dr. Yar also did not fill out or sign the hospital protocol form for the use of thrombolytics, which technically would make any order invalid as pointed out by defence counsel. The College and defence expert witnesses concurred that it was not an appropriate order from the overall evidence.

The Committee finds that there was clear, convincing and cogent evidence in the testimony of the two nurses and one physician that Dr. Yar's intent was to give thrombolytics to this patient in whom the criteria did not exist and in whom the

administration of thrombolytics would have been inappropriate. The very specific written note by a nurse and Dr. Yar's own notation further confirms this finding. The written order is flawed and conditional but the Committee finds that it clearly indicates Dr. Yar's intent to order thrombolytics without the required criteria.

The Committee therefore finds that Dr. Yar has committed an act of professional misconduct in that she failed to meet the standard of the profession as set out in the Notice of Hearing, specifically with regard to the use of thrombolytics with respect to patient B.

Although Dr. Yar displayed a lack of judgment in this individual case, in the opinion of Drs. S and W, it did not amount to incompetence and the Committee accepts their opinion in this regard. Specifically, Dr. Yar's professional care in this case did not display a lack of knowledge, skill or judgment of nature or to an extent that demonstrates Dr. Yar is unfit to continue her practice or that her practice should be restricted. The Committee therefore finds that the allegation of incompetence with respect to patient B is not proven.

Issue 1b) - Patient A

Dr. O initially assessed this 69-year-old lady at the emergency department of the hospital in May, 2004. Dr. O ascertained that the patient most likely had a myocardial infarction that occurred more then 24 hours previously. Dr. X took over the responsibility of patient A's care. Patient A was a patient in Dr. Yar's practice.

Nurse F testified that she received a phone order from Dr. Yar requesting that she give thrombolytics to patient A. Nurse F asked Dr. Yar if she was in or was coming in to the hospital and was informed that she was not. Nurse F testified that she told Dr. Yar that it could not be given and referred her to Dr. X who was the emergency physician. No note was made in the patient's chart with regard to this discussion, nor was any order written.

Dr. X testified that he heard Nurse F say on the phone that she "couldn't do that". Dr. X spoke to Dr. Yar with regard to the administration of TNK to patient A. While Dr. Yar

waited on the line, he looked at the ECG and inquired about the patient. He explained to Dr. Yar that there was no basis for the use of TNK. He explained the criteria for using thrombolytics, which included pain and ECG changes, were not present in patient A's situation. Dr. Yar did not push the issue after that. Dr. X testified that he did not record the event as patient A was not his patient and he did not want to create a problem. About two weeks later, Dr. X spoke to Dr. O, the Chief of Emergency, about Dr. Yar's request for TNK for patient A.

Dr. Y's report did not refer to patient A as he testified there was no evidence of the order and he did not feel comfortable with the case. Dr. Y agreed that, on the assumption that thrombolytics were ordered in these circumstances, it would be below the standard of care with regard to judgment and possibly knowledge.

Dr. S testified that, if the order for thrombolytics was given for this patient, it would not be appropriate and would be below the standard of care expected and would display a lack of knowledge and judgment. However, he was not aware of any such order, hence, the questions were hypothetical.

Dr. Yar disagreed with the evidence of both Nurse F and Dr. X. She testified that she had no notes of the above events and does not remember them. She also testified that she was unlikely to order thrombolytics in this case and disagreed that she ordered TNK.

FINDINGS AND DECISION

Issue 1b) - Patient A

Based on the evidence, in particular that of Dr. X and Nurse F together with Dr. Yar's approach to the use of thrombolytics, the Committee finds the evidence sufficiently clear and convincing and cogent that Dr. Yar did intend to order thrombolytics and attempted to do so in her telephone discussion with Nurse F.

On this basis, the Committee therefore finds that Dr. Yar committed an act of professional misconduct in that she failed to meet the standard of practice of the profession with regard to the use of thrombolytics for patient A.

Although Dr. Yar showed a lack of knowledge and possibly judgment in this case, the Committee does not find it to be sufficient to indicate incompetence. Ultimately, thrombolytics were not ordered or administered.

With respect to the allegation of incompetence relating to the use of thrombolytics, the Committee wishes to make clear that it has carefully weighed the evidence. Not every error in professional care or lack of judgment demonstrates incompetence. Each must be weighed as to their nature and extent. The Committee has done so and is satisfied that the allegation of incompetence with respect to the use of thrombolytics was not proven to the requisite standard.

Issue 2 - Communication skills

The particulars, as set out in Schedule A of the Notice of Hearing, relate to Dr. Yar's practice of emergency medicine asserting that:

> Dr. Yar has poor communication skills, compromising her relationships and interaction with patients, family members of patients, co-workers and colleagues, and is insufficiently receptive to feedback.

The College witnesses included Dr. Z, Director and Chief of Emergency Services at another hospital. The defence witnesses included several physicians, some of whom commented on various aspects of Dr. Yar's communication skills.

As a result of issues raised about Dr. Yar's practice, the hospital retained Dr. Z to perform a practice review of Dr. Yar's practice standards and to assess Dr. Yar's competency to practise emergency medicine and in-patient care in a community hospital setting. He reviewed forty-seven charts, six of which were selected by the hospital administration, thirty-five were randomly selected charts from Dr. Yar's emergency practice and several

were drawn based on complaints and concerns from patients, nurses, medical staff, etc. Dr. Z's focus was not related to communication.

During the process of chart review and interviews, Dr. Z concluded that Dr. Yar's communication with patients, nursing staff and medical staff is clearly confrontational at times. On some occasions, the nursing staff documented their concerns about patients' dissatisfaction with the way events were unfolding. Their attempts to intervene were not met with collegiality by Dr. Yar.

The College's other expert witness was Dr. Y, a family physician and Chief of Emergency, at another hospital. Five nurses also testified as witnesses with regard to matters that included Dr. Yar's communication skills.

Dr. Y was appointed by the Registrar of the College of Physician and Surgeon of Ontario to act as the investigator of Dr. Yar under section 75(a) of the *RHPA*. Dr. Y acknowledged that he had prior involvement when he provided advice to the CEO of the hospital regarding the process to deal with an unidentified member of the medical staff where there had been issues of concern raised. The College of Physicians and Surgeons of Ontario did not regard this prior involvement as sufficient to raise a conflict of interest with his role as a medical investigator.

Dr. Y performed a chart audit. There were twenty-one randomly selected office charts from Dr. Yar's practice, twenty-three emergency room charts, three of which were selected by the hospital, and fourteen inpatient files, seven of which were selected by the hospital. Interviews were held by Dr. Y with five community physicians and six members of the nursing staff of the hospital. Dr. Y presented a detailed review with comments on his findings. His report was filed as an exhibit. He also gave extensive testimony at the hearing.

Dr. Y's observations and conclusions with regard to Dr. Yar's communication skills were carefully considered by the Committee. His summary of interviews with physicians and

hospital staff including nurses was supplemented by his chart reviews as well as his interview with Dr. Yar. Dr. Y noted that there was a uniform feeling that Dr. Yar did not listen to input which differed from her opinion. Several participants illustrated the problem using chart reviews of patients with third degree heart block as well as her orders for thrombolytic therapy without acceptable criteria. There was also a general view that Dr. Yar was not good at conflict resolution with nurses.

Dr. Yar, in her interview with Dr. Y, acknowledged that she respected the other doctors and they respected her. She indicated that she had some problems with several nurses in the past, but that was now "resolved". Dr. Yar in her interview with him stated that she would be receptive to feedback to a certain extent.

Dr. Y recommended that Dr. Yar needed to improve her communication skills. He noted that she has a desire to overcome the problems she is now facing.

The evidence relevant to the nine selected cases, some of which had communication issues was as follows:

Case 1 – Patient G

This 84-year-old man was admitted for uncontrolled diabetes. He had complete heart block, which was asymptomatic. The nurses reported this to Dr. Yar. The patient was put in a monitored bed. The office chart indicated a previous bradycardia. He had previous assessment by a cardiologist, Dr. R, who testified in this regard. Dr. Y noted that Dr. Yar's charting was incomplete. There was no note with regard to the initial request for transfer to the care of a cardiologist. Dr. Yar did not record the admission history and physical examination until three and a half months later.

Dr. Yar had written a note that was critical of the nursing staff in the order sheet, and that was upsetting to the nurses. The note referred to the incorrect charting of vital signs i.e., 80 rather than 39 or 40 on two occasions. The note was inappropriate in content and location. Dr. Y regarded this as an angry accusation of the nurses. Three defence

witnesses did not regard the entry as appropriate to resolve the problem. Dr. Yar acknowledged that her note was inappropriate and the matter should have been discussed with the nurses but was written due to her frustration.

Case 2 – Patient H

This 48-year-old man presented to the emergency room for the administration of rabies vaccine. A fox had bitten him three days earlier. His family doctor had administered immunoglobulin and the first of five doses of vaccine. Dr. Yar had not read the nurse's note and had not seen the patient. She assumed that the patient was seeking further immunoglobulin and refused to authorize the vaccine. The patient subsequently returned and another physician authorized the vaccine. Dr. Yar agreed that she should have taken the history herself and the problem would have been avoided. She regards this as a misunderstanding, which is supported by her brief note and referral to the family physician.

Case 3 – Patient I

A mother brought her one-year-old child to the emergency because of vomiting. Three days earlier, she had been seen by another doctor. Dr. Yar diagnosed otitis media and pneumonia. The mother requested intravenous prednisone and was not happy with the care given by Dr. Yar. Nurse E's note refers to the mother being extremely upset and offended by Dr. Yar. Her note indicated that, according to the mother, Dr. Yar was rude and abrupt, and that the mother said that Dr. Yar told her that she was not doing her job as a mother. Dr. Yar denied making any such statement. The nurse's note also indicated that the baby did not appear to be too ill and was eating freezies and playing. At the nurse's request, Dr. Yar spoke to the mother again, however, this was not productive. Dr. Yar testified that the mother was upset and not receptive. She acknowledged that, at times, you cannot make everyone happy.

Case 4 – Patient J

This 77-year-old man was admitted through emergency with a gastrointestinal bleed and anemia. He had a high INR of 3.3 secondary to coumadin, which he was taking for atrial fibrillation. He had been given a blood transfusion. On the following day, a nurse ordered a haemoglobin test. According to the nurse's note, Dr. Yar was extremely upset with the nurse's order, stating that it was a waste of supplies and was not needed, and wanted to know which nurse had ordered the test. Dr. Yar apparently stated that the orders to be followed were those that she had written that morning.

Dr. Y regarded this incident as an example of Dr. Yar's lack of receptiveness to well intended assistance from a colleague. Dr. Yar denies that she was angry and acknowledges that discussion with the nurse would have been appropriate.

Case 5 – Patient K

This 22-year-old man was brought to the emergency by a police officer. His wife, from whom he was separated, had called indicating that he was suicidal. Upon arrival, the patient was angry and wanted to be admitted to another hospital. The patient had a history of depression with wrist slashing and overdose of medication. Dr. Yar discussed the option of staying overnight in the hospital and treating him with antidepressants, to which he was agreeable. Her diagnosis was mild depression and possible borderline personality disorder. She contacted the other hospital for follow up. Dr. Yar thought he had passive suicidal thoughts.

The nurses, the patient and his wife were concerned about Dr. Yar's intent to discharge him. Following discharge, she saw him in her office and he was seen at St. Joseph's hospital that same day.

The diagnosis at the other hospital was dysthymic disorder with marital problems. He was not admitted to the hospital and was sent home, which was consistent with Dr. Yar's management of the patient.

Case 6 – Patient L

This 46-year-old man was admitted for pyelonephritis. There was a history of chronic back pain following an injury. He had received oxycontin for relief of pain with dosage as high as 80 mgs TID. Dr. Yar's note on the day of admission stated that he walked well and was able to bend his back without pain. The note also indicated that he did not use pain pills more than once a day. He received disability compensation. Dr. Yar was not certain why, as he was able to work on a farm and raised cows. Her note indicated that she discussed the use of oxycontin with him. He was also taking clonazepam 10 mgs daily, and marijuana (3 joints daily).

The nurse's note of February, 2004 referred to a complaint from the patient and his wife that Dr. Yar was treating him like a drug abuser. Dr. Yar confirmed discussion with regard to the use of oxycontin and clonazepam. She was concerned about possible addiction. She testified that she did not indicate that he was a drug abuser. She did not take away his medication. He indicated that he used oxycontin 80 mgs once a week. Dr. Yar's summary of the course in hospital supports this information. The patient was referred back to his family physician.

Patient 7 – Patient M

This 66-year-old woman presented at the hospital with a history of shortness of breath. The initial diagnosis was pneumonia. Her oxygen saturation was 86%. The ECG done shortly after admission revealed third degree heart block. The condition was stable but the patient was seriously ill. Dr. Yar called Criticare and she was transferred to another hospital within three hours. The nurses were concerned that Dr. Yar did not recognize the seriousness of the complete heart block. The nurses discussed the use of an external pacemaker with Dr. Yar. She did not agree with their recommendation as the patient was stable and her heart rate was 54. The nurses put on the pacemaker pads but they were not used.

Following transfer, the patient was determined to have aortic valve endocarditis and acute myocardial infarction. Dr. S, in his evidence, was in support of Dr. Yar's management of

this situation. He stated that external pacing was very painful and was not indicated in this patient simply because there was third degree heart block. Dr. Yar indicated that there was confusion surrounding the care of this patient as there were multiple nurses around and the patient was affiliated with the hospital and known to the nursing staff. This difference of opinion, in which Dr. Yar proved to be correct, led to the confrontation with the nurses.

Case 8 – Patient A

This patient has been discussed in detail above relative to a disputed telephone request in which Dr. Yar was alleged to have ordered thrombolytics without adequate criteria and protocol. Nurse F testified that she had received a phone order from Dr. Yar requesting that she give thrombolytics to patient A. Nurse F asked Dr. Yar if she was in the hospital or coming to the hospital. When she was told that Dr. Yar was not coming in, she told Dr. Yar that it could not be given and referred her to Dr. X who was the emergency physician. There was no notation made in the patient's chart with regard to this alleged conversation.

Dr. X who was the emergency physician testified that he heard Nurse F say over the phone that she could not do that. Dr. X spoke to Dr. Yar by phone with regard to the administration of TNK to patient A. He testified that, while Dr. Yar waited, he looked at the ECG and inquired about the patient. He then explained to Dr. Yar over the phone that there was no basis for the use of TNK in this patient. He explained that the criteria for the use of thrombolytics were not present in this patient who had a myocardial infarction without the essential ECG findings, etc. Dr. Yar did not push the issue after that. Dr. X testified that he did not record the discussion as she was not his patient and he did not want to create a problem. He testified that about two weeks later he spoke to Dr. O, Chief of Emergency, about Dr. Yar's request.

Patient 9- Patient B

This issue related to Dr. Yar's discussions and alleged request for the use of thrombolytics in this patient has been presented in detail above. The communication issue in this case

relates to whether or not Dr. Yar ordered thrombolytics by phone and/or by written order as well as the method in which these alleged requests were made. Dr. Yar denied the phone order and the defence evidence indicated that no acceptable written order was made as both the hospital and the nursing protocol have specific requirements for the administration of thrombolytics. Any phone order would be invalid as the protocol states that the doctor must be in the hospital. Furthermore, the necessary form and signature must be completed, prior to the administration of thrombolytics.

The evidence of the various nurses and physicians who either participated in the patients care or gave opinions with regard to the care has been described in detail and will be summarized.

The patient B had been admitted with chest pain and Dr. Yar was suspicious of acute coronary artery syndrome. The accepted criteria for the use of thrombolytics were never present according to all the medical witnesses who gave evidence in this regard. Two nurses and Dr. X gave evidence that Dr. Yar had initially requested the use of thrombolytics by telephone which in itself is not appropriate. This was followed by a further request when she arrived at the hospital. Dr. Yar was apparently very upset when she was informed that it had not been given. Dr. Yar's note indicated that she discussed the matter with the nurses, including criteria. Her note indicated that she won't give it because the nurses were uncomfortable.

She subsequently wrote an ambiguous inappropriate conditional order dated 1/7/04 "TNK as per protocol if there is any ABN ECG ō S" (with symptoms). The telephone request and conditional written order, according to both the College and defence witnesses, were inappropriate. Dr. Yar's denial of this evidence and the confusion caused by these events, as noted by Dr. Y, indicate that, at a minimum, she miscommunicated by not making it explicitly clear to the nurses and Dr. X that she did not intend to initiate thrombolytics.

Other witnesses that testified with regard to Dr. Yar's communication skills included several of the nurses who had worked with her. Nurse E had known Dr. Yar for three and

a half years. She did not regard Dr. Yar's communication as a problem but there was a listening problem as noted in the case of patient B. She liked and respected Dr. Yar and had a good working relationship with her. Dr. Yar wanted her orders carried out.

Nurse N testified that Dr. Yar was not always receptive to the ER nurses and others. She tended not to listen and not to change her mind.

Dr. X, who was involved in both of these cases in relation to thrombolytics, stated that, at times, Dr. Yar could not accept feedback. There are some personal conflicts between him and Dr. Yar after he reported the thrombolytics incidents in a letter to the hospital CEO.

Nurse D stated that Dr. Yar did most of the talking, not much listening. She based this view solely on the patient B thrombolytic case as this was the only situation where she had a disagreement with Dr. Yar. Her testimony with respect to communication was, therefore, not of substantial assistance to the Committee.

Nurse F was involved in the patient A´s case regarding the alleged phone order for thrombolytics. She stated that Dr. Yar listened to patients and their families. She had no concern with regard to Dr. Yar's interaction with other nurses. She handled stress well.

Nurse AA stated that Dr. Yar was not confrontational but was pretty sure that she was right.

Another witness called by the defence was Dr. V who did an emergency shift at the hospital. She testified that the hospital administration was difficult to work with. Two other physicians had problems with the hospital prior to Dr. Yar. She testified that the CEO was vindictive and not to be trusted. Following an investigation, he left the hospital.

Dr. V had a collegial relationship with Dr. Yar. She had no concern with her communication skills, judgment or care. Dr. V characterized Dr. Yar as a perfectionist,

tough and hard working. The current Medical Advisory Committee trusted Dr. Yar and appointed her president of the medical staff in June 2005.

Dr. U, a geriatric psychiatrist who conducted a weekly clinic at the hospital, testified that there was no dissatisfaction by any of the patients that he encountered upon Dr. Yar's referral. He noted that they all praised her for her care.

Dr. T, a cardiologist, described his interaction with Dr. Yar in September 2004 when he provided a comprehensive review of cardiac cases including thrombolytics for a total of fifteen hours at her request. He concluded that she appeared knowledgeable and up to date.

Witness Ms. C has worked in Dr. Yar's office since July 2002 as an office person and technician. She regarded Dr. Yar as a good boss who listened to suggestions. In her view, there were no problems in Dr. Yar's communication with patients or the hospital. She reviewed a pilot project questionnaire with regard to physician communication skills with patients sponsored by the College of Family Physicians of Canada. Dr. Yar scored above average in both the patient and physician evaluation groups.

Dr. R, a specialist in internal medicine and cardiology who consults weekly at the hospital, stated that he had no concerns based on Dr. Yar's referrals to him. Her requests for consultation were clear.

FINDINGS AND DECISION

Issue 2 – Communication Issues

The findings follow consideration of the extensive evidence that was presented to the Committee in specific areas of communication. This included:

- Review of cases
- Dr. Y's observations

- Other witnesses

The evidence with regard to communication that was obtained by the detailed review of the nine patient charts that were selected from an initial review of fifty-eight patient charts was considered by the Committee initially on an individual basis and, subsequently, as a possible combined pattern with regard to communication.

Case 1 – Patient G

The Committee accepted the evidence that Dr. Yar's critical entry in the order sheet that was upsetting to the nurses was inappropriate both in content and location. Dr. Yar acknowledged this inappropriateness and indicated that she was frustrated and should have discussed the matter with the nurses.

While Dr. Yar's method of dealing with this issue demonstrated poor communication, the Committee also considered that it showed her perfectionist quality and caring attitude. Dr. Yar's acknowledgement of the error showed insight. Overall, the Committee did not consider this incident as having a level of importance sufficient to support the allegation of failure to maintain the standard of the profession nor did it indicate incompetence.

Case 2 – Patient H

The Committee accepted the clear evidence that there was a deficiency in Dr. Yar's communication with both the nurse and patient with regard to the administration of rabies vaccine. Dr. Yar agreed that she should have taken the history herself, which could have avoided the problem. Dr. Yar considered this failure as a misunderstanding. Her brief note supports this interpretation.

The Committee considered this incident to be a relatively minor miscommunication, which caused no harm and only slight inconvenience to the patient.

Case 3 – Patient I

The evidence clearly indicates that the child's mother was upset and was not receptive to Dr. Yar's explanation in this regard. The Committee notes that Dr. Yar made a second effort to satisfy the mother's request which would indicate her concern for the mother and the situation. The Committee did not find this case as indicative of a problem in communication.

Case 4 – Patient J

The evidence with regard to Dr Yar's response to a minor order of a hemoglobin test by a nurse was accepted. Dr. Yar denied that she was angry and indicated that she was in charge of writing orders. She acknowledged that discussion with the nurse would have been appropriate. The Committee finds that there was no communication problem in this case and it appears the incident has been overstated.

Case 5 – Patient K

The Committee considered that Dr. Yar's management of this patient was entirely appropriate. There was evidence to support Dr. Yar's discussion with the patient, although there was concern by the patient's wife and a nurse. Dr. Yar efficiently arranged for transfer at the patient's request. He was assessed at the psychiatric facility and sent home, which was consistent with Dr. Yar's management. The Committee did not find this case indicative of any communication problem.

Case 6 – Patient L

The evidence indicated that Dr. Yar discussed the use of oxycontin and clonazepam with the patient in an appropriate manner. She was duly concerned about possible addiction in a chronic pain problem. There was no evidence to indicate that Dr. Yar considered this patient to be a drug abuser other than the patient's feeling that that was Dr. Yar's opinion. The discharge summary supports Dr. Yar's intent and he was duly transferred to his family physician. The Committee did not find fault in Dr. Yar's communication with the patient.

Case 7- Patient M

The Committee concluded from the evidence that was presented that Dr. Yar discussed the use of an external pacemaker with the nurse. There was a difference of opinion and the nurses were not happy. This in turn led to a disagreement and confrontation. Dr. Myers' evidence clearly supported Dr. Yar's decision. The Committee noted that, although the disagreement occurred, it was primarily as a result of Dr. Yar's appropriate management, which was challenged by the nurses. The Committee did not find this to be a communication issue demonstrative of any deficiency in Dr. Yar's skills.

Case 8 – Patient A

There was no documentary evidence in this case. However, as set out above, the Committee concludes that the evidence given by both the nurse and Dr. X was credible and consistent. This was further supported by Dr. X's evidence that he discussed his concern with Dr. O. Dr. Yar disagreed with the evidence and does not remember the events, which she regarded as unlikely despite the absence of any written evidence.

The Committee concludes and finds that the telephone conversation did take place between Dr. Yar and the nurse and Dr. X and that Dr. Yar made an inappropriate request for thrombolytics. The major issue in this particular case has been discussed regarding the criteria for thrombolytics and any communication issue is secondary in this matter. In the Committee's view, there was not evidence that there was a communication problem in this case.

Case 9 – Patient B

The Committee considered the evidence in detail with regard to the allegation that Dr. Yar had discussed and ordered thrombolytics for the patient despite the lack of acceptable criteria.

The Committee, as noted above, found that Dr. Yar failed to meet the standard of the profession with regard to the use of thrombolytics. The communication issues were a significant component of the evidence as described. This involved a phone order as well as an inappropriate ambiguous conditional written order for the administration of thrombolytics. Dr. Yar denied making a phone order and testified that she was thinking out loud. However, the evidence of Nurse D, including nurses notes, as well as the nursing supervisor and Dr. X, was clear, and convincing and cogent and is accepted by the Committee.

Dr. Yar acknowledged that the conditional order that she wrote was ambiguous and inappropriate. Both the phone order and written order were regarded by the multiple witnesses representing the College and defence as inappropriate and problematic. The Committee accepts these concerns and regards them as demonstrating a communication problem which in itself is not sufficient to indicate a failure to meet the standard of practice of the profession. However, these specific communication problems pertaining to the problematic orders in patient B, when considered together with the thrombolytic issue in the absence of the appropriate criteria, were found by the Committee to indicate a failure to meet the standard of practice of the profession, as previously discussed.

The Committee agreed with the College experts, Dr. S and Dr. W, that these findings, which included the communication issue, although indicative of lack of judgment and possibly knowledge were not sufficient to demonstrate incompetence.

The Committee considered its findings with regard to the alleged communication issues in the other cases that were reviewed in order to determine whether cumulatively they demonstrated a problem. At times, Dr. Yar displayed a communication style that was somewhat confrontational, with nurses in particular and, at times, with other medical staff. In general, such events were infrequent and, for the most part, of mild to moderate significance. None of these other issues were found to represent failure to meet the standard of practice of the profession, and would not reasonably be regarded by members as disgraceful, dishonourable or unprofessional conduct. The evidence of the College

experts, which followed the review of multiple charts and was supplemented by interviews, concluded that Dr. Yar did have some communication problems with nurses and medical staff. They recommended that Dr. Yar needed to improve her communication skills by means of remedial programs. The Committee agrees with the College experts. Dr. Yar indicated that she would be receptive to feedback. She has already participated in programs that have upgraded her communication skills.

The Committee finds Dr. Yar's records are generally satisfactory. She documented pertinent information in an appropriate fashion. Occasionally, the records were skimpy and her dictated notes were delayed. The Committee found that her records were within the accepted standard of practice for the profession.

The Committee regarded Dr. V, a colleague of Dr. Yar's, as a credible witness. She testified that she had no concerns with regard to Dr. Yar's communication skills, judgment or care. She confirmed that some of Dr. Yar's problems, as well as problems pertaining to two other physicians, were the result of the hospital administration. She informed the Committee that the CEO did not like women or doctors and that he could not be trusted. It was difficult to work with him. Following an independent investigation, he resigned. This information confirmed some of the previous testimony that Dr. Yar worked in a sometimes hostile environment.

Dr. U, psychiatrist, had testified that there was no dissatisfaction with Dr. Yar's patients who praised her care. Dr. Yar's office assistant testified that there were no communication problems with patients or the hospital.

The Committee regarded both of these witnesses as credible. This information further confirmed the Committee findings that the allegations with regard to Dr. Yar's communication skills were not proven to the requisite standard.

SUMMARY OF FINDINGS

In summary the Committee's findings are as follows:

Issue 1

The Committee finds that Dr. Yar committed an act of professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act 1991 (O.Reg 856/93) in that she failed to maintain the standard of practice of the profession in her contemplated use of thrombolytics in two cardiac patients, namely patient B and patient A.

The Committee finds that the allegation of incompetence regarding the use of thrombolytics in patients B and A is not proven.

The other allegations with regard to Dr. Yar's cardiac care were withdrawn. The allegation that Dr. Yar lacks skill and knowledge in intubation was also withdrawn after extensive evidence had been heard.

Issue 2

The Committee finds that the allegations of failing to meet the standard of practice, disgraceful, dishonourable or unprofessional conduct and/or incompetence pertaining to Dr. Yar's communication skills were not proven. Dr. Yar has some minor communication issues that were considered to be within the standard of practice of the profession. These should be remediable by means of communication programs and courses, some of which she has already completed.

The Committee accepts the evidence that Dr. Yar worked in a somewhat hostile environment, which undoubtedly contributed to some of the allegations and problems that occurred.

The Committee finds that Dr. Yar had insight and that she was anxious to maintain and improve her abilities. This was supported by the evidence that she had participated in multiple maintenance and upgrading programs, which included cardiac issues

encompassing the use of thrombolytics and communication issues over a period of at least the past five years.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Fatemeh Roya Yar, 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 subsection 45(3) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

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.

Indexed as : Yar (re)

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

IN THE MATTER OF a Hearing directed by the Executive Committee of the College of Physicians and Surgeons of Ontario, pursuant to Section 36(2) of the ***Health Professions Procedural Code***, being Schedule 2 to 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. FATEMEH ROYA YAR

PANEL MEMBERS: P. BEECHAM (CHAIR)
DR. O. KOFMAN
J. DHAWAN
DR. J. DOHERTY

Hearing Dates: July 10, 2006
November 22, 2006
March 12 & 13, 2007

Decision Date: March 13, 2007

Release of Written Reasons Date: April 25, 2007

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 September 19 to 23, November 7 to 11 and December 12 to 15, 2005. At the conclusion of the hearing, the Committee reserved its decision. On March 17, 2006, the Committee found that:

> Dr. Yar committed acts of professional misconduct, pursuant to paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act 1991*, in that she failed to maintain the standard of practice of the profession in her contemplated use of thrombolytics in two cardiac patients, namely Patient B and Patient A.

The Committee heard evidence and submissions on penalty on July 10 and November 22, 2006 and on March 12 and 13, 2007. On March 13, 2007, the Committee delivered its penalty order with written reasons to follow.

PUBLICATION BAN

On September 19, 2005, 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 subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

EVIDENCE AND SUBMISSIONS ON PENALTY

The penalty hearing was unusually prolonged and fragmented primarily because of issues related to the defence. These included two changes in defence counsel, as well as Dr. Yar representing herself for a portion of time. In addition, there was the introduction of written evidence by defence counsel without the required notice to College counsel, which resulted in further delay. There was also a request to reconsider the Committee's finding

Phase I

College counsel sought four elements as an appropriate penalty for Dr. Yar as follows:

1. Pre-approval prior to administration or ordering of thrombolytics, which was already in place pursuant to an order made pursuant to section 37 of the Code. Specifically, Dr. Yar is not to administer or order the administration of a thrombolytic to a patient unless there is prior approval by a physician who has been approved by the College. The requirement for pre-approval is to remain in place for twelve months, or until three such thrombolytic cases have been handled by Dr. Yar, which could entail a longer period.

2. Dr. Yar is to undergo a chart review of thrombolytic cases every three months by a supervisor who is approved by the College and who will report to the College quarterly.

3. Dr. Yar is to take an approved educational program with regard to the use of thrombolytics within six months. The educational program is to include the American College of Cardiology/American Heart Association Guidelines (ACC/AHA guidelines).

4. The penalty shall appear on the public register.

College counsel did not recommend a suspension as there had already been an order imposing a lengthy restriction with regard to emergency medicine practice, which was rescinded on April 11, 2006, and replaced by the current restriction regarding the administering or ordering of thrombolytics.

Defence counsel on November 22, 2006, submitted two extensive “Member’s Brief of Documents” as exhibits. In addition, he tendered an exhibit entitled “Member’s Filing of Medical Literature on Penalty Hearing”. This consisted of three articles that were published in medical journals between 1989 and 1998 and that apparently led Dr. Yar to contemplate the use of thrombolytics in the cases of Patient B and Patient A.

Defence counsel stated that he did not know why the articles were not introduced during the hearing as they may mitigate the conduct. Reference to the articles had been made on several occasions during the hearing, but they had not been specified or introduced into evidence during the hearing by the previous defence counsel.
College counsel objected to the introduction of these articles during the penalty hearing as the College had not had the opportunity to review them and to consider them with the advice and assistance of an expert. After receiving advice from independent counsel, the Committee allowed the articles to go into evidence through the testimony of Dr. Yar in the penalty phase only for the limited purposes of the penalty decision. The Committee agreed that College counsel should be able to challenge the evidence and, on this basis, College counsel's request for an adjournment was granted by the Committee.

Phase II

The penalty hearing resumed on November 22, 2006. Defence counsel called two character witnesses in support of Dr. Yar. They reiterated some of the background information pertaining to the administrative problems and shortage of doctors in their community, as several doctors had left the hospital. Dr. Yar testified and further confirmed some of the educational courses and programs that she had taken.

Defence counsel attempted to justify Dr. Yar's ordering of thrombolytics based on the influence of the three journal articles that had been entered into evidence. The three articles were reviewed. The ISIS-2 Trial article that was reported in 1998 stated that in terms of eligibility, ECG changes at entry were not a requirement of the study. However, it was noted by College counsel that this study encompassed a period from 1985 to 1987 and was not consistent with the current guidelines.

Defence counsel referred to the ACC/AHA guidelines published in 2004. The preamble states, "The ultimate judgment regarding care of a particular patient must be made by the health care provider and patient in light of all the circumstances presented by that patient. There are circumstances where deviations from these guidelines are appropriate."

College counsel submitted that the articles were old and were not relevant as they did not conform to the current guidelines. Therefore, they did not justify Dr. Yar's decision.

Dr. Yar testified that she was not saying that the articles justified ordering thrombolytics, rather, they justified thinking and considering whether thrombolytics should be given if the criteria are met. She had previously testified that she never deviated from the hospital protocol and always followed the current guidelines. This was not consistent with the Committee's findings. She agreed that there was no indication for ordering thrombolytics other than within the established criteria. Dr. Yar clearly exhibited her awareness of the established criteria.

Defence counsel requested a further adjournment to arrange for additional witnesses, which was granted.

Phase III

The penalty hearing resumed on March 12 and 13, 2007. On this occasion, new defence counsel appeared on behalf of Dr. Yar. Dr. Yar, through counsel, requested that she be allowed to examine witnesses herself with respect to technical medical testimony during this portion of the hearing. Her counsel supported this request on the basis that he had limited knowledge of the technical medical matters and had only recently been retained. The Committee permitted Dr. Yar to participate directly in this limited capacity.

College counsel at this stage did not provide additional evidence, but indicated that evidence may be presented in reply. Two physicians were called as witnesses for the defence and both were accepted by the Committee as experts. They submitted written reports and gave testimony.

Dr. R reviewed the three published articles on the use of thrombolytics that had previously been filed as an exhibit. They had been published in 1989, 1998 and 1997. Dr. R testified that the guidelines have changed between 1998 and 2004. He acknowledged that, although thrombolytics should be considered and contemplated, the

current guidelines do not recommend their use in acute coronary syndrome without established criteria, including ST elevation. Dr. Yar referred Dr. R to the ISIS-2 study performed in 1985 to 1987. During this study on the use of thrombolytics, ECG changes were not a requirement. Dr. R indicated that these guidelines had changed between the 10 year survival study, which was published in 1998, and the 2004 guidelines.

Dr. BB, who was accepted by the Committee as an expert in cardiology, had reviewed the same three articles. He considered it reasonable to contemplate the use of thrombolytics without ST elevation but, according to the 2004 criteria, they should not be administered without ST elevation.

In reply evidence for the College, Dr. Y submitted a report pertaining to the three journal articles and testified with reference to them. He testified that the articles were either out of date or did not address the question of who should receive thrombolytic therapy. He concluded that the three articles provided by Dr. Yar did not support her suggestion that thrombolysis was justified in the cases of Patient B and Patient A. Once again, Dr. Yar referred to the 1998 ISIS-2 study with regard to her intention of ordering thrombolytics.

The Committee unanimously concluded that the evidence provided in the three journal articles did not change or influence the findings with respect to Dr. Yar's contemplation and attempts to order thrombolytics in patients Patient B and Patient A.

Counsel for Dr. Yar requested that the Committee reconsider its findings based on what counsel regarded as differences between the body of the reasons and the summary of those reasons. Defence counsel submitted that Dr. Yar was being penalized for merely contemplating the use of thrombolytics.

Counsel for the College correctly noted that the Committee had to first determine whether it had the power to reconsider its findings and, if so, whether this was an appropriate case in which to exercise such a power. College counsel argued that if a decision could be reopened there would be no finality. She submitted that section 70 of

the Code is very broad and allows for full appeal of the decision to the Divisional Court and that, in these circumstances, the decision should not be reconsidered. College counsel also noted that, in any event, the findings should be considered as a whole and that, in this case, they were appropriately described on pages 10 and 12 of the Decision and Reasons for Decision.

On this basis, the Committee disagrees that there is any discrepancy or ambiguity in its reasons. Dr. Yar not only contemplated the use of thrombolytics, she intended to order them.

Therefore, the Committee did not consider that it was necessary to decide whether it had the power to reconsider in view of the fact that, even if it did have that power, it would not be justified to exercise it in this case.

PENALTY AND REASONS ON PENALTY

The Committee acknowledged that Dr. Yar's attempted use of thrombolytics was well intended but it was dangerous and the patients were put at risk. All of the physicians, with one exception, which included defence experts during the main hearing and the penalty hearing, agreed that thrombolytics should not be given in the absence of the specified criteria, which included ST elevation or LBBB (left bundle branch block) and clinical symptoms. The Committee accepted the evidence that the three journal articles were old and did not conform to the 2004 criteria. The Committee concluded that Dr. Yar's position with regard to the three articles was inconsistent and indicated a lack of insight as well as a lack of acknowledgement of the findings of the Committee. This conclusion was supported by her repeated reference to the ISIS-2 study as some justification of her intended use of thrombolytics without the criteria of ECG changes. This lack of insight and her lack of acceptance of the findings was also clearly demonstrated by Dr. Yar's unusual request in the penalty phase for the Committee to reconsider, and essentially reverse, its findings.

For these reasons, the Committee agreed with the approach in the College's proposed order that included a restrictive component, a monitoring component, as well as an educational component. Although Dr. Yar had already taken remedial courses and was aware of the established criteria pertaining to the use of thrombolytics, she clearly had not fully accepted the current guidelines. The Committee also agreed that Dr. Yar should pay costs for unnecessary delay during the penalty phase of the hearing, which resulted in two adjournments. In addition, the costs would include the preparation of a report and appearance of an additional witness for the College that was necessary in the penalty phase as a result of the changes that were encountered. The Committee also accepted that there was no need for a suspension as Dr. Yar had already had lengthy restrictions on her practice that went well beyond restricting just the administration of thrombolytics. In addition, there were mitigating factors in that Dr. Yar essentially had very good credentials and had practised in a hostile environment. The Committee was of the opinion that a suitable penalty should serve the purpose of protecting the public and also act as a deterrent to other physicians who would deviate from the accepted guidelines.

ORDER

Therefore, the Discipline Committee ordered and directed that:

1. The Registrar impose a term, condition and limitation on the certificate of registration of Dr. Fatemah Roya Yar that she shall not administer or order the administration of a thrombolytic to a patient, unless she obtains the prior approval of a physician who has been approved by the College. This approval requirement will remain in place for a minimum of twelve (12) months or, if after twelve (12) months Dr. Yar has not handled three (3) cases where thrombolytics were properly administered, until she has handled three (3) such cases.

2. The Registrar impose a term, condition and limitation on the certificate of registration of Dr. Fatemah Roya Yar that Dr. Yar be required to undergo a chart review of cases involving thrombolytics that she handles during the time paragraph [1] is in effect, with the supervisor who is responsible for approving her

use of thrombolytics every three (3) months. In the chart review, the supervisor will review the charts, discuss the cases with Dr. Yar, and discuss her knowledge with respect to thrombolytics. The supervisor is required to submit reports to the College quarterly.

3. The Registrar impose a term, condition and limitation on the certificate of registration of Dr. Fatemah Roya Yar that Dr. Yar is required to engage in a course of self-study of the American College of Cardiology/American Heart Association Guidelines for Management of Patients with ST-Elevation Myocardial Infarction (2004), and the American College of Cardiology/American Heart Association 2002 Guideline Update for the Management of Patients with Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction, prepare a report on those guidelines with respect to the use of thrombolytics, and engage in a follow-up discussion of the guidelines with the supervisor referred to in paragraph [1]. The supervisor shall report to the College that the course of self-study has been satisfactorily completed. This educational program shall be completed within six months of the date the penalty is imposed.

4. Dr. Yar pay to the College costs in the amount of $9,765.00 within six (6) months of the date of the Order.

5. The results of this proceeding be included in the register.