Indexed as: Vaidyanathan (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 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. SANKAR VAIDYANATHAN

PANEL MEMBERS: J. MARTEL (CHAIR)
DR. J. THOMPSON
DR. P. NOBLE
DR. B. GIBLON
P. BEECHAM

Hearing Dates: August 15 – 18, 2001
September 7 & 8, 2001

Decision/Released Date: September 8, 2001

Penalty Decision/Released Date: November 8, 2001

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

This matter was heard by the Discipline Committee of the College of Physicians and Surgeons of Ontario in Toronto on August 15 - 18, 2001, and on September 7 and 8, 2001. The Committee found Dr. Vaidyanathan guilty of the allegations in the Notice of Hearing and issued a penalty decision on November 8, 2001. These Reasons supplement that earlier Decision, the particulars of which are set out at page 32, and following, below.

PUBLICATION BAN

At the commencement of the hearing, the Committee ordered a publication ban prohibiting the publication of the names of the complainants/witnesses, and any information which could lead to their identification under section 47 of the *Health Profession Procedural Code* ("the Code"). The Committee also ordered a publication ban prohibiting publication of personal matters concerning Dr. Vaidyanathan under section 45(3) of the Code.

ALLEGATIONS:

It was alleged that Dr. Vaidyanathan committed an act of professional misconduct

1. under paragraph 1(1)3 of Ontario Regulation 856/93("O.Reg 856/93") made under the *Medicine Act, 1991*, in that he failed to maintain the standard of practice of the profession;

2. under subsection 1(1)16 of O/Reg.856/33, in that he falsified a record relating to his practice; and,

3. under paragraph 1(1)33 of O/Reg. 856/93, in that he committed an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional.

It was further alleged that Dr. Vaidyanathan is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the "Code"), which is schedule 2 to the *Regulated Health Professions Act, 1991,* in that his care of a patient displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates that he is unfit to continue practice or that his practice should be restricted.

PLEA

At the beginning of the hearing, Dr. Vaidyanathan pleaded guilty to allegation #2 in the Notice of Hearing. Dr. Vaidyanathan initially entered a plea of not guilty with respect to allegation #1, allegation #3, and the allegation of incompetence in the Notice of Hearing. However, towards the end of the case for the defence, and presumably by reason of Dr. Vaidyanathan's refusal to take the stand to be cross-examined, Dr. Vaidyanathan changed his plea to "no contest" with respect to allegations #1 and #3 in the Notice of Hearing. Thereafter, the only remaining issue concerned the allegation of incompetence, and the hearing proceeded on that issue alone.

THE CASE FOR THE COLLEGE

DR. NATHAN ROTH

With the consent of the defence, Dr. Roth was qualified and accepted as an expert to give opinion evidence in Obstetrics and Gynaecology.

At the request of the College, Dr. Roth prepared a report dated June 26, 2001, in which he considered 26 cases chosen jointly by the hospital **(**Humber**)** and the College. Dr. Roth also relied on interviews conducted with hospital staff physicians and nurses when preparing his report. While Dr. Roth considered all of the information available, he indicated that he relied predominantly on Dr. Vaidyanathan's office and hospital charts. He also indicated that he based his opinions on the expected standard of practice applicable to an average community clinician. Dr. Roth then reviewed the following cases:

i) PATIENT 1

This patient had a previous caesarean section (C-section) in 1999 and the chart, at that date, disclosed a diagnosis of cephalopelvic disproportion (CPD). During the subsequent pregnancy, the treatment of which was the subject of this hearing, the patient was admitted to hospital on September 7, 2000 with spontaneous rupture of membranes at 34 weeks of gestational age. She was seen by another physician who put her on Celestone (to help mature lungs) and antibiotics (to prevent possible infection due to the broken membranes).

The patient was seen a few days later by Dr. Vaidyanathan and discharged on September 13th to be followed with bi-weekly Non Stress Tests (NST) and CBC's (Complete Blood Counts). Another NST was done on September 15th.

The patient saw Dr. Vaidyanathan again on September 18th, at which time the NST was "non-reassuring" (according to Dr. Roth and the Obstetrical Review Panel), and the patient indicated that the baby's movements had "slowed down". The records do not indicate any discussion of expectant management versus active management (i.e., induction) at that time, nor any discussion with the patient on how to monitor fetal activity. The patient was discharged, and returned on September 22nd for the next NST, when the baby was found to be deceased.

Dr. Vaidyanathan used prostaglandin gel to help stimulate labour, despite the prior diagnosis of CPD in the chart. Dr. Roth opined that CPD would be a contraindication for attempting to perform a vaginal delivery. Following an unsuccessful vaginal delivery, the baby was eventually delivered by C-section.

In formulating his opinion, Dr. Roth also referred to the autopsy report, as well as to the Obstetrical Care Review Committee's Report. He agreed with the conclusion of that committee, that plans should have been made on September 18, 2000, for delivery because of the patient's increased white blood cell count and the non-reassuring NST.

Dr. Roth also stated that with the presentation at 34 weeks with ruptured membranes and an ultrasound which estimated the baby's weight at 8 pounds 8 ounces, he might reasonably have concluded that either the estimated date of confinement (EDC) was wrong or that the ultrasound was wrong. Dr Roth was of the view that these facts, coupled with the decelerations seen in the NST on September 18th, suggested that Dr. Vaidyanathan should have taken a more aggressive approach to the management of this patient.

Additionally, there is no indication that there was any discussion with the patient of keeping track of fetal activity, fever, and abnormal discharge. Dr. Roth stated that the patient was inadequately monitored, and, after September 18th, the patient should have been brought back within a day or two for a repeat NST and further investigations, such as a biophysical profile. He indicated that this fetal death was preventable, that the documentation was inadequate, and that the patient wasn't made part of the decision whether the pregnancy should continue.

In summary, in reviewing this case, Dr. Roth's opinion was that Dr. Vaidyanathan demonstrated a lack of knowledge, skill and judgment, or regard for the patient's welfare. On a scale of 1 to 10, with 1 being the poorest and 10 being the best, Dr. Roth assigned Dr. Vaidyanathan a grade of 1 out of 10.

ii) PATIENT 2

This patient was a 29-year-old female with a history of premature labour and expected date of confinement of November 19, 1998. A second trimester ultrasound had revealed an intra-uterine pregnancy. On September 22, 1998 she saw Dr. Vaidyanathan with a complaint of decreased fetal movement. Dr. Vaidyanathan did a portable ultrasound which was described as normal, but no biophysical profile was carried out.

On September 30, 1998, at 33 weeks gestation, she attended the hospital complaining again of decreased fetal movement, and an ultrasound subsequently confirmed fetal death. Later that evening, in order to induce the delivery of the dead fetus, the patient

was started on misoprostol. Misoprostol is a drug normally used for the treatment of duodenal ulcers, but was used in many centres for the "off-label" purpose of inducing labor. One of the known side effects of using misoprostol in this fashion is the risk of uterine hyperstimulation and possible uterine rupture.

No misoprostol protocol was in place at the hospital, and the nurses, according to their interviews with Dr. Roth, were completely unfamiliar with this medication. At 22:00 hours the patient was contracting every 2 minutes, while the norm should have been every 3 to 5 minutes. On October 1, 2001, from 00:30 hours onwards, the patient had faint blood pressure, her heart rate was elevated, she complained of chest pain, she was clammy and tachycardic. Dr. Vaidyanathan was called, came to the hospital, and assessed the patient at 01:20. The nurses were very concerned and expressed their concerns to Dr. Vaidyanathan on many occasions between then and 06:15. They continued having difficulty obtaining the patient's blood pressure, her pulse remained rapid, and there was no improvement in her signs and symptoms. At 06:15, Dr. Vaidyanathan called for a medical consultation, the internist was located, assessed the patient, and determined that she was in shock.

At some point thereafter, the patient was transferred to ICU, and an epidural was ordered. Dr. Roth expressed the concern that a side effect of epidurals is that it will lower blood pressure, which would aggravate the situation because the blood pressure was already quite low. The patient was taken for an ultrasound between 09:00 and 10:00, the results of which reflected an extra uterine pregnancy. The patient was eventually taken to the operating room at 14:25 hours for a laparotomy. She was found to have a ruptured uterus, which was repaired successfully.

In summary, when the patient first presented on September 22nd with the complaint of decreased fetal movement, Dr. Roth opined that more investigations should have been done, i.e. biophysical profile and a NST. Additionally, on September 30th, after fetal death was discerned, misoprostol was ordered even though there was no protocol in place

at the hospital for its use and the nurses were unfamiliar with this drug. Informed consent, if given, about the risks of this drug, was not documented.

Dr. Roth testified that he would not have used misoprostol in this situation. He would have used an intravenous medication to induce labour. He also would not have allowed this critically ill patient to be transported to ultrasound, but would have ordered a portable ultrasound. As well, he would have advised the O.R. (Operating Room) of the severity of the situation, in order to get an earlier time for the C-section. He stated that there was nothing in the record to indicate that Dr. Vaidyanathan tried to arrange an earlier time with the O.R. Dr. Roth also noted that there was no informed consent for the use of misoprostol; no record to indicate discussion of the risks of uterine hyperstimulation and uterine rupture; and no record that the patient had been told that this was the first time this off-label medication had been used in the hospital to induce labour.

Dr. Roth was also of the view that the nurses' concerns in the early morning of October 1st were not heeded and that the patient was not adequately assessed. The missed diagnosis of a ruptured uterus was of particular concern, especially given Dr. Roth's opinion that the previous ultrasound (confirming intra-uterine pregnancy) and the new ultrasound (indicating an abdominal pregnancy) should have alerted Dr. Vaidyanathan to the possibility of a uterine rupture. Lastly, Dr. Roth was of the view that Dr. Vaidyanathan should have managed the case with much more urgency and taken steps to accelerate the care of this patient, and move her to the operating room.

On a scale of 1 to 10, Dr. Roth again assigned Dr. Vaidyanathan a 1. He found that Dr. Vaidyanathan displayed a lack of knowledge, skill, and judgment or regard for this patient's welfare.

iii) PATIENT 3

This patient was a 37-year-old female with an expected date of confinement of July 24, 2000. The patient was admitted to hospital on April 10, 2000 at 23:00 hours, with spontaneous ruptured membranes, but was not in labour. At the time, she was estimated

to be approximately at 25 weeks gestation. When the patient eventually delivered the baby; the baby weighed only 800 grams and subsequently died.

Dr. Vaidyanathan charted an unsuccessful attempt to transfer the patient to a high-risk unit. He also charted that he ordered Celestone and Ampicilin for the patient. Dr. Vaidyanathan later admitted that neither of these charting entries was accurate, and that neither actually occurred. He therefore admitted that he falsified the medical record.

Dr. Roth had significant concerns with this case. First, the failure to transfer the mother prior to the onset of labour (and with the baby still in utero) was a major error. He opined that at 25 weeks gestation, the baby might, and likely would, have had a better chance of survival if it had been delivered in a tertiary care centre. Dr. Roth also estimated that by his calculations the baby could have had a gestational age of 26 and 4/7th weeks, instead of the 23 to 25 weeks estimated by Dr. Vaidyanathan.

Second, the failure to actually order steroids and antibiotics was another major concern.

Third, the admitted falsification of the records with respect to both the misleading drug orders and the alleged attempt to transfer the patient was completely unacceptable. It again demonstrated a lack of knowledge, skill and judgment and/or regard for the welfare of the patient.

On a scale of 1 to 10, Dr. Roth assigned Dr. Vaidyanathan a score of 1.

iv) PATIENT 4

This was a 45-year-old patient with a history of hypertension and an expected date of confinement of October 10, 1999 who presented at the hospital on September 5, 1999. She was at 35 weeks gestation, and had severe pregnancy-induced hypertension. The baby, a stillbirth, was delivered at 22:20 hours. The obstetrician on call ordered anti-hypertensives and magnesium sulphate to reduce the risk of seizures. The magnesium sulphate was first given at 00:30 hours on September 6, 1999.

At 08:25 on September 6, Dr. Vaidyanathan gave a verbal order for the magnesium sulphate to be stopped. According to the hospital chart, Dr. Vaidyanathan did not assess the patient prior to giving that order. The Chief of Staff, when notified of this situation, overruled the "stop order", and the magnesium sulphate was restarted.

Dr. Roth was concerned by the fact the that this patient was not adequately assessed prior to Dr. Vaidyanathan giving the order to discontinue the magnesium sulphate at 08:25 hours, especially given the fact that this was less than 8 hours after the drug was started. The usual protocol is to continue magnesium sulphate for 24 hours and then to reduce the dosage if indicated. Dr. Roth also expressed concern that any attempt to change an order made by another physician should be well documented with the reasons for the decision being fully articulated. Dr. Roth also of the view that if a physician considered it appropriate to discontinue an order given by someone else, the decision should be discussed with the other physician if possible, discussed with the patient, and then properly documented. Dr. Vaidyanathan took none of these steps.

In this case, Dr. Roth assigned Dr. Vaidyanathan a score of 4 out of 10.

v) PATIENT 5

This 26-year-old patient was admitted to the hospital for termination of pregnancy on September 13, 2000. A D&C (Dilation and Curettage) was carried out, the patient was counselled and had previously agreed to having an IUD (Intra Uterine Device) inserted. While on the operating table, she changed her mind about having an IUD, and was counselled by Dr. Vaidyanathan as to the choices for her contraceptive needs.

The concern of Dr. Roth with the treatment of this patient was that Dr. Vaidyanathan provided contraceptive counselling while the patient was on the operating table. A more reasonable approach would have been to set up an office appointment to discuss contraceptive options. Nonetheless, in this case, Dr. Roth opined that the management of this patient, while not entirely acceptable, met the standard of care.

vi) LACK OF DOCUMENTATION

Of the 26 cases reviewed, Dr. Roth expressed concern that the following 16 cases lacked proper or complete documentation: Patients 1, 6, 7, 8, 2, 9, 5, 10, 11, 12, 13, 4, 14, 15, 16, 17.

SUMMARY OF DR. ROTH'S EVIDENCE

The committee found Dr. Roth's evidence to be clear, helpful, and well-reasoned. Dr. Roth presented as a very credible witness, and the committee did not find any reason to discredit his evidence. He was thorough, well prepared, and articulated his views clearly and concisely in both his examination-in-chief and cross-examination. He exhibited a sense of fairness, indicating both when Dr. Vaidyanathan met the standard and when he did not. When he could not remember specific details, he said so. His opinions were expressed based on his knowledge of Dr. Vaidyanathan's type of community practice. The committee, therefore, accepted his expert opinion, and gave his testimony considerable weight. Based on that testimony, the Committee accepted that Dr. Vaidyanathan's care demonstrated:

1) consistent substandard documentation in the 16 cases referred to above;
2) a failure to obtain informed consent (Patient 1 and Patient 2);
3) the use of misoprostol without any protocol in place at the hospital (Patient 2);
4) the falsification of documents (Patient 3);
5) the discontinuance of a prescribed drug without adequate consultation or assessment (Patient 4);
6) the failure to recognize uterine rupture and the failure to provide adequate and timely treatment (Patient 2); and
7) the lack of knowledge in the management of patients with premature rupture of membranes and decreased fetal movement (Patient 1 and Patient 3).

Additionally, in the case of 4 patients (1, 2, 3, and 4), Dr. Roth opined that Dr. Vaidyanathan's treatment fell below the standard of care. In three of those cases (1, 2,

and 3), Dr. Vaidyanathan's care displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patient.

PATIENT 1

In addition to reviewing the chart of this patient, Patient 1 testified at the hearing. She testified that she had encountered some complications with the delivery of her first child, when her water broke early. She also testified that she had no complaint in regards to the care surrounding that delivery, and that she returned to Dr. Vaidyanathan for her care during her subsequent pregnancy. She testified that Dr. Vaidyanathan had told her that most likely she would have a C-section, as she had previously delivered by C-section.

She testified that when Dr. Vaidyanathan saw her at discharge on September 13th, he did not explain the risk of infection that might occur with the premature rupture of membranes. He only told her to attend for NST's on Mondays and Fridays, and to return to the hospital if she had a fever, if the discharge changed, or if she had concerns with respect to reduced fetal movement.

When she returned on September 18th, she told the nurse that the baby's movement had slowed down. She told Dr. Vaidyanathan that she wanted a C-section that same day, but Dr. Vaidyanathan said the baby was okay and that she could have a C-section on September 25th. She also testified that she did not ask for a vaginal delivery

When she returned on September 22nd, she told the staff that she hadn't felt the baby's movement since the previous evening. When the baby was found to have died in utero, she was asked to return the next day for delivery, but insisted on delivery that day. The attempt was made for her to deliver vaginally, but the attempt was unsuccessful, and she was ultimately taken to the O.R. for a C-section.

The committee found Patient 1 to be credible. She stated only what she remembered, and she was candid and forthright.

THE CASE FOR THE DEFENCE

DR. BERNSTEIN

With the consent of the prosecution, Dr. Bernstein was qualified and accepted to provide opinion evidence in Obstetrics and Gynaecology.

Dr. Bernstein reviewed both the hospital and office records, and prepared a report dated August 13, 2001. That report, as well as a previous report dated November 14, 2000, were entered as an exhibits.

i) PATIENT 1

Dr. Bernstein reviewed the facts of this case, and opined that kick counts are not necessarily used to monitor fetal activity. His preference was to have patients monitor any change in the amount of activity, to discuss this change with patients, and to determine how the change is perceived by the mother. He agreed that it was proper to discharge the patient on September 13th, provided the physician and patient had discussed expectant management versus induction.

With respect to the NST done on September 18th, Dr. Bernstein was of the view that this was a reactive (i.e., normal) NST, and that he would have asked the mother to return in three days. He did not see any need to induce labour. He also thought the attempted vaginal delivery of the dead baby on September 22nd, met the standard of care, even though there had been a previous diagnosis of CPD.

Under cross-examination, Dr. Bernstein agreed that a physician should explain the effect of ruptured membranes to a patient, how the patient is to be observed, and when the delivery might occur. While he disagreed with Dr. Roth's interpretation that the NST was non-reassuring, he did admit that some of the decelerations were "*probably caused by mild cord compression*". He also went on to say that aspects of the NST were *"non-reassuring, but …that parts …were very reassuring"*. Despite these admissions, Dr. Bernstein still maintained his disagreement with both Dr. Roth and the Obstetrical Care Review Committee.

Dr. Bernstein therefore would have sent the patient home on September 18th, but with clear instructions to the patient to monitor fetal activity. In his opinion, failure to give appropriate instructions at that time would not meet the standard. Additionally, when asked what he would have done if the patient had come in on September 18th, with the complaint about decreased fetal activity, Dr. Bernstein indicated that he "*might have increased the frequency of the NST and perhaps kept her in the hospital*". He therefore agreed with the proposition that, under those circumstances, sending the patient home without further investigation would not meet the standard.

ii) **PATIENT 2**

When Patient 2 initially presented with concerns of decreased fetal movement, Dr. Bernstein testified that he had no concern with Dr. Vaidyanathan not having done a biophysical profile. Additionally, when the patient returned on September 30th, and fetal death was discovered, he had no concern with Dr. Vaidyanathan administering a 200 mcg dose of misoprostol to induce labour.

However, when asked about the necessity of appropriate training for nurses on the use of the drug, and assuming that the nurses had not received such training, Dr. Bernstein admitted that the use of the drug under these circumstances *" would not be the ideal thing"*. He also conceded that Dr. Vaidyanathan should have at least alerted the nurses on the ward on how the use of the drug and its potential risks.

When questioned as to whether a patient has a right to know about the nature of the drug, its potential side effects, its off-label use, and the lack of hospital policy, Dr. Bernstein initially agreed that such information should be provided to the patient. However, he later seemed to qualify his answer by stating that the risk of uterine rupture was "*very, very rare*", and that while it would be fair to indicate to the patient the choices that were available, it would be "*stretching the standard*" to go into a whole lot of detail.

Insofar as the overall care of the patient was concerned, Dr. Bernstein was asked if he agreed with Dr. Roth's conclusion that the nurse's concerns over the patient's clinical status were not adequately addressed. While Dr. Bernstein initially thought *"they were addressed"*, he later agreed (after being taken through the nursing notes) that of this patient, the nurse's concerns were not adequately addressed.

Dr. Bernstein agreed that there had been a delay in the management of this patient, and that the final outcome was fortunate. He also agreed that: in view of the previous ultrasound; the new ultrasound; the 2-minute contractions; the clamminess of the patient; the fast heart rate; the low, variable, and difficult to find blood pressure; and the use of misoprostol, that the most likely diagnosis would be a uterine rupture. He also agreed that the delayed diagnosis of a ruptured uterus was an error in judgment.

iii) PATIENT 4

In his testimony in regards to this patient (who had been put on magnesium sulfate by another physician at 0030), Dr. Bernstein was of the view that Dr. Vaidyanathan met the standard of care in discontinuing the order at 0825. He based this opinion on the assumption that Dr. Vaidyanathan had spoken to the nurse and considered the patient's condition as recorded in the chart, as well as other assumptions. However, the assumptions upon which Dr. Bernstein relied in reaching his opinion were not proven, due to Dr. Vaidyanathan's failure to testify and to be cross-examined. Dr. Bernstein's opinion, therefore, was of little assistance.

Dr. Bernstein also had difficulty explaining the discrepancies between his two reports, stating (in the first report) that the medication had been discontinued earlier than normal, and stating (in the second report) that he had no difficulty with the decision to stop the medication after 12 hours. He agreed that magnesium sulfate was traditionally left on for 24 hours, and that not assessing an acutely ill patient prior to changing the patient's management fell below the standard of practice.

iv) PATIENT 3

Dr. Bernstein opined that a physician can take some time to assess a patient who presents with premature ruptured membranes at 24/25 weeks, and is not in active labour. He indicated that the standard is at least to give steroid injections, and that the use of antibiotics is controversial. He also considered the delay in making the call to the tertiary centre "*an error in judgment"*, although he didn't believe it amounted to incompetence.

He testified that a tertiary care centre would have been better equipped to deal with the birth of a baby of that age, and that it would be the standard to attempt to transfer the mother and baby prior to the onset of labour. After some questioning, Dr. Bernstein did eventually agree that *"the baby might well have survived had she been in a level 3 centre*", which is contrary to his report of August 2001, which stated: "*nothing he did or failed to do affected the outcome".*

v) PATIENT 5

Dr. Bernstein agreed that it wasn't ideal to give this patient birth control counselling while in the OR. Nonetheless, he was of the view that such counselling met the standard of care.

vi) DR. BERNSTEIN'S REPORT DATED MAY 28, 2001

In addition to Dr. Bernstein's reports dated November 14, 2000 and August 13, 2001, Defence counsel sought to introduce another report prepared by Dr. Bernstein dated May 28, 2001.

The Committee admitted the report in which Dr. Bernstein considered and additional fourteen patient charts.

Dr. Bernstein opined that in all fourteen cases Dr. Vaidyanathan met the standard of practice, and he concluded that these cases demonstrated Dr. Vaidyanathan's competence. He also concluded that the mentoring of Dr. Vaidyanathan's practice (discussed below) had been successful.

CROSS-EXAMINATION OF DR. BERNSTEIN

i) 14 CASES ASSESSED

In cross-examination, Dr. Bernstein admitted that the fourteen cases referred to in his report dated May 28, 2001, were all picked by Dr. Vaidyanathan. He further admitted that he didn't know if the cases were picked to demonstrate only the best aspects of Dr. Vaidyanathan's care. He also agreed that his opinion of Dr. Vaidyanathan no longer needing a mentor was based on his review of those fourteen cases.

ii) DOCUMENTATION

Dr. Bernstein agreed with the proposition that proper to documentation is important. He also agreed a lack of information on a record could be detrimental to a patient's welfare. He also agreed that falsifying a patient record is a very serious matter, and could, "*under certain extreme circumstances*"; endanger a patient's life. He stated quite clearly that no matter what the circumstances, it is inexcusable to falsify a patient's chart.

When the proposition was put to him that Dr. Vaidyanathan lied to Dr. A. (concerning the alleged attempt to transfer Patient 3 to a tertiary care centre), Dr. Bernstein agreed that such conduct was unprofessional, unacceptable, and fell below the standard. When asked, however, if the falsification of a record showed a disregard for the welfare of the patient, Dr. Bernstein disagreed. He eventually stated that it showed a *"lack of regard*" for the welfare of the patient.

Although Dr. Bernstein was clearly very knowledgeable, the committee found Dr. Bernstein's explanations convoluted and somewhat evasive. He tended to rationalize events to an extent that the Committee did not consider him to be objective. When comparing his two reports (November, 2000 and August, 2001), the Committee found too many instances where they differed in such a way as to put in issue his objectivity. While the Committee does not consider it necessary to list all of the inconsistencies, a number of obvious inconsistencies are as follows:

a) In the case of Patient 2, Dr. Bernstein initially found that Dr. Vaidyanathan's care displayed "a delay in management". He characterized the situation as "an acute problem" in which Dr. Vaidyanathan was not " sufficiently aggressive in his initial management". He considered the final outcome to be "fortunate". However, in his later report, Dr. Bernstein does not refer to any of these problems, and he merely concludes that the delayed diagnosis of a ruptured uterus amounted to "an error in judgment".

b) In the case of Patient 4, Dr. Bernstein initially found that the medication "was discontinued earlier than advisable". He also found that other medical aspects of the case "did not receive appropriate concern from Dr. Vaidyanathan". However, in his later report, he does not express any concern with the care provided by Dr. Vaidyanathan and he had "no difficulty with the decision to stop the MGS04 after 12 hours".

c) In the case of Patient 3, Dr. Bernstein initially found that Dr. Vaidyanathan "made no attempt to transfer the patient to a Level III Centre" and he concluded that Dr. Vaidyanathan "did not demonstrate enough concern for the situation". However, in his later report, Dr. Bernstein is not critical of Dr. Vaidyanathan's care, and he attempts to excuse Dr. Vaidyanathan's decision to delay the call.

The Committee was also disturbed by instances of semantics. For example, the difference between "disregard for the welfare of the patient" and Dr. Bernstein's preference "lack of regard for the welfare of the patient". Dr. Bernstein also tended to accept Dr. Vaidyanathan's explanations, giving more weight to Dr. Vaidyanathan's explanations than to the record. This resulted in the Committee attributing less weight to Dr. Bernstein's testimony. Aside from an apparent lack of objectivity, many of Dr.

Vaidyanathan's explanations were not proven, and there was therefore no foundation for Dr. Bernstein's preference for Dr. Vaidyanathan's explanations.

The Committee therefore preferred the testimony of Dr. Roth where it differed from that of Dr. Bernstein. The only exception to this finding concerns the issue of kick counts, where the Committee accepts as more reasonable Dr. Bernstein's opinion that kick counts are not necessarily the standard, but only one of the methods of monitoring fetal activity.

DR. LIVINGSTONE

With consent of the prosecution, Dr. Livingstone was qualified and accepted to give opinion evidence in Obstetrics and Gynaecology, and particularly with respect to the competence of an obstetrician/gynaecologist.

Dr. Livingstone met with Dr. Vaidyanathan, over the course of 1.5 hours, to assess Dr. Vaidyanathan's knowledge base. He asked some general knowledge questions, as well as specific questions in the areas of uterine rupture, premature rupture of membranes and the prevention and management of intrauterine deaths. He opined that Dr. Vaidyanathan "*did not show any deficiencies which would constitute a danger to the public"*, and that if the examination had been for the purpose of fellowship certification in obstetrics and gynaecology, he would have received a passing grade.

Under cross-examination, Dr. Livingstone indicated that he had read Dr. Roth's report, as well as the comments of Dr. Bernstein, but that he had not gone over the charts pertaining to the cases at issue in these proceedings. The examination of Dr. Vaidyanathan was conducted in a departmental office, and while scenarios were put to Dr. Vaidyanathan, no actual patients were examined. He also agreed that, while a physician might be able to deal with a hypothetical situation, the physician might or might not be able to deal with a real life situation with the same good judgment.

The Committee accepted that Dr. Vaidyanathan passed a test assessing his competence (on the day that Dr. Livingstone assessed him), but it questioned the weight to be assigned to the examination, as more particularly set out below.

DR. ISTBAN

Dr. Istban works at the Church Street site of the Humber hospital. Even though Dr. Istban provided fact evidence, with consent of the prosecution, Dr. Istban was also qualified as an expert to give opinion evidence in the area of Obstetrics and Gynaecology.

Dr. Istban prepared a report in regard to his mentorship of Dr. Vaidyanathan from January, 2001. He indicated that the mentors were asked to give a second opinion on all elective surgical cases, with some exceptions, and also to give second opinions on inducing labour, or interventing during a normal vaginal delivery. Overall, Dr. Istban assisted on a total of some twenty cases, and he opined that in all of those cases, Dr. Vaidyanathan met the standard of practice, and that the indications for surgery were correct.

During cross-examination, Dr. Istban confirmed that he had not reviewed any of the cases at issue in the hearing, nor reviewed Dr. Roth's report. While finding Dr. Vaidyanathan to be a competent obstetrician and gynaecologist, Dr. Istban noted that he "*appears to have an extremely busy practice, and that this may be affecting his judgment in some cases which would more appropriately be treated in a tertiary care unit*".

The Committee accepted Dr. Istban's evidence as being credible, and comments on the weight to be assigned to his evidence below.

DR. WONG

Dr. Wong practices at the Church Street site of the Humber hospital. Dr. Wong provided fact evidence, and with the consent of the prosecution, he was also qualified and accepted to give expert opinion evidence in connection with the competency of an obstetrician/gynaecologist.

Like Dr. Istban, Dr. Wong had also been asked to serve as one of Dr. Vaidyanathan's mentors, starting in January 2001. In terms of Dr. Vaidyanathan's technical (surgical) skill level, he considered his skill to be "*comparable to the other members of the department."* He believed that Dr. Vaidyanathan was capable of operating independently, and that he had a very sound knowledge base. He considered Dr. Vaidyanathan to be a competent obstetrician/gynaecologist.

During cross-examination, the prosecution referred to Dr. Wong's report dated July 24, 2001. That report noted that Dr. Vaidyanathan 's decisions: "*on the most part… were sound*", but it also noted that it was "*imperative"* that *"Dr. Vaidyanathan develop insight into his situation"*. Dr. Wong explained this comment to pertain to circumstances when Dr. Vaidyanathan's workload was so heavy that he often *"got into problems"*. Dr. Wong also stated that he had "*spoken to him* [Dr. Vaidyanathan] *many times about this situation"*.

Dr. Wong also testified about another case when Dr. Vaidyanathan had done two caesarean sections early one morning that resulted in "operative problems". Again, Dr. Wong attributed this to Dr. Vaidyanathan having been up all night, and being in a position where his judgment or skill may have been compromised.

The Committee found Dr. Wong to be a very forthright and credible witness. Again, we will deal with the weight to be given to his evidence below.

DR. VAIDYANATHAN

Following his testimony, Dr. Vaidyanathan refused to be cross-examined. As such, the Committee refused to accept Dr. Vaidyanathan's evidence. Dr. Vaidyanathan then pleaded no contest to allegations in paragraphs 1 and 3 in the Notice of Hearing. He maintained his plea of innocence as to the allegation of incompetence.

FINDINGS

The issue for the Committee to decide was that of incompetence, and it first reviewed the definition.

First, there is the need to establish incompetence at the time of the acts in question. Looking at this issue, the Committee was cognisant that the severity of incompetence must be assessed as of the date of the incidents, and that the severity has to be such as to demonstrate a lack of knowledge, skill and judgment or disregard for the welfare of the patient such that the doctor is "unfit to practice" or have his "practice restricted". In other words, the committee felt that it was sufficient to find Dr. Vaidyanathan to be incompetent to a degree that his practice should be restricted, but not necessarily be unfit to practice.

Second, there is the need to consider incompetence in the current timeframe. The Committee determined that the four main cases in question occurred within a reasonably current timeframe, starting with the first in September 1998 (Patient 2), September 1999 (Patient 4), April 2000 (Patient 3), and September 2000 (Patient 1). These cases occurred within a twenty-five (25) month timeframe, not over four years as alleged by the defence. The date of September 2000 was also within a year of the start of the hearing.

Additionally, both Dr. Istban and Dr. Wong, who had been Dr. Vaidyanathan's mentors from January 2001, gave evidence as to Dr. Vaidyanathan's competence. Dr. Livingstone also testified as to an oral test he had given Dr. Vaidyanathan.

In view of the above, the Committee gave some weight to the evidence of Dr. Vaidyanathan's current skills, but the evidence was considered in the context of Dr. Vaidyanathan's overall competence, including the serious incidents involving Patients 2, 4, 3, and 1.

The Committee also found some guidance in the book authored by Richard Steinecke: "A Complete Guide to the Regulated Health Professions Act". In that text, the author

indicates that incompetence must relate to a status that makes a person unsafe. The Committee agrees, especially where the life of a patient (or her fetus) may be at stake. The Committee also accepted that incompetence must relate to a deficiency, i.e., lack of knowledge or skill, and that it doesn't have to be in all of these areas, but any one of them. Mr. Steinecke further indicates that failure to meet the standard does not necessarily constitute incompetence; however, "*incompetence involves a fundamental or basic error suggesting that the practitioner cannot be trusted with the care of patients in at least some circumstances"*. The Committee accepted these general principles, and kept them in mind in analysing the facts presented in this hearing.

FINDINGS RE: PATIENT 2

The Committee found that Dr. Vaidyanathan made a number of errors in this case. First of all, he should have done additional assessments on September 22nd, when this patient first presented with lessened fetal movement. He subsequently missed the very obvious signs of shock (after fetal death) which were quite classic in this case: clammy appearance; high heart rate; and low, fluctuating and hard to find blood pressures. He did not heed the concerns of the nurses, who were very concerned and who spoke with him many times during the night. While the Committee realizes that Dr. Vaidyanathan did assess the patient at 01:10, and stayed on the floor ("back room"), it is clear that he personally did not attend to the patient again until at least 06:15. To the Committee, that in itself is disregard for the welfare of the patient.

Further, he ordered misoprostol even though there was no protocol in place for its use. He also failed to ensure that the nurses were familiar with the medication and how to properly care for a patient who was receiving it, as well as the side effects of this medication. He also ordered a starting dosage of 200 mcg, while Dr. Bernstein indicated that 100 mcg would have been his own choice.

More importantly, he failed to advise the patient that this medication was being used for the first time at the hospital, and that the nurses were unfamiliar with it, and that one of the very serious side effects was uterine hyperstimulation and uterine rupture. Failure to

notify the patient and to obtain an informed consent when using a medication which has a very serious risk demonstrates lack of judgment, as well as disregard for the welfare of the patient.

Dr. Vaidyanathan was very late in assessing the seriousness of the situation, and delayed calling for a consult. More importantly, he missed the diagnosis of uterine rupture, even with all the clues in place including shock, two-minute contractions, misoprostol, previous ultrasound showing intrauterine pregnancy and a more recent ultrasound showing intra-abdominal. Missing the severity of the situation, he further put the patient at risk by not advising the operating room that this was an extremely urgent case. The Committee found no notation that Dr.Vaidyanathan had attempted to move the patient to the OR as soon as possible. Again, the above shows a lack of judgment, as well as disregard for the welfare of the patient. Indeed, even Dr. Bernstein opined that the overall result was “fortunate” in this case. Dr. Roth opined that the patient was lucky to be alive.

The Committee agrees with the opinion of Dr. Roth who gave Dr. Vaidyanathan a 1 on a scale of 1 to 10. The Committee accepts Dr. Roth's view that Dr. Vaidyanathan was incompetent in the case of Patient 2.

FINDINGS RE: PATIENT 1

The Committee found the NST on September 18th to be non-reassuring, as per the evidence of Dr. Roth, supported by the opinion of the Obstetrical Care Review Committee, and also partly supported by some of the evidence of Dr. Bernstein, who found portions of this NST to be non-reassuring. Additionally, the Committee accepts that Patient 1 did inform Dr. Vaidyanathan that there was decreased fetal movement on that date, and that Dr. Vaidyanathan did not give Patient 1 proper instructions to monitor fetal movement, whether by fetal kick counts or by other acceptable methods. Dr. Bernstein agreed that she should have at least been told to sit down a few times per day, and to really concentrate on the baby’s movement.

Therefore, Dr. Vaidyanathan's failure to take into account the non-reassuring NST, the decreased fetal movement, the increased WBC count, the time since the rupture of membranes (11 days), and the lack of proper instructions, indicate that the management of this patient was inadequate and incompetent. To have asked the patient to wait until September 22nd, was clearly unacceptable, and resulted in a preventable fetal death. Additionally, not performing a caesarean section when this patient had previously had a C-section, had a diagnosis of CPD on her chart, with an estimated weight of over 8 pounds (as per ultrasound), and when requested to do so by the patient upon finding out about the fetal death, was clearly again below the standard to an extent of demonstrating incompetence in terms of lack of knowledge and judgment.

The Committee agrees with the opinion evidence of Dr. Roth who gave Dr. Vaidyanathan a 1 on a scale of 1 to 10, and finds Dr. Vaidyanathan to be incompetent in the case of Patient 1.

FINDINGS RE: PATIENT 3

The Committee again finds incompetence. Firstly, the failure to attempt to transfer the patient who showed up with premature ruptured membranes at 25 plus weeks of gestational age is clear disregard for the welfare of the patient. Both experts agreed that the baby was at least 25 weeks, while Dr. Vaidyanathan, in different documents, indicates anywhere from 23 to 25. That discrepancy alone caused some concern to the Committee, and when added to the reasons given by Dr. Vaidyanathan (i.e. that facilities would not want to accept the patient until labour had started) clearly indicated to the Committee either a lack of knowledge and/or skill, or judgment.

When the Committee adds to these facts the failure to order at least the Celestone, if not the antibiotics, and also the admitted falsification of the chart, the Committee concluded that these acts and omissions clearly showed disregard for the welfare of the patient, as well as lack of knowledge, skill, and judgment. Indeed, when both Dr. Roth and Dr. Bernstein agreed that had Patient 3’s baby been born at a tertiary care centre, it may have survived, this corroborates the Committee’s opinion of incompetence.

The Committee agrees with the opinion of Dr. Roth who gave Dr. Vaidyanathan a score of 1 on a scale of 1 to 10. The Committee finds Dr. Vaidyanathan to be incompetent in the case of Patient 3.

FINDINGS RE: PATIENT 4

In the case of Patient 4, the Committee was quite disturbed that Dr. Vaidyanathan ordered the discontinuation of the magnesium sulfate after only 8 hours. In so doing, he may have put the patient at risk. When a physician steps beyond the established standard of practice, as in this case where the medication is usually given for 24 hours, it behoves the physician to consult and document his/her rationale for stopping the medication. Certainly, the discontinuance of medication without an assessment of the patient falls below the standard.

While the Committee does not find that Dr. Vaidyanathan was incompetent in the care of this patient, the serious breach of standard in this case goes to the totality of the finding of incompetence.

FINDINGS RE: PATIENT 5 AND THE CHARTS

Both Dr. Roth and Dr. Bernstein agreed that giving contraceptive counselling on the OR table did not fall below the standard. The Committee agrees, however, it is disturbed by the lack of Dr. Vaidyanathan's sensitivity, and the extent to which it may reflect his attitude towards other patients.

Additionally, the committee noted the incomplete documentation in 16 of the 26 charts examined by Dr. Roth. This is a disturbing finding, as the Committee heard from both Dr. Roth and Dr. Bernstein as to the importance of accurate and complete documentation. Failure to properly document could, in certain circumstances, put a patient’s health at risk.

Again, in regards to Patient 5 and the incomplete charting, the Committee does not find Dr. Vaidyanathan incompetent on this alone, but these breaches also go the the totality of incompetence.

FINDINGS AS TO THE TOTALITY OF THE EVIDENCE

Having found Dr. Vaidyanathan incompetent in three of the individual cases, and having considered the finding that he did not meet the standard in a fourth case, and also having considered the incomplete charting, the totality of the evidence was such that it confirmed incompetence. The Committee felt that it had clear, cogent, and compelling evidence to make such a finding.

FINDINGS AS TO CURRENCY OF INCOMPETENCE

As set out above, the Committee found Dr. Vaidyanathan to be incompetent in his handling of Patients 2, 1 and 3. The Committee also found that the events occurred sufficiently recently for the Committee to make a finding of current incompetence. To do otherwise, the Committee would have required extremely strong evidence that all of the deficits had been addressed. Such evidence was not forthcoming. Indeed, the Committee was disturbed by some of the testimony in regards to current competence.

First, in regards to the 14 charts selected by Dr. Vaidyanathan and examined by Dr. Bernstein in his report dated May 28th, these charts were not randomly selected; they could have been selected for their highest quality, and Dr. Bernstein's opinion with respect to these charts was therefore given limited weight by the Committee.

Second, the examination given by Dr. Livingstone, while positive, was not done in a way that proved Dr. Vaidyanathan's competence. It was done in an office setting, without real or simulated patients, and there was no actual assessment of skills. This test only demonstrated Dr. Vaidyanathan,'s ability, under the best of circumstances, to adequately answer questions. As this hearing related to real-life situations, under high stress, the results of the examination were not particularly helpful or compelling.

Third, even Dr. Istban expressed some reservations concerning Dr. Vaidyanathan's treatment, especially with respect to cases early on in the mentorship.

Fourth, while Dr. Wong found that Dr. Vaidyanathan had the ability and the skills to be a competent obstetrician and gynaecologist, he expressed some reservations about interactions (unwitnessed by Dr. Wong) with the nurses. More tellingly for the Committee, however, was Dr. Wong's testimony in regards to Dr. Vaidyanathan having operative problems when he was overly tired, and that he, Dr. Wong, had spoken to Dr. Vaidyanathan many times about his workload. Again, these types of instances are similar to the cases reviewed during the hearing, and again occurred in the very recent past, certainly from January 2001 onwards.

Lastly, in his first report of November 2000, Dr. Bernstein identified a wide range of deficiencies (clinical care, communication skills, high risk pregnancy and labour cases). The Committee did not hear evidence that Dr. Vaidyanathan undertook a complete and comprehensive assessment and rehabilitation program in order to address these deficiencies. The only evidence was that Dr. Vaidyanathan took two courses, and attended one annual meeting, as well as being monitored by two of his peers. This, in view of the deficiencies noted by both Dr. Roth and by Dr. Bernstein (as identified in the November report) was not sufficient to establish current competency.

DR. VAIDYANATHAN'S FAILURE TO SUBMIT TO CROSS-EXAMINATION

Additionally, after having established a *prima facie* case that Dr. Vaidyanathan was incompetent, the Committee also considered the inference to be drawn from Dr. Vaidyanathan's failure to submit to cross-examination.

In failing to submit to cross-examination, in the absence of any evidence that he was suffering from a mental illness, Dr. Vaidyanathan did not provide the Committee with any reasonable explanation for his conduct. The Committee is entitled to infer, and does infer, that his evidence would not support his defence. The Committee finds that Dr. Vaidyanathan may have feared that his answers on cross-examination would have

harmed his case, and thus that he would have been unable to explain his summaries of the cases as given to Dr. Bernstein, or to explain his actions in the cases reviewed by Dr. Roth. As such, the above confirmed the Committee's findings of incompetence.

SUMMARY OF FINDINGS

For all the reasons enunciated above, the Committee finds that Dr. Vaidyanathan is guilty of the allegation of incompetence as defined in subsection 52(1) of the Health Professions Procedural Code (the "Code"), which is schedule 2 to the *Regulated Health Professions Act, 1991,* in that his care of a patient displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates that he is unfit to continue practice or that his practice be restricted.

Additionally, Dr. Vaidyanathan had pleaded no contest to allegations 1 and 3, and guilty to allegation 2 in the Notice of Hearing.

The Committee therefore finds Dr. Vaidyanathan guilty of professional misconduct:

1. under paragraph 1(1)3 of Ontario Regulation 856/93 ("O. Reg. 856/93") made under the Medicine Act, 1991, in that he failed to maintain the standard of practice of the profession;

2. under paragraph 1(1)16 of O. Reg. 856/93, in that he falsified a record relating to his practice; and,

3. under paragraph 1(1)33 of O. Reg. 856/93, in that he engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

PENALTY SUBMISSIONS

EVIDENCE

Counsel for the defence requested, under section 45(3), an order banning the publication of any personal health information regarding Dr. Vaidyanathan given the fact that he was under the care of a psychiatrist. The prosecution did not object to such an order, and the Committee therefore ordered, under section 45(3) of the Code, a publication ban prohibiting the publication of personal health information regarding Dr. Vaidyanathan.

With consent of the prosecution, counsel for the defence entered an evidence sentencing book, which contained eight letters of reference from physician colleagues who practice with Dr. Vaidyanathan, as well as two letters from nurses who also work at the hospital. These letters spoke eloquently of Dr. Vaidyanathan's character, his caring nature, and his skill as a surgeon. The evidence-sentencing book also contained a number of certificates of participation by Dr. Vaidyanathan in many courses, symposiums, and educational rounds between April 1997 to November 2000, as well as one additional letter from Dr. Vaidyanathan's family physician.

Counsel for the defence also entered three more letters from physicians, as well as one more from another nurse. Dr. B., the treating psychiatrist for Dr. Vaidyanathan, then gave evidence. Dr. B. elaborated on the reasons that precipitated the triggering incident to this hearing, namely the falsification of the charts. He indicated that Dr. Vaidyanathan was mortified, almost disbelieving of what he did, and was depressed. He encouraged Dr. Vaidyanathan to sending a letter to the Chief of Staff. He used the terms "battle fatigue" and "acute automatic behaviour" in describing Dr. Vaidyanathan. When cross-examined, Dr. B. agreed that this terminology is not listed in the DSM-IV (the Diagnostic Statistical Manual). He also indicated that he was unaware of the specific changes that Dr. Vaidyanathan had made to the charts, i.e., a medication order. Dr. B. did indicate that he felt that Dr. Vaidyanathan was fully able to go back to practice, and that he would not repeat the falsification of documents.

The Committee also heard from two other witnesses, both patients of Dr. Vaidyanathan, who spoke highly of his personal demeanour and his skill level.

With consent of the prosecution, counsel for the defence also agreed on the following facts. First, that Dr. Vaidyanathan had been out of practice for three months from October 2000 to January 2001. Second, that he had been out of practice (on his own undertaking) from August 5, 2001 to the date of the hearing. Third, that Dr. Vaidyanathan and he had not been subject to any other charges by the College.

SUBMISSIONS OF THE PROSECUTION

The prosecution sought the revocation of Dr. Vaidyanathan's licence, on the basis that once a physician was found to be incompetent, he/she should not hold a certificate until the physician has proven his/her competence. The prosecution listed a number of aggravating factors in this case, citing, among others, dishonesty, unreliability, and lack of contrition. The prosecution stated that very little weight should be given to the testimony of Dr. B., who used terms that are not recognized in the DSM-IV, and also referred to Dr. A.'s letter to the College of September 29, 2000, which indicated a number of nursing complaints relating to Dr. Vaidyanathan's pattern of practice. The prosecution also noted that Dr. Vaidyanathan had not taken a record-keeping course.

SUBMISSIONS OF THE DEFENCE

Counsel for the defence argued that revocation was not warranted. Counsel indicated that revocation should be reserved for the most extreme cases, in which the person is both a continuing danger to the public, and a repeat offender. Counsel also went over mitigating factors, such as the stress that Dr. Vaidyanathan was under at the time of the Patient 3 case; the plea of guilt in that case; and the support from colleagues such as Dr. Istban and Dr. Wong.

Counsel submitted that there should be a period of suspension, and that the Committee should take into account the time that Dr. Vaidyanathan had already been away from his practice. Counsel also agreed that there should be some requirement for Dr.

Vaidyanathan to upgrade his record-keeping skills, with the suggestion that Dr. Vaidyanathan submit his records for a peer review after taking the course. The defence submitted that there were a number of ways the Committee could ensure the protection of the public, short of revocation.

PENALTY REASONS

Having considered the thoughtful submissions of counsel, and having carefully considered the list of factors that should be used in determining an appropriate penalty, and the principles of sentencing (as indicated in *Jaswal v. Medical Board*), the Committee came to the conclusion that it could strike an effective balance by having a period of suspension with conditions attached rather than outright revocation. The Committee disagreed with the contention of the prosecution that only revocation would protect the public.

In coming to this conclusion, the Committee agreed with the evidence presented by many professionals (nurses and physicians) that Dr. Vaidyanathan is a caring physician, who seemed to get into trouble mostly due to stress and overwork. The Committee was satisfied that the questions raised by the peer mentors, by Dr. Roth, and by Dr. Bernstein's first report could be addressed with a sound program of remediation. The Committee therefore came to the conclusion that Dr. Vaidyanathan, even when declared incompetent in regard to the cases at issue in this hearing, was indeed capable of rehabilitation.

The committee then listed some of the concerns that needed to be addressed in order to protect the public. These included: a graduated return to work (i.e., not to return with a workload causing him to become overly stressed and tired); that he be under direct supervision for a period of time; that his skills be assessed through a comprehensive specialty assessment program; that he take appropriate courses (i.e., record keeping, as part of the specialty assessment, time management, stress management); that he be audited if necessary (peer review, charting); that he deal with personal issues (and issues identified in this hearing, such as falsification) which may have affected his performance;

and that the clinical issues identified by Dr. Roth and Dr. Bernstein, as well as those identified by the Committee, be dealt with as part of the assessment and remediation. The Committee is satisfied that the above also speaks to the rehabilitation of Dr. Vaidyanathan.

In terms of specific deterrence, the Committee is of the opinion that this entire process has caused Dr. Vaidyanathan a lot of grief, as well as a substantial loss of income, and loss of stature in the community. It is unlikely that the type of behaviour exhibited by Dr. Vaidyanathan will be repeated. Similarly, the conditions imposed by this Committee will also act as general deterrence to others in the profession.

In terms of denunciation and the maintaining of the reputation of the profession, the Committee is of the opinion that the penalty to be imposed, along with a reprimand in regards to the falsification of the charts, will send a strong message to the public and to the profession that such actions will not be tolerated.

PENALTY DECISION

After careful consideration of the submissions, and for the reasons stated above, and having found Dr. Vaidyanathan guilty of the allegations in the Notice of Hearing, the Discipline Committee, orders and directs that:

1. Dr. Vaidyanathan appear before the Discipline Committee to be reprimanded and that the fact of the reprimand be recorded on the Register.

2. The Registrar suspends Dr. Vaidyanathan's Certificate of Registration for a period of 24 months, beginning on the date that Dr. Vaidyanathan voluntarily agreed to completely withdraw from practice, that being August 10, 2001.

3. Eighteen months of the 24-month suspension will be suspended if, and only if, Dr. Vaidyanathan agrees, within 30 days of the release of this Decision, to comply with all of the terms and conditions set out below and

to satisfy the terms and conditions on or before the 18-month period of suspension expires.

(a) Dr. Vaidyanathan is referred to the Quality Assurance Committee, which Committee will be provided with the Notice of Hearing, the Decision of the Discipline Committee, and the report of Dr. Roth. The Quality Assurance Committee will appoint a practice supervisor to monitor Dr. Vaidyanathan's office and hospital based practice, with emphasis on the practice areas enumerated in sub-paragraph 3(b) below. The supervisor will monitor Dr. Vaidyanathan's practice for a period of 6 months from the date of his return to practice or for any additional time as may be recommended by the Quality Assurance Committee. The supervisor will report his/her observations on Dr. Vaidyanathan's practice, including patient load, to the Quality Assurance Committee. The parameters, duration, and frequency of supervision and the supervisor's obligation to report to the Quality Assurance Committee will be determined by the Quality Assurance Committee.

Dr. Vaidyanathan shall abide by, and implement forthwith, any recommendations made by the Quality Assurance Committee. The Quality Assurance Committee may also, at its discretion, conduct an independent peer review at any time.

(b) The Quality Assurance Committee will assess Dr. Vaidyanathan's competence through a Specialty Assessment Program ("S.A.P."). Such assessment should consider and address the concerns raised in Dr. Roth's report, and focus on a general Obstetrics/Gynecology practice, with emphasis on the diagnosis and care of the following: premature ruptured membranes; premature labor; fetal distress/in-utero death; pregnancy-induced hypertension; and emergency obstetrical care and management.

The S.A.P. is to be at Dr. Vaidyanathan's cost, and may occur anytime after May 10, 2002, but must be completed on or before

March 10, 2003. Dr. Vaidyanathan shall abide by, and implement forthwith, any recommendations made by the S.A.P. or by the Quality Assurance Committee. Dr. Vaidyanathan must also file proof of his successful completion of the S.A.P., and his successful implementation of its recommendations, if any, with the Registrar before July 10, 2003.

(c) Dr. Vaidyanathan will return to work gradually (i.e. he is not to assume his pre-hearing caseload). Dr. Vaidyanathan must restrict his hospital practice to the hospital where he holds an active staff appointment until the end of the suspended portion of this penalty. In the event that Dr. Vaidyanathan should move his active staff appointment to a different hospital, he must continue to restrict his hospital practice to one active staff appointment only during the suspended portion of the penalty. In the event Dr. Vaidyanathan does not hold an active staff appointment, he may obtain temporary privileges (locum tenens) provided he only works at no more than two hospitals at any given period of time through until the end of the suspended portion of the penalty.

Dr. Vaidyanathan will confirm his compliance with this restriction by providing the Quality Assurance Committee with written confirmation of such compliance upon his return to practice and every 4 months thereafter.

(d) Dr. Vaidyanathan will attend (at his cost, if any) and successfully complete courses acceptable to the Registrar, on "Stress Management" and "Time Management". These courses must be completed, and Dr. Vaidyanathan must provide the Registrar with evidence of his successful completion of the courses on or before July 10, 2003.

(e) Dr. Vaidyanathan will refer himself to a psychiatrist acceptable to the registrar within 30 days from the release of this Decision. Dr. Vaidyanathan must receive psychiatric treatment on a regular basis (at the discretion of the treating psychiatrist) for a period of at least

six (6) months, or for such additional time as Dr. Vaidyanathan's psychiatrist deems necessary.

At his first appointment, Dr. Vaidyanathan shall provide the psychiatrist with a copy of the Amended Notice of Hearing, (Exhibit 1), the report of Dr. Roth (Exhibit 3), and a copy of the Discipline Committee's Decision and Reasons for Decision in this case. An undertaking from the psychiatrist, in the form attached hereto, shall be obtained and filed with the Registrar, acknowledging the psychiatrist's responsibilities.

The psychiatrist shall provide the College with a written report on Dr. Vaidyanathan's condition within six (6) months of the first appointment. The report should address whether further treatment is necessary. If treatment is continued, the psychiatrist will continue to report to the College at six (6) month intervals.

4. Any costs relating to the implementation of this order, including costs of preparing reports, which are not covered by OHIP, shall be paid by Dr. Vaidyanathan within thirty days of Dr. Vaidyanathan's receipt of the relevant invoice.

5. In the event Dr. Vaidyanathan elects not to return to practice after the 6-month period of suspension, (i.e. if he elects not to comply with the terms and conditions in paragraph 3 above in order to suspend 18 months of the 24-month suspension) then Dr. Vaidyanathan shall immediately, and in no event later than Thursday, February 28, 2002, notify the Registrar of his decision, whereupon the Registrar shall, and is hereby directed to, impose the terms and conditions enumerated in paragraph 3 above as terms, conditions and limitations on Dr. Vaidyanathan's certificate of registration. Dr. Vaidyanathan shall comply with those terms, conditions and limitations upon his return to practice, and they shall remain on his certificate of registration until satisfied.

6. Dr. Vaidyanathan shall pay to the College costs in the amount of $12,500 within a period of eight (8) months following the day that Dr.

Vaidyanathan returns to practice or within twelve (12) months from the day following the last day of the license suspension, whichever first occurs.

7. In the event that Dr. Vaidyanathan breaches or fails to fulfill any one of the foregoing conditions, his certificate of registration shall immediately be suspended until such time as the conditions are fulfilled.