NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Sankar Vaidyanathan, 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(1) 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: 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 and the Complaints Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 36(1) and 26(2) of the ***Health Professions Procedural Code,*** being Schedule 2 of the ***Regulated Health Professions Act, 1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. SANKAR VAIDYANATHAN

PANEL MEMBERS: DR. R. MACKENZIE (CHAIR)
E. COLLINS
DR. W. KING
DR. B. TAA (PHD)
DR. J. DOHERTY

Hearing Dates: **October 17 to 21, 31, November 2 to 4, 22 to 25, 2005 and January 23 to 25, 2006**
Decision Date: **July 7, 2006**
Release of Written Reasons Date: **July 7, 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 October 17 to 21, 31, November 2 to 4, 22 to 25, 2005 and January 23 to 25, 2006. At the conclusion of the hearing, the Committee reserved its decision.

PUBLICATION BAN

On October 17, 2005, the Discipline Committee made an order pursuant to subsection 45(3) of the *Health Professions Procedural Code* (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, prohibiting the publication or broadcast of the names of patients in this proceeding, or any information that could disclose the name or identities of patients.

ALLEGATIONS

The Notice of Hearing alleged that Dr. Vaidyanathan 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 he has failed to meet the standard of the profession;

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

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

Prior to commencement of the hearing, the College withdrew allegation #2.

RESPONSE TO THE ALLEGATIONS

Initially, Dr. Vaidyanathan denied allegation #1 and the allegation of incompetence, in all particulars. However, at the conclusion of testimony, he changed his response to "no contest" with respect to the allegation that he had committed an act of professional misconduct in that he failed to meet the standard of the profession in the management of one patient (Case #39).

The management of thirty-nine patients originally formed the basis of the College's allegations against Dr. Vaidyanathan, although two patients (#'s 35 and 36) were withdrawn prior to the hearing. At the conclusion of the evidentiary portion of the hearing, the College conceded that its case had not been established, to the Bernstein standard of clear, cogent and convincing proof, with respect to a further eleven patients, identified below.

THE ISSUES

The Committee identified the following issues:

1. To determine, on the basis of the evidence presented at the hearing whether, in each case, Dr. Vaidyanathan's management met the standard of care expected of a community obstetrician/gynaecologist during the period in question and, if it did not, whether any single case was sufficiently mismanaged as to constitute incompetence as defined in section 52 (1) of the Code.

2. To determine whether, in total, the management of the cases considered constituted a pattern of incompetence, either global or in specific areas, sufficient to meet the requirements of section 52 (1) of the Code.

The witnesses for the College included two complainants, patients #38 and 39, Dr. A, Chief of Obstetrics and Gynecology at Markham-Stouffville Hospital, who gave expert evidence with respect to each patient and Dr. B, who testified as a fact witness. Dr. B was subsequently qualified by the defence as an expert in obstetrics/gynecology for the purpose of eliciting opinion evidence as well.

A total of eleven witnesses gave evidence for the defence with respect to one or more cases. These included: Dr. C, Head of Gynecologic Oncology at the University of Toronto; Dr. D, an Obstetrician/Gynecologist at St. Joseph's Hospital in Hamilton; Dr. E, an Obstetrician/Gynecologist at Soldiers' Memorial Hospital in Orillia; Dr. F, an Obstetrician/Gynecologist at Women's College Hospital in Toronto; Dr. G, an Internist at Humber River Regional Hospital; Dr. H, an Obstetrician/Gynecologist at Credit Valley Hospital; Dr. I, Professor of Obstetrics/Gynecology at the University of Toronto; Dr. J, presently associated with the patient safety division of the Society of Obstetricians and Gynecologists; Dr. K, Professor of Obstetrics and Gynecology at the University of Western Ontario; Dr. L, an Obstetrician/Gynecologist at Humber River Regional Hospital; and, Dr. M, a General Surgeon at Humber River Regional Hospital. Each of these was qualified by the Committee to give expert evidence with the exception of Dr. M who testified as a fact witness. As mentioned above, Dr. B was also qualified as an expert during cross-examination by the defence.

THE EXPERT WITNESSES

Dr. A was the sole expert testifying on behalf of the College, and opined on all the cases presented to the panel. Dr. A was appointed to review Dr. Vaidyanathan's practice under a section 75 investigation.

Dr. A initially reviewed the records of all patients managed by Dr. Vaidyanathan during a two-month period. He then requested and reviewed all patient records, over a two-year period, selected by hospital-identified "complications".

Dr. A interviewed unspecified colleagues of Dr. Vaidyanathan's from the staff of Humber River Regional Hospital. No evidence was introduced with respect to their opinions or the extent to which these opinions contributed to Dr. A's overall opinion of Dr. Vaidyanathan's competency.

Dr. A accepted that, where he criticized Dr. Vaidyanathan's surgical skill, his criticism was based solely on the records review. He did not seek to observe Dr. Vaidyanathan actually performing surgery.

Dr. A testified in a very clear and cogent manner. He impressed the panel as a very knowledgeable expert in the field of obstetrics and gynecology. It was also very clear that he sets a very high standard of care for both himself and his specialist colleagues. In many cases, the Committee felt that this standard was set unreasonably high when balanced against the opinions provided by the defence experts.

With the exception of the two complainants, the majority of the cases that formed the basis of the other allegations were drawn from the files that had been selected on the basis of statistical complications. The Committee was concerned that this methodology could potentially introduce an element of unintentional negative bias to Dr. A's opinion.

The Committee was similarly impressed with the level of knowledge and expertise demonstrated by each of the ten experts called by the defence. Since their testimony was divided amongst the cases, the Committee will consider their testimony in more detail in the discussion on the evidence set out below.

THE EVIDENCE

The following section summarizes the clinical evidence respecting each patient and includes a summary of the expert testimony, the Committee's opinion with respect to whether or not Dr. Vaidyanathan met the standard of care in each of the individual cases and the reasons for its conclusions. A second section will deal with the overall pattern of competency in Dr. Vaidyanathan's management of all the cases and the reasons for the Committee's decision with respect to this aspect of the allegation of incompetence.

Case #1

The patient was a 26-year-old woman who was referred from the Women's Care Clinic on Saturday, September 18, 2004. Complaints of abdominal pain had led to a portable

ultrasound with findings suspicious of ruptured ectopic pregnancy. She was hemodynamically stable. Dr. Vaidyanathan phoned the Emergency Department of Humber River Regional Hospital (HRRH) at 1:30 p.m. with orders for a second ultrasound (which confirmed the diagnosis of ruptured ectopic pregnancy). He first saw the patient at 4:10 p.m. and did laparoscopic surgery at 5:30 p.m., from which she recovered uneventfully.

Dr. A criticized the ordering of the second ultrasound and the delay in getting the patient to surgery, both of which he considered substandard.

Dr. H testified for the defence in this case and several others. He impressed the Committee as being very knowledgeable, and presented his evidence in a very balanced and thoughtful manner. He was consistent and unshaken when subjected to vigorous cross-examination. In his opinion, the patient had actually been very well-managed. He agreed that a formal ultrasound was both appropriate and valuable in confirming the verbal report of a portable study and that an interval of less than four hours from patient presentation to actual surgery was more than reasonable, given that the patient was stable and that these events occurred on a Saturday.

This was a particular instance where the Committee was of the opinion that Dr. A was imposing an unreasonably high standard of care upon Dr. Vaidyanathan, or any other gynecologist for that matter and preferred the evidence of Dr. H for that reason.

At the conclusion of testimony, the College conceded that the evidence did not support a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case #2

The patient was 37 when she saw Dr. Vaidyanathan on March 12, 2003. Her last menstrual period had begun January 30 but she had had vaginal spotting for 14 days and increasing abdominal pain for one day. Two days previously, her beta HCG (a pregnancy test) was 8600 (suggesting pregnancy) and her haemoglobin level was 115. Dr. Vaidyanathan

diagnosed incomplete abortion, on the basis of history and physical examination and a portable ultrasound (never formally reported), which he felt showed retained products of conception.

She was sent to the Emergency Department at HRRH where the nurses noted her overt bleeding to be scant. A repeat haemoglobin determination was 89. At 6:49 p.m., her blood pressure was recorded as 68/41, down from 94/55 approximately one hour previously. An intravenous was started and a rapid infusion of 1 litre of normal saline was given with improvement in the blood pressure.

At 8:30 p.m., Dr. Vaidyanathan performed a D&C. His OR note records that, "The products of conception were emptied.", but makes no comment with respect to quantity. The patient had another hypotensive episode during surgery. A repeat haemoglobin determination, done postoperatively, was 55. Dr. Vaidyanathan could not explain the disproportionate drop in the haemoglobin level; he ordered two units of blood transfusion.

The patient was monitored overnight and remained stable. Her morning haemoglobin level was 71 (following the transfusion). Dr. Vaidyanathan ordered a repeat ultrasound, which was done at 11 a.m. and showed a large amount of fluid in the pelvis and abdomen. At 2:25 p.m., Dr. Vaidyanathan ordered four more units of blood to be transfused and, at 6:15 p.m., he performed a laparotomy with the preoperative diagnosis of "possible ectopic pregnancy." A right tubal ectopic pregnancy was found and removed along with 1400 cc of blood. While the patient was still under anesthetic, Dr. Vaidyanathan consulted a general surgeon concerning other potential sources of bleeding, but none was found. The patient's recovery from surgery was subsequently uneventful.

Dr. A opined that the failure to diagnose ectopic pregnancy in this case fell below the standard of the profession. Not only were the history and physical findings typical, in his opinion, but the lack of overt bleeding, sufficient to explain the dropping haemoglobin, and the hypotension, should have alerted Dr. Vaidyanathan to consider another diagnosis. The

delays on the following day, to ultrasound and to the second operation, were also unacceptable, in Dr. A's opinion.

Dr. H did not testify in chief with respect to this case but, under cross-examination, did recall that he had reviewed the records. He was presented with a hypothetical case summary and, while he did not state explicitly that the care was substandard, he expressed "concerns about the time intervals and the length of time it took to diagnose this patient." He agreed that the delay posed a potentially-serious risk to the patient.

The hypothetical case summary posited, in summary form, the facts we had found in the case referred to above.

Dr. D was also cross-examined and recalled having reviewed the case record. He was presented the same hypothetical case summary. He opined that the failure to diagnose the ectopic pregnancy fell below the standard of the profession.

Faced with no opinion supportive of the care provided this patient, the Committee agreed that it fell below the standard of the profession.

It only remained to determine whether the care, in this single instance, was sufficiently egregious to constitute incompetence, as defined by the Code. It was the Committee's unanimous opinion that Dr. Vaidyanathan's care of this patient, while acknowledged to be substandard, was not incompetent. No defence of the misdiagnosis was advanced, but there were mitigating circumstances including: Dr. Vaidyanathan's belief in the ultrasound findings (admittedly self-interpreted), his prompt transfer of the patient to hospital, the fact that she was carefully monitored throughout her period at risk, the documented evidence of Dr. Vaidyanathan's continuing close involvement and concern and the eventual good outcome. It was the opinion of the Committee that, absent evidence of similar misdiagnoses, a single instance of professional misjudgement or failure did not justify a finding of incompetence.

Case # 3

The patient was 24-years-old and 13-weeks-pregnant with her first pregnancy when she saw Dr. Vaidyanathan on September 14, 2004. His examination demonstrated a normal sized uterus, not consistent with the 13-week pregnancy, and cervical excitation, a sign which might suggest ectopic pregnancy (among other conditions). From her family physician, he learned that her beta HCG 12 days previously had been 8900. A portable ultrasound showed no intrauterine pregnancy. Dr. Vaidyanathan concluded that an ectopic pregnancy needed to be ruled out. He ordered a repeat of the pregnancy test and a repeat ultrasound, which was done the following day at the hospital. He made arrangements for the patient to be admitted to hospital and obtained consent for laparoscopy and surgery appropriate for ectopic pregnancy, should his suspicions be confirmed. In fact, the ultrasound showed no sign of an ectopic pregnancy and the beta HCG from the previous afternoon was 58, indicating that the pregnancy had terminated some time previously. The patient was discharged from hospital the same day without undergoing surgery.

Dr. A criticized Dr. Vaidyanathan's management of this patient which he felt failed to meet the standard of the profession. He opined that it was unreasonable to suspect ectopic pregnancy and that the diagnosis of miscarriage should have been obvious. He criticized the lack of documentation of bleeding, although on cross-examination he was taken to a notation which indicated (too briefly, in his opinion) that such a history had been taken. He opined that appropriate action would have been to repeat the beta HCG, but take no further action, unless the level remained elevated.

Dr. H testified that Dr. Vaidyanathan's management was reasonable and appropriate. He considered it "astute" to rule out ectopic pregnancy, given the finding of cervical excitation, since it is possible for an intrauterine pregnancy to coexist with a second pregnancy in the tube. He disagreed that it was unreasonable to admit the patient or that it demonstrated a lack of diagnostic skill.

In this case, the Committee preferred the opinion of Dr. H that Dr. Vaidyanathan had acted with reasonable caution in ruling out ectopic pregnancy and that his actions in admitting the

patient to hospital, while unnecessary in retrospect, could reasonably be interpreted as a desire to shorten the wait for necessary treatment, should the diagnosis be confirmed. The Committee noted the significant discrepancy between one expert who opined that the care failed to meet the standard and another who felt the case was managed well and astutely. In this instance, it is again the Committee's opinion that Dr. A has set an unreasonably high standard.

The College further argued that, in the aggregate, the management of the first three cases demonstrated a pattern of incompetence in the diagnosis and treatment of ectopic pregnancy. Having found that two of the three cases met or exceeded the standard of the profession, the Committee did not agree.

Case #4

The patient was a 47-year-old woman who was referred to Dr. Vaidyanathan because of an enlarging right adnexal mass, causing pain with intercourse. Dr. Vaidyanathan performed laparoscopic surgery on October 21, 2002, removing a twisted right fallopian tube and securing the stump with a single PDS endoloop (a pre-tied suture used in laparoscopic surgery). The patient bled postoperatively, her haemoglobin falling to 74 from the preoperative level of 116, and had to undergo a second laparoscopic surgery the same evening. At the second operation, Dr. Vaidyanathan found bleeding from the cut end of the fallopian tube, where the endoloop had become dislodged, and 500 to 600 cc of blood in the pelvis. He stopped the bleeding using monopolar cautery. The patient was given a transfusion of two units of blood. Postoperatively, she had delayed return of bowel function and a somewhat-prolonged hospital stay but, in other respects, recovered uneventfully.

Dr. A had multiple criticisms of Dr. Vaidyanathan's management of this case.

Firstly, he opined that Dr. Vaidyanathan should have used two, rather than one, endoloops to secure the stump of the tube and that to use one fell below the standard of the profession. On cross-examination, he conceded that he could give no reference or authority for his opinion but stated that it was "standard gynecological knowledge." On the contrary, he was taken to:

"Operative Gynecologic Laparoscopy, Principles and Techniques," which he agreed was an authoritative text, and which supported the use of a single endoloop. He stated that the circumstances described in the text were different.
Secondly, Dr. A criticized the choice of PDS suture material which he opined to be too slippery for use in this situation. His testimony was unclear with respect to whether this choice fell below the standard. On cross-examination, he conceded that PDS is a standard and widely-used material and that he could provide no authority in support of his opinion.

Thirdly, Dr. A criticized the choice of monopolar, rather than bipolar, cautery to stop the bleeding. Bipolar cautery, in which the electrical current passes from one paddle, through the tissue, to the other paddle, would be expected to carry lower risk of damage to adjacent structures, such as bowel. He conceded that, in this case, monopolar cautery "did the job," without collateral damage.

Fourthly, Dr. A criticized the decision to give a blood transfusion to a stable patient with a haemoglobin level of 74. On cross-examination, he was taken to the Society of Obstetricians and Gynecologists of Canada (SOGC) guidelines, which indicate that a transfusion of two to four units would be appropriate. Nonetheless, he maintained his opinion that the transfusion was *in*appropriate in this case.

Dr. H testified that the care in this case fell within a reasonable and expected standard of practice. He stated that slippage of a loop or suture is a common complication in gynaecologic surgery, not necessarily reflective of lack of skill. He agreed that it is common to use two endoloops but did not feel that using one fell below the standard. He described PDS ligature material as a "recognized tool," available in most operating rooms, although he does not use it personally. He described the blood transfusion as "very appropriate" for a patient undergoing a second general anesthetic for bleeding and opined that, if Dr. Vaidyanathan had not ordered the transfusion, the anesthetist almost certainly would have.

Dr. D, on cross-examination, recalled that he had reviewed the records in this patient, although he had not submitted a written report. He was presented a hypothetical summary

containing the essential facts of the case as found above. He stated that, in doing the surgery, he would probably have used two endoloops, although he disagreed that the failure to do so was substandard. He disagreed that PDS was an inappropriate suture. He agreed that bipolar cautery is generally safer. He disagreed that Dr. Vaidyanathan fell below the standard with respect to performing surgery without the requisite level of skill.

In her summary, College counsel conceded that the cautery issue may be controversial and that the use of monopolar cautery is not necessarily substandard.

The Committee noted that all four of Dr. A's criticisms of the management of this case were seriously tested on cross-examination where his opinions were directly contradicted by authoritative sources. It therefore preferred the opinions of the defence experts in this case and concluded that the College failed to establish that Dr. Vaidyanathan's care of this patient fell below the standard of the profession

Case # 5

The patient, a 68-year-old woman, was undergoing laparoscopic surgery for a right ovarian mass. Bleeding was encountered and Dr. Vaidyanathan decided to convert to a laparotomy. He found a small tear in the mesentery, which he repaired, and he requested a consultation from a general surgeon who explored the abdomen and assisted with the repair of the mesenteric tear. The patient recovered uneventfully.

Dr. A opined that Dr. Vaidyanathan should have been able to detect the source of the bleeding and manage it laparoscopically. To have required a more-extensive operative procedure for this common complication fell, in his opinion, below the standard of the profession. He also criticized involving a general surgeon in the operation as evidence of Dr. Vaidyanathan's inability to manage his own complications.

This was the first instance where Dr. D provided evidence on a case that he was asked to review as opposed to providing opinions on hypothetical situations. The Committee again was very impressed with Dr. D's knowledge and expertise. His testimony was thorough and

internally consistent. At no time did he adopt an advocacy position for Dr. Vaidyanathan, and he was prepared to criticize him when he felt his care was less than optimal.
In this case, Dr. D disagreed with the College's position and opined that the decisions and treatment were appropriate. He testified that it is not always possible to identify the source of bleeding through the laparoscope and that, particularly since bowel injuries may be associated, a prudent surgeon should always be prepared to convert to laparotomy. He also supported involving a general surgeon, particularly if one were readily available. He testified that clinical practice guidelines advise conversion to laparotomy, if in doubt, and support obtaining consultation, where thought appropriate.

At the conclusion of testimony, the College conceded that the evidence did not support a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case # 6

The patient was a 22-year-old woman with her first pregnancy, admitted at term and in labour at 4:25 p.m. on September 21, 2004. Her cervix was 4 cm dilated and 90% effaced and the baby's head was at "spines minus one." At 6 p.m., the cervix was 5 cm dilated and 100% effaced and the head was at spines. At 7 p.m., the cervix was 7 cm dilated and the head at spines plus 1. Dr. Vaidyanathan ordered oxytocin to stimulate labour. At 8 p.m., a healthy boy was delivered spontaneously.

Dr. A testified that there was no indication to use oxytocin for this patient since the progress of labour was normal. In his opinion, its use in this situation fell below the standard of the profession, since it incurred a risk of impairing blood supply to the baby by making uterine contractions too strong, too frequent, or both.

Dr. H testified that stimulation of labour with oxytocin is appropriate for situations of inadequate progress of labour or inadequate strength of contractions. He agreed that this labour had progressed satisfactorily. "Strength of contractions" is a subjective assessment by the obstetrician. While he agreed that there was no documentation of poor contractions in the

records, he felt that Dr. Vaidyanathan would have made such an assessment and that it was appropriate to give oxytocin if he found contractions to be less than adequate. He described the amount of oxytocin given over a one-hour period as "trivial" and he felt that it carried little risk for the baby. He testified that, were there a pattern of inappropriate oxytocin use, it would be a matter which should be brought to the attention of the Chief of the department, but that he would expect such a pattern to be exposed by routine quality assurance measures.

Dr. D did not review this case in preparation for his testimony, but during cross examination he was asked, in the form of a hypothetical question, whether there was any indication in this case for oxytocin augmentation. He opined that there was not.

The Committee accepts the unanimous opinion of the experts that there was no documented indication for the use of oxytocin in this case. However, it is inclined to agree with Dr. H's opinion that only Dr. Vaidyanathan was able to assess the strength of contractions at the time he ordered the oxytocin. If he simply failed to document poor strength of contraction in the record, the Committee does not feel this to be sufficient reason to make a finding that he failed to meet the appropriate standard of care.

Case # 7

The patient was 24-years-old and approximately 39 weeks pregnant in her first pregnancy when she was admitted in labour at about 4 a.m. on September 8, 2004. At 4:15 a.m., she was found to be fully dilated with the membranes intact and bulging. At 4:50 a.m., her membranes were ruptured and the fluid was stained with thin meconium. Cervical dilation was re-evaluated to 8 cm. An epidural catheter was placed at 5:30 a.m. At 7 a.m., Dr. Vaidyanathan ordered oxytocin to stimulate labour. Fifteen minutes later, he reassessed the situation, found the cervix to be unchanged and recommended Caesarean section, which was performed, with a good outcome for both mother and child.

Dr. A testified that Dr. Vaidyanathan's care fell below the standard of the profession in two respects:

Firstly, he felt the Caesarean section was a "rush intervention." He did not disagree that there was desultory labour or that the use of oxytocin was justified, but he testified that a 15-minute trial was completely inadequate to assess the effect.

Secondly, he pointed out discrepancies in the medical records which could be interpreted as an attempt to justify an unjustified intervention. Dr. Vaidyanathan's operative report states that oxytocin was tried for approximately 2 ½ hours, whereas nursing notes show that it was started at 7 a.m. and that Dr. Vaidyanathan called for Caesarean section at 7:15 a.m.

Also, the discharge summary, dictated September 20, indicates two reasons for proceeding to section, cephalopelvic disproportion and "oblique lie." The latter is incompatible with notes (both Dr. Vaidyanathan's and the nurses') that the baby's head was in the pelvis.

Dr. H testified that the clinical care provided this patient was reasonable and the decision to proceed to section was appropriate. Adequate labour had resulted in no progress over 2 ½ hours, whereas one would expect cervical dilation of about 1 cm per hour. The head was noted to be "deflexed;" this might have caused the failure to progress. He interpreted the diagnosis, "oblique lie," to be an inadvertent misstatement in dictation, when what was meant was that the head was in the oblique position. He testified that Dr. Vaidyanathan's options at 7 a.m. would have been to "wait-and-see," to proceed directly to Caesarean section or to try to augment labour with oxytocin. He agreed that 15 minutes would be an inadequate trial of oxytocin but interpreted the sequence of events to mean that Dr. Vaidyanathan initially thought to try augmentation of labour and then changed his mind. He agreed that the operative report was inaccurate with respect to the duration of oxytocin administration.

The Committee accepted that the clinical care of this patient was reasonable and met the standard of the profession. If it would have been reasonable to proceed to Caesarean section *without* a trial of augmentation, then it would appear supportable to make such a decision 15 minutes later, whether or not oxytocin had been given in the interim. The Committee concluded that it was impossible to glean the entire picture from the medical record and that some deference should be accorded to the judgment of the physician "at the bedside."

The Committee also accepted Dr. H's interpretation of Dr. Vaidyanathan's use of "oblique lie," particularly since any obstetrician would know that an oblique lie was an impossibility in the documented circumstances. The Committee does have concern respecting the misrepresentation, advertent or inadvertent, of the duration of oxytocin administration. In an operative report, dictated the same day as the procedure, such a misstatement is hard to dismiss as "sloppy recordkeeping." However, it noted that the recordkeeping error had no bearing on the clinical outcome in this case. The Committee also took some comfort in its concern from the defence submission that, were there a pattern of retrospective justification of inappropriate Caesarean sections, that pattern should be reflected in an increased Caesarean section rate, whereas Dr. Vaidyanathan's section rate falls squarely in the midrange, on peer comparison. Therefore, the Committee did not find that the errors in recordkeeping constituted a failure to meet the standard in this instance.

Case # 8

The patient was 16-years-old and at term with her second pregnancy (first child) when she was admitted in labour at 10:25 p.m. on August 3, 2004. On examination, her cervix was 5 to 6 cm dilated and 100% effaced with the head at spines -2. At 2:15 a.m., she requested an epidural, but none was administered. By 4:50 a.m., she was fully dilated and Dr. Vaidyanathan was called for delivery, arriving at 5:15 a.m. At 5:32 a.m., a healthy boy was delivered using a vacuum extractor. There was no complication associated with its use.

Dr. A reviewed the record of this woman's labour and the fetal heart tracing and opined that there was no indication to intervene with the vacuum extractor. In his opinion, the fetal heart pattern was completely reassuring, although Dr. Vaidyanathan twice noted that the extraction was performed because of a "nonreactive fetal heart rate pattern." He expressed concern about the potential for tearing of maternal tissues or an injury to the baby's scalp from the use of the extractor.

On cross-examination, Dr. A admitted that the fetal heart recording showed decelerations on two occasions, but maintained that they were mild and of no concern.

Dr. H testified that he believed the course followed to have been reasonable and that he has intervened in similar circumstances in his own practice. He postulated that the patient was not coping well with the pain of labour, that she had reached the limit of cooperation with the effort to deliver the baby and that it was a reasonable exercise of judgment to expedite the delivery. He agreed that there was no documentation on the records of meconium in the amniotic fluid, inability to push or maternal exhaustion. With respect to the fetal heart rate tracings, Dr. H pointed out several instances of moderate, variable decelerations. He disagreed with Dr. A that the tracings were, in fact, entirely reassuring.

In this case, the Committee preferred the opinion of Dr. H that it was supportable to expedite the delivery of a 16-year-old woman who had laboured more than seven hours, without benefit of anesthesia. It was also unable to accept Dr. A's opinion that the fetal heart tracings were entirely reassuring.

The Committee therefore found that Dr. Vaidyanathan met the standard of care in this instance.

Case # 9

The patient was 34-years-old, p.0 g.2, when she was admitted at 4:15 a.m. on August 28, 2004, approximately 10 days before her due date. Her membranes had ruptured two hours previously. On examination, her cervix was 1 cm dilated. At 7:10 a.m., oxytocin stimulation was begun and labour progressed. At 9:33 a.m., an epidural catheter was placed and, by 10:10 a.m., she was fully dilated. Dr. Vaidyanathan arrived for delivery and, 10 minutes later, delivered a healthy baby, employing the vacuum extractor, without complication. His documented indication for low vacuum extraction was, "nonreassuring fetal heart pattern."

Dr. A testified that the care of this patient fell below the standard of the profession in that there was no indication for the use of the vacuum extractor.

Having heard a number of experts opine on the interpretation of fetal heart tracings during the course of this hearing, the Committee had great difficulty accepting Dr. A's opinion that the tracings in this case were completely reassuring. The Committee preferred Dr. H's evidence that there was a true indication for intervention in this labour, and that Dr. Vaidyanathan's management met the standard of care.

Case # 10

The patient was a 26-year-old woman admitted in labour at 41 weeks gestation. She was delivered using low forceps and suffered cervical and vaginal tears which Dr. Vaidyanathan repaired after repairing the episiotomy. He also inserted a vaginal pack, to be left for 24 hours, and a urinary catheter (necessary because of the pack). Blood loss was estimated at 500 cc.

Dr. A criticized several aspects of the treatment: 1) the use of forceps as unnecessary or used too soon; 2) the order of the surgical repairs, as repairing the episiotomy first would limit access to the cervix and upper vagina; and, 3) the use of the vaginal pack which he felt was unnecessary and might mask uterine bleeding. Dr. A reviewed the fetal heart tracing and found no problem. "Maternal exhaustion" was recorded, but the patient had only been pushing for 35 minutes. Dr. A was also concerned about the use of forceps for a patient who was described as "thrashing."

On cross-examination, Dr. A was taken to a section of the textbook: "Human Labor and Birth," which he agreed was authoritative. He agreed that the section of the text dealing with repair of lacerations of the upper vagina recommends packing of the vagina, in some instances.

Dr. H testified that the standard had been met in all aspects of the care of this patient. He thought the use of forceps was reasonable as the patient had lost control and was not pushing effectively. He was not concerned by the order of the surgical repairs and opined that the most obvious repair should be performed first. While Dr. H does not use vaginal packs personally, he had no concern with the use of one in the circumstances recorded here and he

testified that significant uterine bleeding would soon overwhelm a vaginal pack, and therefore negate any concern for obscuring blood loss.

At the conclusion of testimony, the College conceded that the evidence did not support a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case # 11

The patient, who was 27 and pregnant for the second time, was admitted at 39 weeks, in labour. Her first child had been delivered by Caesarean section and the treatment plan was to attempt vaginal birth after Caesarean (VBAC). On admission at 5:45 a.m., her cervix was 2 to 3 cm dilated and 100% effaced with the head at spines -2. At 7:45 a.m., she was experiencing 3 to 4 minute, moderate contractions. Dr. Vaidyanathan examined her at 8:15 a.m., determined that her cervix was unchanged and recommended Caesarean section.

Dr. A opined that, at 8:15 a.m., the patient was just starting into active labour and that recommending a Caesarian at that time was unjustified and fell below the standard of care of the profession. On cross-examination, he admitted that he had overlooked a notation in the patient record, "lot of pain in uterine scar" (a possible indication of impending uterine rupture – one of the most serious complications of VBAC). He was also reminded that another patient in the series, (Case #30), had ruptured her uterus just three weeks prior to these events. When directly asked whether he would accept that it was reasonable for Dr. Vaidyanathan to recommend Caesarean section in this case, based on previous recent experience and pain in the uterine scar, Dr. A agreed that it was.

Dr. H was also concerned by the pain in the uterine scar which he described as a "definite warning sign." In his opinion, Dr. Vaidyanathan's care was reasonable and met the standard of the profession.

While not formally conceding a failure to meet the evidentiary standard, College counsel, in her summation, did concede that it was "not a strong case" with regard to this case.

The Committee agreed and found that the standard of the profession had been met in the care of this patient.

Case # 12

The patient was a 36-year-old woman, referred to Dr.Vaidyanathan in April of 2004 because of uterine fibroids. She was experiencing pain and was having difficulty getting pregnant. She had been advised by another gynecologist to undergo a hysterectomy. Dr. Vaidyanathan's assessment was that the uterus was the size of a 20-week pregnancy. Ultrasound confirmed a fibroid uterus but the report made no comment as to the number, size or location of fibroids.

After preliminary tests to rule out other causes of infertility, Dr. Vaidyanathan recommended myomectomy. Dr. A testified that this management and recommendation were appropriate.

Surgery was performed on August 18, 2004. Dr. Vaidyanathan encountered multiple fibroids. He made two large incisions in the uterus, one anterior and one posterior, and removed a total of five fibroids, leaving others behind. The reasons given for the incomplete myomectomy were that bleeding was worrisome and that proceeding might lead to the need for hysterectomy and permanent infertility.

Dr. A characterized the surgery as a "failed operation" and opined that Dr. Vaidyanathan should not have undertaken it, lacking the skill to complete the job. Nothing in the report indicated to him that the remaining fibroids were in a dangerous location. Leaving them, in his opinion, left the patient no better off than before the operation. He was particularly concerned by Dr.Vaidyanathan's response (on interview) that he had "already made two incisions", the implication (to Dr. A) being that making more incisions would be dangerous or impossible.

On cross-examination, Dr. A agreed that it represents sound surgical judgment for a surgeon to abandon a myomectomy if he feels that he cannot proceed in safety and that this determination can be made better in the operating room than retrospectively through records.

Dr. H was supportive, both of the decision to recommend myomectomy, with the goal of relieving symptoms while preserving fertility, and the decision to abandon it when Dr. Vaidyanathan felt that he could not safely continue. He stated that he, in company with other gynecologists, has had the experience of failing to complete a myomectomy. He stressed the exercise of surgical judgment and principle of *primum non nocere* (firstly, do no harm). He testified that it was reasonable to expect that this patient would experience at least partial relief of symptoms from the surgery which Dr. Vaidyanathan performed and that her fertility might be enhanced. He attached little weight to the remark referred to above that had concerned Dr. A, characterizing it as a "throwaway comment."

The Committee was not persuaded that the evidence had established that the management of this operation represented a surgical failure, as opposed to a reasonable exercise of surgical judgment.

The Committee therefore decided that the standard of care had been met in this case.

Case #13

This 34-year-old woman had a complex history, well-known to Dr. Vaidyanathan who had operated on her twice. She had undergone a myomectomy for uterine fibroids in 1997 and a Caesarian section in 2000. She had also miscarried three times, most recently in April, 2003, and had required a D&C for retained products of conception, which he performed. She returned to Dr. Vaidyanathan in June, 2003, wanting another pregnancy but aware that she had multiple, large uterine fibroids. Dr. Vaidyanathan recommended another myomectomy and she agreed.

The surgery took place July 14, 2003. Adhesions from the previous surgery made the uterus impossible to mobilize. Dr. Vaidyanathan attempted lysis of the adhesions but was unsuccessful and had to abandon the myomectomy.

Dr. Vaidyanathan met with the patient and her husband on July 28 to discuss treatment options. Dr. Vaidyanathan's notes indicate that he thought hysterectomy was the preferred option but pregnancy was still a high priority for the patient. He discussed the option of uterine artery embolization (UAE) and the patient ultimately chose this course of treatment. There is no indication that the option of another myomectomy, either by himself or by another surgeon, was discussed.

The procedure of UAE was performed by an interventional radiologist on September 4. The patient returned to Dr. Vaidyanathan on September 30, in sufficient pain to have required several Emergency visits and the ongoing use of narcotic analgesics. The Committee was instructed that pelvic pain is a frequent, although usually temporary, complication of the procedure.

Dr. Vaidyanathan recommended hysterectomy and, this time, the patient consented. The surgery was performed on October 6, with the assistance of a general surgeon to take down the adhesions and appropriate bowel prepping in case of an inadvertent bowel injury. The operation was concluded successfully, but the postoperative course was complicated by a wound dehiscence, which required a return to the hospital for a resuture, and which led to a subsequent wound infection. The patient continued to see Dr. Vaidyanathan on several occasions for ongoing pain and required another minor procedure for removal of retained suture material.

Dr. A testified that the myomectomy recommended by Dr. Vaidyanathan in June was appropriate and indicated. He had multiple criticisms of the subsequent care which he felt to be below the standard of the profession.

He had minor criticisms of the conduct of the July surgery. He criticized the choice of incision, the placing of stay sutures in the fundus of the uterus in the attempt to mobilize it and Dr. Vaidyanathan's inability to take down the adhesions himself.

However, his greatest concern was with the apparent presentation of UAE, at the subsequent office visit, as the sole option which might preserve fertility. He testified that UAE is a relatively new procedure whose effect on fertility is unknown and which is associated with a 10% risk of premature menopause. It should not be recommended to a woman who is trying to get pregnant. He testified that, as all the same precautions would be required for hysterectomy, the patient should have been offered the option of another myomectomy and that the failure to do so constituted a lack of knowledge and judgment.

Dr. A also criticized a perceived failure to prescribe prophylactic antibiotic following the resuture of the abdominal wound dehiscence but admitted, on cross-examination, that he had missed a notation in the records indicating that Clavulin had been prescribed.

Dr. H testified that, in his opinion, the care provided this patient was attentive and careful and that it met the standard of the profession. He described the abandoned myomectomy as a *prudent* exercise in risk avoidance, in the circumstances. He testified that there were ambiguities in the area of the indications for UAE and that the SOGC guidelines, to which reference had been made, were "fuzzy" on the subject. He opined that referring the patient for UAE was "not perfect, but a reasonable decision" and that it carried a lower risk than further surgery. With respect to the chronic pelvic pain, he testified that it was primarily the responsibility of the radiologist to explain the risks and to obtain informed consent for UAE. In the circumstances of the pain which the patient was experiencing when she saw Dr. Vaidyanathan on September 30, Dr. H testified that the recommended hysterectomy was indicated. He described as "wise" the decision to involve a general surgeon for his greater expertise in the lysis of adhesions and the management of potential bowel complications. He testified that wound dehiscence is a common complication, not indicative of a lack of skill on Dr. Vaidyanathan's part.

The College submitted that Dr. Vaidyanathan's care fell below the standard in three respects: 1) that he undertook the July 2003 myomectomy without the requisite skill; 2) that he failed to inform the patient of the option of a second myomectomy; and, 3) that he referred for UAE a patient who wanted to preserve fertility.

The Committee struggled to come to its conclusions in this very complicated case but ultimately decided that the care did not fall below the standard of the profession.

The Committee did not agree that the decision to abandon the myomectomy represented a lack of skill but preferred the opinion that it represented prudent risk avoidance. It did agree with the earlier submission that Dr. Vaidyanathan might have anticipated encountering adhesions, given the patient's surgical history. The Committee found that the criticisms of Dr. Vaidyanathan's technique were matters of individual surgical judgment and that his choices were supported by opinion reflected in the literature. The Committee accepted that it was reasonable to refer a patient for UAE, even one who wanted to preserve fertility, given the complexity and potential for risk of the surgical alternatives.

Although the Committee agrees that a second attempt at myomectomy was an option for this patient, it does not find fault with Dr. Vaidyanathan's recommendation for UAE.

The College further submitted that this case formed part of a pattern of failed surgeries which would justify a finding of incompetence on the basis of a lack of knowledge, skill and judgment. Having found the care of neither of the two contested fibroid cases to be substandard, and the other two cases being conceded by the College as not below the standard of the profession, the Committee could not agree that there was a demonstrated pattern of incompetence in this area.

Case # 14

The patient was a 47-year-old woman, undergoing hysterectomy for fibroids, who was also booked to have a bladder repair. During the hysterectomy, Dr. Vaidyanathan encountered bleeding on the left side of the pelvis and called in a urologist to assist him in controlling the

bleeding and to ascertain that there had been no injury to the left ureter. Subsequent testimony revealed that the urologist had been pre-booked for, and was awaiting, the bladder repair. The bleeding was controlled and no ureteral injury was found.

Dr. A was critical of the need to involve the urologist which, he felt, implied a lack of ability on Dr. Vaidyanathan's part to manage his own complication. He subsequently testified that the care did not fall below the standard.

Dr. H found the care to be reasonable. He opined that it would have been inappropriate not to have involved the urologist. He also pointed out that the urologist had been pre-booked to perform part of the surgery and was already standing by.

The Committee was troubled by Dr. A's repeated criticism of Dr. Vaidyanathan for involving other specialists in management of surgical complications or complex presentations. In each instance, the expert for the defence opined that, not only was doing so appropriate, but that it was prudent. In this case, it noted Dr. H's testimony that failure to involve a urologist would have actually been *in*appropriate.

At the conclusion of testimony, the College conceded that the evidence did not support a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case # 15

The patient was a 31-year-old woman, undergoing myomectomy for uterine fibroids. She had been given a drug called Lupron preoperatively to shrink the fibroids. The surgery was bloody (recorded loss, 1500 cc) but proceeded, otherwise, without incident. Her haemoglobin level fell to a low (on the evening of surgery) of 76 and she was given a transfusion of four units of blood, raising the haemoglobin to 116. She developed a temporary cardiac arrhythmia (premature atrial beats) for which she was seen by an internist, who felt that no treatment was necessary.

Dr. A had multiple concerns regarding the care of this patient.

He felt that the amount of blood loss demonstrated a lack of surgical skill. He testified that a uterine tourniquet could have been used for control and that vasopressin could have been injected into the fibroids to induce vasospasm. On cross-examination, he was taken to a reference to vasopressin in the nursing records, but testified that the record could be interpreted that the drug was prepared, but not used.

Dr. A testified that there is no evidence that Lupron reduces blood loss in myomectomy and that, in his experience, it may make surgery more difficult by blurring tissue planes.

Lastly, he criticized the transfusion as possibly unnecessary (since the haemoglobin level never fell below 60), and certainly excessive. On cross examination, he agreed that the patient's blood pressure improved coincident with the transfusion and that it was reasonable to consider, in deciding to transfuse, the fact that she had three young children at home.

Dr. H testified that this was, "a well-documented procedure meeting the standard of care." He described the 1500 cc. blood loss as, "significant but not unusual," and found no evidence of lack of skill. He explained the theoretical basis for the use of Lupron and agreed that it is not universally accepted. He has never used a uterine tourniquet and does not believe that its use is common practice. With respect to the haemoglobin determination of 76, he testified that it is important to ask, "What is the trend likely to be?" In this case, it was downward in his opinion. He also testified that it was definitely in this patient's best interest to transfuse.

At the conclusion of testimony, the College conceded that the evidence did not support a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case # 16

This patient saw Dr. Vaidyanathan on January 8, 2003 with complaints of three months of pelvic pain, four months of distension and difficulty voiding. Dr. Vaidyanathan diagnosed a large uterine fibroid impacted in the pelvis. Ultrasound had shown a 9 cm fibroid and mild hydronephrosis of the right kidney. Dr. Vaidyanathan discussed the treatment options and recommended hysterectomy.

Dr. A agreed with both the diagnosis and the recommendation.

The patient did not return until February 4. She informed Dr. Vaidyanathan that she had been to Emergency several times with urinary retention and was wearing a urinary catheter since her last Emergency visit. She was also constipated and throwing up.

Dr. Vaidyanathan admitted her to hospital, "for conservative management," and performed a hysterectomy the next day, as well as removing both ovaries (for which there had been no written consent). The pathologist's examination of the ovaries revealed no abnormality.

Dr. A criticized the delay in surgery stating that, "there *was* no conservative management" option available for this patient. He also criticized the removal of the ovaries without indication or consent.

Dr. H testified that the fact that the patient entered the operating room at 7:20 p.m. indicated that she was on an urgent surgical list and that he could see no justification for "bumping" her further up the list. He testified that the orders indicated that she had been provided adequate analgesia and that the intervening time had been well spent, rehydrating her and preparing her for surgery.

On cross-examination, Dr. H agreed that clear consent should be obtained before elective removal of a 45-year-old woman's (or, indeed, any woman's) ovaries and that she should be aware that it would lead to menopause. He agreed that there was no indication in the records that such a discussion took place and that he saw no consent for the removal of the ovaries in

the course of his review. In addition, he saw no indication in the operative record that any complication, arising in the course of the procedure, necessitated removal of the ovaries.

College counsel submitted that the delay in surgery "for conservative management" fell below the standard since there was no conservative management option, but she conceded that it was "not a strong case." She further submitted that removal of the ovaries, without consent, indication or pathology, was definitely substandard.

The Committee agreed fully with the latter submission and agreed with College counsel's assessment of the weakness of the case referred to in her former submission. It found that Dr. Vaidyanathan fell below the standard of the profession but only with respect to the unjustified removal of the ovaries.

College counsel invited the Committee to make a finding of incompetence in respect of this failure to meet the standard. Inasmuch as this was the only case in which oophorectomy (removal of ovaries) was performed without consent, the Committee could not find a sufficient basis for such a finding. Although it could be argued that this represented a lack of judgment on Dr. Vaidyanathan's part, it is not repetitive, nor, in the Committee's opinion, to such an extent that demonstrates that he is unfit to continue practice or that his practice should be restricted. Rather, the Committee finds this to be an isolated error in judgement.

Case # 17

The patient was a 42-year-old woman who spontaneously delivered a healthy male child at 7:46 p.m. on January 5, 2004. The umbilical cord was tightly wrapped around the baby's neck.

At 7:41 p.m., the cervix had been noted to be fully dilated. At 7:39 p.m., the fetal heart rate had dropped to 50 beats per minute and, at 7:42 p.m., it dropped again to between 60 and 100.

At 7:43 p.m., when she began to push, Dr. Vaidyanathan called for forceps, although their use was never required. The baby delivered spontaneously at 7:46 p.m.

At 8:55 p.m., the placenta had not delivered and Dr. Vaidyanathan unsuccessfully attempted manual removal. The patient was taken to the operating room, given a general anesthetic and the placenta was manually removed, "without any difficulty." Dr. Vaidyanathan used a curette to ensure that the uterine cavity was empty.

Dr. A criticized two aspects of this patient's care.

He described the call for forceps as "premature" and maintained his criticism despite the evidence of fetal distress and the fact that the forceps were not used. He did not opine that this aspect of care was below the standard.

Dr. A also criticized the use of the uterine curette, particularly as Dr. Vaidyanathan's note stated that he had felt the uterine cavity to be empty by direct palpation. In Dr. A's opinion, the use of the curette would tend to promote scarring and adhesions in the uterine cavity, a condition known as Asherman's Syndrome (AS). There was lack of clarity in his testimony concerning whether the use of a curette in this instance fell below the standard of the profession.

A lesser criticism was of the choice of general anesthetic for the manual placental removal, although Dr. A conceded that he did not know whether the patient was willing to have an epidural anesthetic or whether the anesthetist was willing to administer one.

Dr. H testified that the care of this patient was reasonable in all aspects. He testified that it was quite reasonable to call for forceps, in the face of significant slowing of the fetal heart, in case it should prove necessary to expedite delivery. He opined that the choice of anesthetic was largely that of the anesthetist and the patient. He felt that the decision to wait over an hour before attempting manual removal demonstrated admirable patience and that using a uterine curette to ensure that the cavity was empty was fully justifiable. He testified that he

had seen AS perhaps twice in his practice lifetime. While he conceded that overly vigorous curretage might tend to promote AS, he added that, so too could retained placental fragments.

In her summation, College counsel advised the Committee that, when the conflicting views of experts with respect to the standard of care are found to be equal, the Committee should not find that there was a failure to meet the standard. The Committee found Dr. H's testimony to be clear, forthright, logical and consistent in support of the reasonableness of Dr. Vaidyanathan's actions. On the other hand, Dr. A seemed to have difficulty determining his own definition of the standard of care and his criticisms carried the flavour of "looking to find fault." The Committee was puzzled how Dr. A could possibly be critical of Dr. Vaidyanathan simply for asking that forceps be made available.

The Committee found that Dr. Vaidyanathan met the standard of the profession in the care of this patient.

Case # 18

The patient was a 40-year-old woman, having her first baby, who was admitted at term and in labour. She delivered a healthy boy at 12:45 a.m. on April 25, 2004. At 1:00 a.m., Dr. Vaidyanathan noted that the placenta remained *in utero*, that it was rigid and that the cord had snapped attempting to deliver it. At 2:14 a.m., she was taken to operating room for manual removal. The placenta came out "piecemeal" and, although he stated that the uterine cavity felt empty, Dr. Vaidyanathan used a large suction tube to ensure complete removal, a fact which was verified the next morning by ultrasound. Blood loss during the procedure was estimated at 1500 cc.

Dr. A opined that it fell below the standard of the profession to suction the uterine cavity when manual exploration had found it to be empty. In his opinion, uterine suction carries a risk, similar to curretage, of increasing AS. He criticized the fact that Dr. Vaidyanathan broke the umbilical cord, although he did not suggest it to be substandard.

Dr. H was supportive of all aspects of Dr. Vaidyanathan's care. He testified that umbilical cords are frequently fragile and that all obstetricians break them, however skilled they may be. He stated that, particularly as the placenta had come out in pieces, he had no problem with the use of suction to ensure completeness. He testified that there is no evidence that uterine suction increases the risk of AS.

The Committee could find no more reason to prefer the evidence of Dr. A over that of Dr. H in this case than in the previous. It therefore found that the standard had been met in the care of this patient.

Case # 19

The patient was a 34-year-old woman, pregnant for the sixth time, who was admitted in labour, six days prior to term, on January 18, 2003. At 12:15 p.m., her cervix was 3 to 4 cm dilated and, at 6:15 p.m., fully dilated. At 6:50 p.m., Dr. Vaidyanathan performed a low forceps delivery. In his contemporaneous note, he indicated the reasons for the use of forceps to be: 1) cystocele (bladder hernia); and, 2) maternal exhaustion. His discharge summary, dictated some two weeks later, indicates that the forceps delivery was done for non-reassuring fetal heart rate pattern.

Ten minutes after delivery, the umbilical cord broke in an attempt to deliver the placenta and the patient had to be taken to the operating room for manual removal (this time without either curretage or suction).

Dr. A expressed concern with both the fact, and the timing, of the broken umbilical cord, stating that there was no reason to be pulling on it, 10 minutes after delivery. Again, he did not opine that Dr. Vaidyanathan failed to meet the standard of care.

On cross-examination, he agreed that his written report may have given the impression that he thought that Dr. Vaidyanathan had a "problem" with breaking umbilical cords, when that opinion would have been drawn from a highly-skewed sample.

His principal criticism in this case was that no indication existed for forceps delivery. He reviewed the fetal heart tracing and found it entirely reassuring. He stated that cystocele is not an indication to use forceps and that he found no evidence of maternal exhaustion.

On cross-examination, Dr. A was taken to a notation on page 142 of the hospital record, and agreed that it stated that the patient was not pushing effectively.

Dr. D testified for the defence that the management of this patient fell within an accepted standard of practice. He agreed that he did not find a non-reassuring fetal heart rate pattern. He also testified that cystocele "isn't much of an indication" for the use of forceps, but that maternal exhaustion *is*, and that the use of forceps or vacuum extraction with that indication is both justifiable and common. He was asked about the use of general anesthesia for manual removal of the placenta and testified that he would prefer epidural anesthesia, where an epidural catheter is already in place, but would consider general anesthesia acceptable, where there is none. He testified that he was not concerned about the broken umbilical cord and that "it happens to all of us." He agreed that it is common to see inconsistencies in charts, dictated two weeks after the fact.

On cross-examination, he agreed that he could point to no obvious indication in the record for the use of forceps on this patient.

The Committee found that the clinical care of this patient met the standard of the profession. It accepted that maternal exhaustion is a common indication for assisting delivery and that there is sufficient evidence to believe that it existed in this case.

The Committee also considered alternative explanations for the discrepancy between the delivery notes and the discharge summary: 1) that it represented a falsehood, attempting to justify an unjustifiable intervention; or, 2) that it represented a clerical error or memory lapse. The Committee, cognizant of the demands of a busy medical practice, is prepared to accept the latter explanation in this instance, particularly since the note was dictated two weeks after the fact.

Case # 20

The patient was a 21-year-old woman who was admitted at term and in labour. Her labour progressed uneventfully to full dilation and she spontaneously delivered a healthy child. Shortly after delivery, she was given a bolus of oxytocin; it was unclear from the record whether by intramuscular or intravenous injection. An oxytocin infusion was started. Dr. Vaidyanathan then repaired the episiotomy. Ultimately, manual removal of the placenta in the operating room was required.

Dr. A criticized the timing of the bolus administration of oxytocin and the episiotomy repair, both of which occurred prior to delivery of the placenta. He testified that oxytocin should be given with the delivery of the anterior shoulder, or after delivery of the placenta, lest the cervix clamp down and trap the placenta. He also opined that repairing the episiotomy made subsequent delivery of the placenta more difficult and/or required taking down the repair to manually remove it.

He maintained his criticism despite being taken to SOGC guidelines which allow administration of oxytocin after delivery of the baby and indicate that there is no increased risk of retained placenta. He was also shown a textbook reference stating that the "interval is an excellent time to sew up tears while waiting for the placenta" but maintained that the text was not in accord with modern practice.

Dr. D testified that Dr. Vaidyanathan's care fell entirely within clinical practice guidelines. He had no concerns with respect to the administration or timing of the oxytocin and stated that no literature supports its contribution to retained placenta. He stated that it is common to repair episiotomies prior to a placental delivery in order to limit bleeding.

At the conclusion of testimony, the College conceded that the evidence did not support a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case # 21

The patient was a 27-year-old woman who was admitted, six days post term, for induction of labour. On examination, her cervix was 1 cm dilated and 30% effaced. She was given Prostin gel and sent home.

She returned the following morning, in active labour since 1 a.m. She progressed to full dilation by 7:16 a.m. There were fetal heart decelerations while pushing, initially reassuring, but developing non-reassuring features. Dr. Vaidyanathan felt delivery should be expedited and a healthy baby was delivered by low forceps at 7:50 a.m.

Two minutes later, Dr. Vaidyanathan left to go to the operating room; there is no record of his checking for vaginal or cervical injury before doing so. At 8:10 a.m. the patient complained of abdominal pain and had a large gush of blood. At 8:20 a.m. Dr. Vaidyanathan returned, delivered the placenta and went back to the operating room. At 8:55 a.m. he returned and repaired the episiotomy.

Dr. A testified that it falls below the standard of the profession to leave a patient, except in an emergency situation, before the delivery of the placenta, following an operative (forceps) vaginal delivery. He stated that trying to manage two patients concurrently puts both at risk. He admitted that he had no knowledge at the time he wrote his report of the status of the operating room patient. Evidence was subsequently introduced that Dr. Vaidyanathan had performed an elective repair of cystsocele/rectocele and that the anesthetic for that patient had commenced at 7:53 a.m. Dr. A accepted that delivery room nurses were competent to monitor this patient.

Dr. E testified for the defence. He was a very credible witness whose testimony did not convey an advocacy position. He stated that it was not “ideal” to leave a patient in the third stage of labour but that he felt it was reasonable to exercise judgment in so doing, the prime consideration being the stability of mother and child. He testified that, in his own practice, he is required to leave in similar circumstances to attend surgeries, emergencies, etc., several times each year. He believes the practice is equally common among his colleagues. He

testified that, if a surgeon does not make himself available to the operating room, his case may be bumped to the next available slot, likely at the end of the day.

In the Committee's view, Dr. E's testimony represented the "real world" and that Dr. A's standards, while reflective of his own practice and high standards, did not represent the practice, as opposed to the ideal, of the profession.

The Committee therefore found that Dr. Vaidyanathan's care of this patient did not fall below the standard.

Case # 22

The patient, a 36-year-old woman, spontaneously delivered a healthy baby (her second) at 10:20 a.m. on September 10, 2004. Four minutes following the delivery, Dr. Vaidyanathan returned to the operating room (which he had, presumably, left to perform the delivery). At 11:28 a.m., he returned to deliver the placenta and repair the episiotomy. There were no adverse events.

The testimony of the experts was similar to that in the previous case, i.e., for the College, that it was below the standard to leave a patient in the third stage of labour to go to the operating room and, for the defence, that it was not, provided that mother and child were stable.

There were no new issues to consider in this case compared to the previous one. The Committee therefore determined that, similar to the previous case, the standard of care had been met.

Case # 23

The patient was a 34-year-old woman who was admitted at 41 weeks gestation for induction of labour. She delivered at 2:14 p.m. and the placenta delivered at 2:18 p.m. At 2:25 p.m., Dr. Vaidyanathan was repairing a tear when he was called back to the operating room. He returned at 3:15 p.m. to complete the repair.

Dr. A opined that the patient should not have been induced on a day when Dr. Vaidyanathan had an operating list.

Dr. E disagreed. He stated that getting time to do inductions is a significant issue and that, in practice, if a booking is available, it is rare to turn it down.

Once again, the Committee accepted that Dr. E was describing the "real world" version of the standard.

At the conclusion of testimony, the College conceded that the evidence did not support, a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case # 24

This patient was 36 and pregnant for the fourth time. Her previous obstetrical history was relevant. Her first child delivered at 28 weeks and subsequently died. Her second child was delivered at term by Caesarean section (indication unknown). Her third pregnancy was carried to term and delivered vaginally. The child had cerebral palsy.

For the fourth pregnancy, she had requested VBAC. She was admitted, in labour, at 39 weeks gestation. Her cervix was fully dilated by 3:35 a.m. At 4:20 a.m. her membranes were ruptured and thick meconium was noted (a presumptive sign of fetal distress). There was a fetal heart deceleration at 4:30 a.m. At 4:35 a.m., Dr. Vaidyanathan assessed the situation and recommended Cesarean section. The operating room staff was paged at 4:39 a.m. to come from home for the delivery (a process estimated to take at least 20 to 30 minutes). The patient requested to be allowed to push in the interim. A healthy child delivered spontaneously at 5:07 a.m.

The events of the intervening 28 minutes are somewhat in dispute. The delivery room staff was preparing the patient for the section. This included inserting a urinary catheter, accomplished with some difficulty due to a previous circumcision. Dr. Vaidyanathan's

actions with respect to the eventual vaginal delivery of the child are not documented, i.e. there is nothing in the record to indicate that he: 1) discouraged the patient from pushing; or, 2) worked with the patient to encourage pushing. He did not choose to expedite delivery, either with forceps or a vacuum extractor.

The above issue arose with respect to Dr. A's criticism that Dr. Vaidyanathan's focus was wrong during that period. He felt that, despite having made the decision to proceed to section, Dr. Vaidyanathan's efforts should have been directed, not to preparing the patient for surgery, but to expediting vaginal delivery.

Dr. D disagreed with the suggestion that using forceps would have been indicated as the head was not in a favourable position. He felt that continuing labour and preparing for section could go on in parallel. He testified (in paraphrase) that the successful vaginal delivery spoke for itself – whether accomplished with Dr. Vaidyanathan's encouragement or not.

A second issue surrounded the genesis of cerebral palsy. Both experts agreed that the majority of cases are believed to arise from uterine, as opposed to birth, events; however, Dr. D stressed that intra-partum events are rare, while Dr. A stressed that they sometimes occur. Based on this belief, Dr. A opined that the safer course for the health of the child would have been to recommend elective Cesarean section. He felt sufficiently strongly about this view that he testified that he would refuse to participate in the further care of a patient who refused his recommendation. Nothing in the record documented that Dr. Vaidyanathan had recommended, let alone insisted upon, elective Cesarean section. Dr. A allowed that the consent form signed by the patient (see page 009 of the hospital record), while not specifically mentioning cerebral palsy, set out the risks of VBAC in detail and clearly constituted informed consent.

Dr. D opined that it was reasonable to permit a trial of vaginal delivery. Nothing, in his review of the record, indicated the cause of the previous cerebral palsy. He testified that, if the mother was particularly concerned about cerebral palsy, then that concern might

constitute a reason to recommend Caesarean section but that he would not insist. He praised Dr. Vaidyanathan's VBAC consent form as "unusually good practice."

The Committee had some difficulty appreciating Dr. A's adamantine insistence upon elective Caesarean section, coupled with his equally strong insistence upon stressing vaginal delivery when emergency section was chosen. It agreed with Dr. D that the cerebral palsy issue, while not totally irrelevant, could reasonably take second place to the mother's wishes. It also agreed that, while the record did not document that Dr. Vaidyanathan encouraged vaginal delivery while waiting for the operating room staff, it equally failed to document that he did not.

The Committee found unanimously that the standard of the profession had been met in the care of this patient.

Case # 25

The patient was a 36-year-old woman, pregnant for the fourth time and scheduled for elective section because of a previous, traumatic birthing experience. She was due May 3, 2004 and her section was scheduled for April 26.

On April 5, she came to the hospital having passed an "orange-sized" blood clot. Her membranes were intact and she had some cramps, but no active labour. Dr. Vaidyanathan assessed her and found that her cervix was 2 to 3 cm dilated and 50% effaced, with the head at spines -2. The fetal heart tracing was reactive and reassuring and the abdomen was soft, neither tense nor tender. There was no active bleeding. A previous ultrasound had shown that the placenta was in a normal position (i.e. no placenta previa).

At 3:51 a.m., Dr. Vaidyanathan ruptured the membranes, "to rule out abruption." The rupture of the membranes did not bring on labour so, at 6:30 a.m., oxytocin was started and, by 11:30 a.m., the patient had progressed to full dilation. At 11:54 a.m., she spontaneously delivered a healthy child, without incident.

Dr. A testified that vaginal bleeding is very common in pregnancy. It can be divided into two categories: either a potential threat to mother and baby, warranting delivery; or, a non-threatening situation, warranting either monitoring or discharge home. In his opinion, the latter situation pertained in this case. Placenta previa had been ruled out by ultrasound, the patient was hemodynamically stable and not actively bleeding and there was no sign of fetal distress. Dr. A felt that Dr. Vaidyanathan had all the information he needed to make a diagnosis of "marginal placental separation", a common problem in which a small area of the margin of the placenta becomes detached from the uterine wall and which is appropriately treated by monitoring.

Dr. A criticized the rupture of the membranes since doing so does not "rule out abruption" (because the placenta/uterine interface lies *outside* the amniotic sac) but does commit the obstetrician to induce labour (or to proceed to section at that time). He testified that the additional three weeks *in utero* until the planned section on April 26, would have rendered the baby less prone to respiratory complications through further maturation of the lungs. He drew attention to the SOGC guideline which indicates that elective induction *at* term should be discouraged, and that elective induction *before* term is not acceptable.

Dr. A noted that, where the delivery record, at page 19, states "spontaneous" under the heading "Labour Onset," and at page 2, where the discharge summary states, "admitted in active spontaneous labour," both statements are false.

He opined that this management failed to meet the standard of care of the profession.

Dr. H testified that his review of the record led him to the opinion that Dr. Vaidyanathan was reasonable in making a diagnosis of abruption of the placenta and inducing labour. He testified that, with the pregnancy at 36-37 weeks, the baby *is* "at term," and that there would be no benefit, either to mother or child, in watching and waiting. While there was some ambiguity in his earlier testimony on the point, he clarified that rupturing membranes cannot "rule out" placental abruption, but only provoke concern if there is blood in the amniotic

fluid. He agreed that rupturing the membranes commits the obstetrician to induction of labour. He also agreed that the records respecting the onset of labour were inaccurate.

The Committee closely considered the evidence with respect to the standard of care of the profession in this case. It ultimately accepted that it was reasonable for Dr. Vaidyanathan to induce labour as treatment for what he diagnosed as placental abruption and that his clinical care did not fall below the standard.

The Committee did express concern about the inaccuracies in the records. While it might be possible to explain the inaccuracy in the discharge summary as a "lapse in memory," it is hard to extend the same interpretation to the misstatement in the delivery record, which is a contemporaneous document. It is not within the Committee's purview to impugn Dr. Vaidyanathan for deliberately misrepresenting the facts in this situation. However, whether deliberate or careless, the Committee finds that this aspect of the recordkeeping error in this instance constitutes a failure to meet the standard of the profession.

Case # 26

This 53-year-old woman consulted Dr. Vaidyanathan on May 13, 2004 for a 4-week history of pain in the right lower abdominal quadrant, aggravated by intercourse. An ultrasound, done April 5, had shown a right ovarian, or paraovarian, cyst. There was no history of vomiting, weight loss or systemic symptoms. Her past gynaecologic history included a hysterectomy, a bladder repair and, prior to that, a tubal ligation.

At the time of her 1998 consultation, Dr. Vaidyanathan noted, under Personal Family History, "no family history of breast or ovarian cancer." The history taken in 2004 contains the notation, "Mother? Ovarian? Peritoneal ca."

A CT scan was done on August 12 and the radiologist reported, "no significant abnormality demonstrated."

Dr. Vaidyanathan met with the patient on August 19. She was still having pain with intercourse and wanted to undergo removal of her ovaries (whether for pain or fear of cancer is uncertain, and in dispute). Dr. Vaidyanathan was concerned by the normal CT findings and advised postponement. Nonetheless, the same day, he submitted a booking request for laparoscopy and oophorectomy (removal of ovaries) and a possible laparotomy. The preop diagnosis was, "ovarian cyst pain."

Surgery was performed August 30 and both tubes and ovaries were removed. Pathology examination showed no abnormality. The OR report indicated the preoperative diagnosis to be "remote history of ovarian cancer in the family."

Dr. A contested the indications for surgery. In his assessment, there *was* no ovarian cyst at the time the surgery was booked and the sole clinical problem was abdominal/pelvic pain which had not been adequately investigated to justify proceeding to surgery. He discounted the familial history of cancer, stating that the patient's primary concern was pain, not fear of cancer. He disapproved of the concept of, "surgery on request."

Dr. C testified for the defence. He is a specialist in gynaecologic oncology and Director of the Familial Ovarian Clinic at Princess Margaret Hospital. He testified that non-invasive testing for ovarian cancer is an inexact science. Genetic testing for ovarian cancer is not perfect and there always remains some uncertainty, despite normal test results. He believes that it is reasonable for a woman, fully apprised of the risks and benefits, to decide to undergo prophylactic oophorectomy, and for her gynaecologist to perform it. He testified that this surgery is a regular feature of his own practice. He indicated that his review of the records of this patient led him to the belief that such a risk/benefit discussion had taken place, that the patient had a genuine fear of cancer and that Dr. Vaidyanathan acted reasonably in removing her ovaries. The fact that no abnormality was found did not, in his opinion, make the decision to remove the ovaries any less reasonable.

The Committee found Dr. C to be a very credible witness, whose practice in the care of ovarian cancer patients might reasonably be regarded as the Canadian benchmark for this

area of gynaecologic practice. His support for the acceptability of offering prophylactic oophorectomy to selected patients carried considerable weight. Furthermore, it seemed illogical to the Committee that a woman who had no concern with respect to cancer, would press her gynaecologist to remove *both* her ovaries for *unilateral* pain.

The Committee therefore found that Dr. Vaidyanathan's clinical care met the standard of the profession.

Case # 27

The patient was 32 and pregnant for the third time. She was due on October 20, 2004. Throughout this, and previous pregnancies, her blood pressure had been normal. She saw Dr. Vaidyanathan on September 28 and complained of headaches and feeling unwell. She had ankle swelling and 3+ protein in her urine and her blood pressure was 160/100. Dr. Vaidyanathan diagnosed pre-eclampsia and admitted her to hospital the same day for induction of labour. Dr. A agreed with both the decision and the diagnosis.

Induction of labour was started by the insertion of 2 mg of Prostin gel. The patient's labour proceeded normally and she delivered a healthy baby, without incident.

Her blood pressure remained elevated and she was started on Labetalol in a dose of 100 mg twice a day, by mouth. Over the next four days in hospital, she remained on the same drug, in the same dose, and her blood pressure was closely monitored, showing a fluctuating pattern, with a possible tendency to rise in the evening.

She was discharged on October 2. Her blood pressure, as recorded by the nursing staff at 11:09 p.m. on October 1, was 160/110 and, at 11:34 p.m., 219/125. At 5:19 a.m. on the morning of discharge, the blood pressure had dropped to 155/90.

On the evening of October 3, she returned to see her baby in the nursery and complained of feeling unwell. The nurses noted that she was upset by concerns about the health of her child. She was sent to Emergency where her blood pressure was 219/121. She was given

100 mg of Labetalol, intravenously. Two hours later her blood pressure was 193/130. She was referred to Medicine and admitted to the care of Dr. N, an internist, who continued the intravenous Labetalol. She remained in hospital three more days during which time Adalat was added.

Dr. A criticized the use of 2 mg, rather than 1 mg, of Prostin gel, opining that it would increase the risk of over-stimulation of the uterus and was inconsistent with Dr. Vaidyanathan's own stated policy of using 2 mg of Prostin if the cervix is unfavourable, and 1 mg, if it is favourable.

Dr. A's chief concern was that the blood pressure had not been brought under adequate control prior to the initial discharge of the patient from hospital. He felt this management was substandard.

A third criticism was of the referral of the patient to Medicine when she returned to Emergency. He opined that the best person to look after hypertension, arising as a complication of pregnancy, is the obstetrician. On cross-examination, he agreed that it was the Emergency physician who made the referral to Medicine.

Dr. G, who is an internist at HRRH, but was not involved in the care of this patient, gave expert testimony for the defence. He testified that he consults frequently on postpartum patients with hypertension.

He testified that his review of this patient's record indicated that the average blood pressure was trending down during the hospital stay. He opined that it was reasonable to discharge the patient on October 2 and conduct further management on an outpatient basis. He made reference to the standards of the Joint National Committee on Hypertension and the American Society of Hypertension to place the majority of her blood pressure readings in the "mild-moderate hypertension" range. He testified that the return the day following discharge with an elevated blood pressure reading did not invalidate the decision to discharge her.

Dr. H was cross-examined using a hypothetical summary of case facts and selected blood pressure readings. His initial opinion was that the blood pressure was not under control and that discharging the patient fell below the standard. On re-examination, he was provided with other, and lower, blood pressure readings and changed his opinion, opining the standard had been met.

Dr. J was cross-examined on the same hypothetical facts. He disagreed that it was unacceptable to discharge the patient, noting that the majority of the blood pressure readings, including the last, were in an acceptable range and that the patient was discharged by the internist from her second admission, with hypertension which was virtually unchanged from the level at her first discharge. He testified that it was acceptable, even advisable, to involve an internist and stated that he frequently does so himself.

The Committee considered each issue raised by Dr. A.

In the view of the Committee, when both 1 mg and 2 mg of Prostin gel are used correctly under differing circumstances, the use of 2 mg, when 1 mg would have been preferable, does not constitute a “standards” issue.

The Committee found, on the balance of the expert evidence, that only two blood pressure readings during the first admission (those at 11:09 p.m. and 11:34 p.m. on October 1) were actually concerning, and that factors external to the patient’s hypertension (maternal upset) might account for those. Accordingly, the Committee did not find that the patient’s discharge on October 2 fell below the standard of the profession.

With respect to the referral to an internist, the Committee felt that the relative abilities of different disciplines in the management of pregnancy-induced hypertension were not the central issues and that involving a colleague who might bring different skills, to the benefit of the patient, should not be interpreted as a sign of inadequacy but rather as one of prudence.

Case # 28

The patient was a 45-year-old woman who had been treated by Dr. Vaidyanathan for heavy menstrual bleeding. This problem was associated with uterine fibroids and was sufficiently severe to require iron supplements. Her initial consultation took place on September 4, 2003, Dr. Vaidyanathan was of the opinion that hysterectomy would be the best management but the patient was afraid of surgery. She was given a pamphlet detailing the options of treatment. He noted that she was not a suitable candidate for UAE.

Ultrasound confirmed multiple fibroids but also suggested the possibility of a polyp in the uterine cavity. D&C and hysteroscopy was performed on November 10. No uterine polyp was found. There were multiple fibroids, the largest indenting the cavity from behind. Dr. Vaidyanathan was unable to remove it during the hysteroscopy procedure.

He saw the patient again on December 10. She was taking Cyclomen and had had some improvement in the bleeding. It is not clear from his records when Cyclomen was started nor was the dose employed stated. The Anesthesia Patient Questionnaire, which she completed on October 30, indicated that she was taking 200 mg per day of Cyclomen.

Dr. Vaidyanathan continued to recommend hysterectomy although the patient was still reluctant to undergo surgery as late as a visit on June 17. At that visit, Dr. Vaidyanathan again noted, “pamphlet given” and also, “do not recommend continues Cyclomen.”

Abdominal hysterectomy was performed on August 30.

Dr. A testified that the failure to discuss further medical options of treatment, and to document that discussion, fell below the standard of the profession. He also criticized the failure to document the prescription date and the dose of Cyclomen.

On cross-examination, Dr. A agreed that the OR note (page 172) states, “pros and cons discussed,” but maintained that, to be acceptable, it should have read, “medical options discussed.” He agreed that he had not looked at the brochure (Exhibit 19 - a copy of the

brochure apparently given the patient) and agreed that it fairly set out the medical issues. He was taken to a notation (on page 168 A. of the record), "Cyclomen renewed," written on December 1, and agreed with the defence suggestion that, if Dr. Vaidyanathan always used the same dose of Cyclomen, that note would be meaningful to him.

Dr. J testified for the defence in this case. As with the previous experts, the Committee once again was impressed by his obvious knowledge and expertise. It was also impressed by the thorough and balanced assessments of the cases he reviewed. Dr. J agreed with the recommendation for hysterectomy. He opined that the patient had already been on medical therapy and that none of the other medical options offered a cure for fibroids and/or was economically practical. He testified that, in his own practice, he was very conservative in his recommendations for surgery and that he *would* have offered surgery to a woman in this situation.

The Committee preferred Dr. J's evidence in this case and felt that Dr. A's criticisms in this matter were very minor in nature. There was nothing to suggest that this patient did not make a fully informed decision to go ahead with hysterectomy. It felt that the record-keeping deficiencies, if any, were also minor, and certainly did not constitute substandard care.

Case # 29

The patient was pregnant for the second time, her first pregnancy having terminated in fetal death when the membranes ruptured at 26 weeks. An ultrasound done at 18 weeks in the second pregnancy showed a possible lax cervix. Dr. Vaidyanathan sutured the cervix under general anesthetic.

Dr. A agreed that the procedure was correct but opined that it should have been done under spinal/epidural anesthetic which, in his opinion, would be safer for both the mother and the fetus. When he questioned Dr. Vaidyanathan about the choice of anesthetic, Dr. Vaidyanathan replied that it was basically the choice of the anesthetist and the patient (a position supported by Dr. J). Dr. Vaidyanathan also stated that it was hospital policy that a

patient having a spinal anesthetic could not go home the same day (The actual policy specifies eight hours' observation).

Dr. A testified that the care in this case was not substandard but that Dr. Vaidyanathan should have pressed for the purportedly safer anesthetic, based on the specialized knowledge of the obstetrician.

At the conclusion of testimony, the College conceded that the evidence did not support a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case #30

This 33-year-old woman was admitted in labour with her second pregnancy. Her first pregnancy had resulted in Caesarean section and she was undergoing a trial of VBAC. After several hours of labour, at 6:49 p.m., she developed severe abdominal pain with slowing of the fetal heart. Dr. Vaidyanathan attended immediately and correctly diagnosed uterine rupture. The patient went to the operating room at 7:03 p.m. for emergency section. The section was begun at 7:12 p.m. and the baby was delivered at 7:15 p.m.; the mother recovered uneventfully.

Dr. A testified that uterine rupture is an obstetrical emergency where time is of the essence for maternal, but particularly for fetal, salvage. He criticized the fact that Dr. Vaidyanathan chose to approach the abdominal cavity through the previous Pfannenstiehl incision, rather than using a midline incision, and opined that it fell below the standard of the profession to do so. He testified that 10 minutes is an ideal time for delivery, although he conceded that it is a standard which is not often met.

On cross-examination, he maintained that no reasonable obstetrician would have used the previous Pfannenstiehl incision, although he could provide no authority or guideline in support of that statement.

The Committee took note of the fact that, while there was a maximum of twenty-six minutes from diagnosis to delivery, the actual surgery consumed only three minutes. It seems hard to imagine how such a time could have been bettered significantly by using a different incision.

At the conclusion of testimony, the College conceded that the evidence did not support a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case # 31

The patient was 31-years-old when she was admitted in labour on June 17, 2004. Throughout the period from her admission at 3:00 a.m. to delivery at 9:03 a.m., the fetal heart tracing was variably concerning. The detailed opinions of the experts (Dr. F testified for the defence) differed markedly, both with respect to the interpretation of the tracings and the degree of concern to be attached to the interpretation. In the end, the College conceded that there was insufficient evidence to support a finding with respect to the timing of the delivery.

Dr. Vaidyanathan delivered the baby by low forceps at 9:03 a.m. The baby was "flat," with a heart rate of 60 beats per minute and no movement or spontaneous respiratory effort. At 9:05 a.m., "Code Pink" was called. At 9:07 a.m., Dr. Vaidyanathan intubated the baby.

The time of the anesthetist's arrival is not specified in the record. His/her note states that cardiopulmonary resuscitation was taking place and that the baby was, "cyanotic, with no respiratory effort, bradycardia of 60 and weak pulse." The anesthetist found the air entry to be "questionable" and removed the endotracheal tube, delivering positive pressure ventilation with an AMBU bag and confirming that there was good, bilateral air entry. Colour and heart rate slowly improved over about five minutes. The anesthetist reinserted the tube and confirmed bilateral air entry. Improvement continued and the baby was transferred to the neonatal intensive care unit at The Hospital for Sick Children; the eventual outcome is not in the record.

Dr. A's opinion, with respect to this area of the case, assumes that the baby was misintubated (i.e., that the tube was placed in the esophagus, rather than the trachea). He testified that, in an emergency situation, it is very easy to put the tube in the wrong place. He criticized not so much the misplacement of the tube as the failure to check (or, at least, to document checking) correct placement.

The defence did not call expert testimony on this point but submitted, correctly, that the anesthetist's note does not state that the tube had been misplaced.

Indeed, the Committee could find nothing in the record, or in testimony (the anesthetist was not called), to support the assumption of the misintubation. In the absence of such evidence, it did not feel justified in making that assumption.

The Committee therefore found that the College failed to establish substandard care of either mother or child.

Case # 32

The patient was 27-years-old and was admitted in labour at 38 weeks gestation. The first stage of labour lasted 18 hours and 15 minutes. She then pushed for 1 ½ hours with little result, before being delivered by low forceps. Dr. Vaidyanathan's delivery note (hand-written and contemporaneous) documents maternal exhaustion and states that forceps were employed after the vacuum extractor slipped. The dictated note, dated the following day, again indicates maternal exhaustion. The discharge summary, dictated five days later, indicates that the forceps delivery was done because of nonreassuring fetal heart rate pattern. (There was none.)

Dr. A was in agreement with the intervention but criticized the poor documentation.

The Committee concurred, but was willing, in this case, to accept that a simple error had been made, particularly in light of the fact that there was another valid and well-documented

indication for the intervention and that the recordkeeping error had no bearing on the clinical outcome.

At the conclusion of testimony, the College conceded that the evidence did not support a finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case #33

The patient was 29, p. 1 g. 2, admitted at 41 weeks gestation for induction of labour, which was accomplished with Prostin gel and oxytocin. After eight hours, cervical dilation had only progressed from 3 to 4 cm. Dr. Vaidyanathan diagnosed cephalopelvic disproportion and recommended Cesarean section; Dr. A agreed with both the diagnosis and the recommended intervention.

The surgery proceeded uneventfully, with the exception that a hematoma developed in the right broad ligament, possibly the result of traction or a sharp injury. Dr. Vaidyanathan managed it appropriately.

Dr. A testified that the care of this patient was not, in itself, substandard, but that the complication, when taken in conjunction with other cases, raised concern about lack of skill.

Dr. J testified that intraoperative hematomas of this sort are uncommon, but not rare. He does not regard its occurrence as evidence of substandard care and testified that the management was appropriate. He commented on the difficulty of trying to assess a surgeon's skill from an operative note.

At the conclusion of testimony, the College conceded that the evidence did not support finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

Case # 34

The patient was a 30-year-old woman receiving pregnancy care. On September 29, 2004, at a little more than 37 weeks gestation, she underwent a specialized ultrasound examination which revealed the baby to be lying in a transverse position (as opposed to up and down), although the baby had been noted (by another physician) to have been lying in the normal position, the previous day. She saw Dr. Vaidyanathan on September 30 at which time the transverse lie was confirmed on clinical examination. She was experiencing some pain which Dr. Vaidyanathan attributed to a coincidental uterine fibroid. The antenatal record contains the notation, "to go to L & D, prn" (to go to Labour and Delivery, if necessary). The same advice is documented elsewhere in the record.

The patient returned the following day in true labour, with the transverse lie persisting. Dr. Vaidyanathan recommended and performed an emergency Cesarean section.

Dr. A explained the significance of the transverse lie. If the baby is lying back-down, the situation is not dangerous, although, unless the lie can be converted, vaginal delivery will not be possible. If the baby is lying back-up and the membranes rupture, the umbilical cord may prolapse through the cervix – a true obstetric emergency!

Dr. A had no major criticism of this patient's management, except that he found no (or inadequate) indication that the relevant facts were conveyed to the patient or the importance stressed of going to the hospital promptly should labour begin or the waters break.

Dr. H was supportive of all aspects of the clinical care, although he accepted the suggestion that the specific documentation required by Dr. A is lacking.

The Committee accepted that the notation, "go to L & D, prn," while minimal, can be construed as representing instructions to the patient to go to hospital in the appropriate circumstance.

It therefore found the standard to have been met in the care of this patient.

Case # 35 and Case # 36 were conceded by the College prior to the proceedings and no evidence was presented with respect to either patient.

Case # 37

The patient, a 30-year-old woman, saw Dr. Vaidyanathan on August 6, 2003. She was having side effects from her birth control medication and requested tubal ligation and endometrial ablation. He recommended a preliminary Pap smear and colposcopy (to rule out cervical cancer) as well as an endometrial biopsy, and these procedures were performed. The endometrial biopsy was normal; the cervical biopsy showed an early precancerous lesion.

Dr. Vaidyanathan recommended a loop electrosurgical excision procedure (LEEP), a selective removal of areas of the cervix, as well as laparoscopic clipping of the tubes and microwave endometrial ablation (MEA). The operation was performed December 29, 2003 in the following order: laparoscopy; LEEP; and, finally, MEA. Dr. Vaidyanathan's operation report contains no indication that anything untoward was suspected. Indeed, the section concerning the MEA contains the statement, "There were no complications."

The patient was discharged following recovery from anesthetic but returned at 2:26 a.m. the following morning complaining of abdominal pain. Dr. Vaidyanathan assessed her and admitted her to hospital. She was observed in hospital over the following three days while supported with intravenous fluid, analgesics and antibiotics. She exhibited a number of worrisome, but inconclusive, features, including elevated pulse, respiratory rate and white blood cell count, low-grade fever, failure of gas passage, abdominal tenderness (although no clear peritonitis) and a CT scan finding of fluid around the right lower lung and in the right abdomen. General Surgery consultation was obtained on January 1 and a different general surgeon saw her on January 2, on which day she was taken back to the OR. Dr. Vaidyanathan followed her throughout this period and was present at her abdominal surgery. Multiple bowel perforations and abdominal abscesses were found, associated with what was interpreted, at least by those present, as a perforation of the uterus. The bowel damage was

repaired and the patient made a protracted, but successful, recovery, being discharged from hospital on January 16.

Dr. A explained the machinery and the procedure of microwave endometrial ablation. After determining the depth of the uterine cavity with a uterine sound, the cervix is dilated and the microwave probe inserted. The surgeon should feel resistance when the probe reaches the fundus of the uterus and the depth of insertion, which can be determined from gradations on the side of the probe, should be correlated with the previous measurement. The tip of the probe is then swept across the fundus of the uterus; according to Dr. A, it would not be possible to perform this maneuver if the probe were lodged in the uterine muscle. Once the position is confirmed, power is applied to the probe, heating the tip and, swinging it from side to side, the probe is gradually withdrawn, ablating the endometrium. The temperature in the uterine cavity is continuously recorded and, while it will fluctuate with movement of the probe, the therapeutic range for this machinery is between 70 and 80°C.

In the case of this patient, the therapeutic range was not reached and the temperature recordings are between 50 and 70°. In Dr. A's opinion, that should have raised concern that the probe was not in the proper place – for example, it might have been in the peritoneal cavity where the larger volume would promote dissipation of heat.

Dr. A's other principal concern was the order in which the three procedures were performed. He testified that the fact that Dr. Vaidyanathan performed the laparoscopy first, instead of last, denied him the opportunity of verifying whether or not a complication, such as perforation of the uterus, had occurred during the other procedures, allowing any consequences to be appreciated and treated in a more timely fashion. He testified that his suggested order of procedures was simple "good risk management."

In Dr. A's view, a uterine perforation by the microwave probe resulted in a thermal injury to the bowel and consequent bowel perforation. He opined that the sequence of acts during this surgery constituted a lack of skill, knowledge and judgment and fell below the standard of the profession because of: 1) the failure to recognize, on measurement and mechanical grounds,

the possibility of uterine perforation; 2) the lack of recognition of the significance of the failure of the temperature readings to reach the therapeutic range; and, 3) the inappropriate sequence of operative procedures.

On cross-examination, Dr. A agreed that there was documentation that the risks of endometrial ablation, including perforation of the uterus, were discussed with the patient.

Dr. B, the Acting Head of Obstetrics/Gynecology at HRRH at that time, testified that he was called from the operating room by Dr. Vaidyanathan for help in turning on the microwave machine. This equipment was normally kept in the Outpatient Department and would, therefore, not be familiar to the OR nurses. The College contended that this exemplified Dr. Vaidyanathan's lack of knowledge of the procedure. Dr. B testified that Dr. Vaidyanathan did, in his opinion, have the skill to perform this procedure. To his knowledge, no previous patient of Dr. Vaidyanathan's had suffered a perforation of the uterus during a MEA.

Dr. M, a general surgeon at HRRH, testified. He saw the patient in consultation on January 1, 2004. He thought the clinical picture was more in keeping with an injury to the uterus than to the bowel. He thought that the clinical course was one of gradual resolution and he advised continuing intravenous fluid, antibiotics and observation, but recommended laparotomy if further improvement was not evident by the next day. He testified that it was reasonable for Dr. Vaidyanathan to rely on his opinion.

Dr. J testified that, in his opinion, there was no area in which the care of this patient failed to meet the standard, but admitted that he had no personal experience with microwave ablation and that his opinion was based solely on a literature review.

Dr. L, Dr. Vaidyanathan's College-appointed supervisor, testified that he reviewed this case and discussed it with Dr. Vaidyanathan. He opined that Dr. Vaidyanathan had taken all the standard precautions. He stated that a perforation of the uterus took place, "which happens to us all the time; unfortunately, this time it happened with the microwave probe."

The last witness to testify with respect to this patient was Dr. K, a professor of obstetrics and gynecology at the University of Western Ontario with special expertise in endometrial ablation, and Chairman of the SOGC committee responsible for writing the guidelines in this area. His CV is impressive and his expertise in this area, obvious from his testimony. However, he testified that, following the initial pilot studies done more than six years ago, he has made no further use of MEA in his own practice and has no specific knowledge of the manufacturer's updates or policies over the last six years.

From his review of the record, Dr. K opined that Dr. Vaidyanathan's care met the standard of the profession.

With respect to the order of the procedures, he testified that the order followed by Dr. Vaidyanathan was actually *safer* than the reverse. Vaginal surgery is classified as "clean contaminated" because of bacterial flora normally resident in the vagina and perineal area. Therefore, to perform a vaginal procedure first would increase the potential for contamination of the peritoneal cavity by subsequent laparoscopy.

However, on cross-examination, Dr. K was taken to the SOGC guideline (which he, himself, had authored) which recommends hysteroscopy before and after endometrial ablation, in part, to detect such complications as uterine perforation (although Dr. K indicated that this recommendation is the subject of recurring debates). He agreed that laparoscopy would be equally likely to detect uterine perforation, but opined that it might miss a bowel injury. He agreed that, in the United States, as a result of an FDA ruling, the manufacturer recommended using ultrasound to determine the thickness of the uterine wall. He was not aware of the protocol in Canada.

Dr. K disputed the assumption that the bowel injury had to have resulted from a perforation of the uterus. He opined that heat could have been transmitted through the wall of the uterus, for example, through an area of scar tissue (this patient had had previous D& C's). Dr. K acknowledged that, in his operative note (at which operation Dr. Vaidyanathan was also

present), the general surgeon recorded that, “there may have been an inadvertent perforation of the fundus of the uterus,” with thermal injury to the adjacent bowel.

Respecting the therapeutic temperature range for microwave ablation, Dr. K testified that it should be between 60 and 90° C. He subsequently testified (based on studies using different technology) that any temperature above 45° C would be equally effective and that using lower temperatures would carry less risk to the uterus and adjacent organs.

On cross-examination, he was taken to a paper, authored by himself and considered authoritative at the time, in which a therapeutic range of 80 to 95° C. is recommended. He testified that his current opinion (60 to 90°) was based upon a conversation, either with a colleague or with a manufacturer’s representative, which occurred within the last six months and that he was unaware of any recent literature which recommended a lower therapeutic temperature for MEA. He was also taken to a paper by a British gynecologist, which he agreed was authoritative (having, himself, designed the technology) which recommended the same therapeutic range (70 to 80° C) stated by Dr. A.

The Committee gave careful consideration to the opinions of all the experts before arriving at the finding that Dr. Vaidyanathan failed to meet the standard of the profession in the care of this patient.

It was necessary for the Committee to consider what weight to give to the conflicting expert opinions.

Dr. A’s testimony bespoke an intimate familiarity with the technique of MEA and the Committee noted that, among the three experts who reviewed the case and commented on the standard of care, he is the only one currently using the technology.

Dr. J admitted a lack of personal familiarity with MEA and the Committee felt that his support for Dr. Vaidyanathan’s care should be given correspondingly less weight.

Dr. K's expertise in the area of endometrial ablation was obvious and unchallenged. However, his familiarity with *this* particular technology did not appear to the Committee to be current. His testimony was, at times, confusing or self-contradictory (for example, in the breadth, 45 to 95° C, of the recommended temperature ranges for MEA) and, at others, appeared to stray beyond instruction and into advocacy.

The Committee accepted, on the overwhelming balance of probabilities, that perforation of the uterus occurred. It preferred the observation of those actually present at the laparotomy to the theory advanced by Dr. K of a burn through the intact uterine wall, which was not supported by any reference to the literature, or even to his own experience. It also found that, whatever subsequent research might have shown, the minimum recommended therapeutic temperature in December, 2003, would have been the 70° C specified by Dr. A and that the failure to achieve that level should have raised concern. Had Dr. Vaidyanathan been alerted by any of the "red flags" described by Dr. A, the injury could have been discovered, either by hysteroscopy or laparoscopy, and appropriate management instituted under the same anesthetic.

The Committee did not consider the issue of the order of the procedures to be fundamental. With appropriate suspicion, a second laparoscopy could have been performed through the same mini-incision and would have been technically simple.

Lastly, the Committee debated the issue of whether the management of this patient was sufficiently egregious as to constitute incompetence.

It took note of Dr. B's testimony that, to his knowledge, the circumstances of this case are unique in Dr. Vaidyanathan's practice. It also noted Dr. L's testimony that uterine perforation, "happens to all of us" and Dr. K's more-quantitative testimony that it occurs approximately once for each 1000 intrauterine operations.

The Committee also noted Dr. K's testimony that bowel injury is not an indication of negligence, but rather an inherent complication of gynecologic surgery. The Committee was

of the opinion that the failure in the management of this patients lay, not so much in the technical performance of the surgery, but in the lack of appropriate suspicion that a serious complication might have occurred.

Nonetheless, the Committee concluded that this care, while admittedly substandard, did not, in isolation, meet the definition of incompetence.

Case #38

This patient was not part of Dr. A's original review. Instead, he was asked to review her records following the investigation, prompted by a letter of complaint sent to the College by the patient concerning Dr. Vaidyanathan's care.

The patient saw Dr. Vaidyanathan originally in 2002, at which time he diagnosed stress incontinence and recommended a course of pelvic floor exercises.

He next saw her in November, 2003. She had had no period since July (a home pregnancy test was negative) and was complaining of weight gain, increased facial hair and decreased libido. Screening hormonal blood tests and ultrasound had been ordered by the family doctor. The hormone tests were normal and included a free testosterone determination which was in the upper part of the normal range. The ultrasound showed multiple ovarian cysts, consistent with polycystic ovarian syndrome, and Dr. Vaidyanathan's clinical diagnoses were: 1) hyperandrogenic chronic anovulation; and, 2) insulin resistance.

Dr. A agreed with the first diagnosis but felt that the second required further investigation to establish the diagnosis.

Dr. Vaidyanathan's treatment plan was multipartite. He recommended: 1) weight loss through diet and exercise; and, 2) improved communication with her partner concerning her poor sex drive.

He prescribed: 1) Androgel (a testosterone-containing medication) for a trial of libido stimulation; 2) Prometrium, a progesterone, intended to bring on withdrawal bleeding, to be followed by a low-dose birth control pill; 3) Minestrin, the low-dose birth control pill; and, 4) metformin, to treat insulin resistance.

(Although Dr. Vaidyanathan's note states that "metformin may be added later", it appears that the medication was prescribed at this visit.)

Dr. Vaidyanathan recorded that he counseled the patient concerning potential side effects of the medications, including: phlebitis; deep vein thrombosis; pulmonary embolism; and, myocardial infarction.

Dr. A was critical of two aspects of this treatment.

First, the dose, duration, etc., of the medications was not recorded.

Secondly, he testified that Androgel was contraindicated because: 1) it is not used for female patients; and, 2) there was no evidence of testosterone deficiency, the free testosterone level being high-normal.

Thirdly, Dr. A testified that Dr. Vaidyanathan should not have prescribed metformin without confirming the diagnosis of insulin resistance. Confirmatory testing could, and should, have been done, including fasting blood sugar, fasting insulin level and/or glucose tolerance test. He was challenged vigorously on this point on cross-examination and taken to two articles in authoritative journals supporting the benefit of metformin in this condition, without the necessity of preliminary testing of insulin levels.

The records of Dr. Vaidyanathan were supplemented thereafter by the direct testimony of the patient and the record of her care at St. Joseph's Health Centre.

The patient testified that she did not start the medications until January because she did not want to diet during the holiday season. Two weeks after beginning the medications, she called Dr. Vaidyanathan's office (she does not remember to whom she spoke) to complain of leg pain and was told that she had nothing to worry about as she was young and she would only be on the medication for a brief period of time. She was not seen and had no investigation. She agreed that no diagnosis of phlebitis or deep vein thrombosis was ever made.

On February 16, she developed chest pressure associated with arm pain and dizziness and went to St. Joseph's Health Centre. She was admitted, investigated over the following four days and readmitted, for a one-day stay, on February 21 because of a recurrence of symptoms. She testified that she was told that she had had a "heart attack" and that "her whole life would be changed" (with respect to insurance). Her hospital records include no evidence of myocardial infarction or pulmonary embolism. There was a normal coronary angiogram and echocardiogram and no definitive diagnosis, with respect to the nature of the chest pains, was made. It was noted that she had been taking ephedrine (although she denied it in testimony) and coronary vasospasm was suspected.

She testified that she called Dr. Vaidyanathan's office on February 25 and told him what had happened. In her account, he told her that he was not surprised, because her cholesterol had been elevated, and he had seen heart attacks before in young women with polycystic ovarian syndrome.

Although he requested that she return for follow up, she decided to go to another gynecologist. When she called his office, seeking a specific figure for her cholesterol, no result could be found, nor any indication that the test had ever been done.

Considering a hypothetical scenario, similar to the facts described above, Dr. A testified that there was no basis to respond to the patient in that fashion.

No expert testified on behalf of the defence.

On cross-examination, Dr. H recalled that he reviewed the case, although he did not submit a report. He was shown a hypothetical scenario containing facts similar to that of the case. He testified that polycystic ovarian syndrome is not a rare occurrence and that the appropriate counseling was offered. He was asked whether prescribing metformin without preliminary testing fell below the standard of the profession and replied that it was "not ideal or desirable." He could see no indication for prescribing Androgel, but did not specify whether it was the choice of Androgel, or the prescription of testosterone, which was contraindicated. He opined that advising a patient who complained of leg pain, under the circumstances described, that she had "nothing to worry about" was substandard.

The Committee gave due consideration to the several issues respecting the care of this patient.

It felt that the prescription of metformin for presumptive insulin resistance, while perhaps not ideal management, or even that adopted by the majority of the profession, did have enough literature support to constitute the "substantial body of opinion" necessary for it to meet the standard.

In the Committee's opinion, the prescription of Androgel, even allowing that it was only for a "trial," and that female libido stimulation might be an "off-label" indication for Androgel, was illogical in a patient with a high normal free testosterone, and who had been diagnosed with *hyper*androgenic chronic anovulation. In the absence of any expert support for this prescription, the Committee accepted Dr. A's opinion that it falls below the appropriate standard of care.

With respect to his advice concerning elevated cholesterol, Dr. Vaidyanathan clearly misspoke. The Committee was of the opinion that the patient, knowing that no blood had ever been drawn, should have been aware that Dr. Vaidyanathan could not possibly have a cholesterol result and that his memory must be in error.

Lastly, the Committee considered the advice, which the patient received when she complained of leg pain. While cognizant of the difficulty of recalling the exact words of a conversation, which took place more than two years previously, the Committee noted that her recollection went unchallenged, either on cross-examination or by conflicting testimony. It therefore accepted the experts' opinions that advising a woman who complains of leg pain while on hormone therapy, without examination and/or investigation that she has "nothing to worry about" is unsupportable and falls below the standard of the profession.

While accepting that there were deficiencies in specific areas, the Committee was of the opinion that the overall care of this patient did not demonstrate a lack of knowledge, skill or judgment sufficient to support a finding of incompetence.

Case # 39

This patient, like the previous, had also complained to the College about Dr. Vaidyanathan's care and testified in her own behalf.

She was 28 when she was referred for tubal ligation in the spring of 2004. She had just undergone a therapeutic abortion (her third) and had two live children.

Although she was originally given an appointment on April 8, she did not see Dr. Vaidyanathan (for reasons unspecified) until July 27. She testified that she told Dr. Vaidyanathan that she had always had highly irregular periods, that she had had no period in the three months prior to the visit, that she had had unprotected sex since the abortion and that she couldn't tell if she might be pregnant. She requested a pregnancy test.

Dr. Vaidyanathan sent in a booking for tubal ligation the same day. His notation under "investigations planned" includes a hormone profile and "rule out pregnancy." The appropriate box for a pregnancy test on the booking request was not ticked off and the test was never done.

Although Dr. Vaidyanathan wrote on the bottom of the slip reporting the hormone levels, dated July 30, “check beta HCG,” when the outpatient tubal ligation was performed on August 5, neither he, the anesthetist, the pre-admission nurses nor the OR nurses picked up the fact that there was no pregnancy test result on the chart.

The patient was, in fact, pregnant at the time. Although the surgery proceeded without incident and her recovery was uneventful, she developed nonspecific symptoms for which she contacted her family doctor on October 15. He diagnosed pregnancy which was confirmed by beta HCG and dated by ultrasound at 17 weeks and six days gestation (placing conception on or about June 12).

Therapeutic abortion at this stage in pregnancy is a much more difficult undertaking than when performed early (for example, at four to six weeks) and the patient decided to carry the pregnancy to term.

Dr. A opined that the failure to have a system in place to ensure the lack of pregnancy prior to performing a tubal ligation fell below the standard of the profession.

The defence experts (Drs. H and D) agreed and Dr. Vaidyanathan conceded the issue by changing his response, at the conclusion of testimony, to “no contest,” with respect to the allegation of the failure to meet the standard.

The College invited the Committee to find that Dr. Vaidyanathan’s, “pattern of carelessness in ordering and following through on investigations prior to treatment” in this case constituted incompetence. The Committee did not observe such a pattern and was mindful that incompetence must be clinical and that purely managerial errors do not constitute incompetence. The Committee therefore found that Dr. Vaidyanathan’s care was not incompetent. There was no suggestion of a knowledge deficit; Dr. Vaidyanathan clearly knew (from his own notes) that a pregnancy test was necessary prior to a tubal ligation – he simply failed to see that it happened. In the opinion of the Committee, this represented a clerical or managerial error, and not a clinical one. The Committee also noted that, while Dr.

Vaidyanathan has to bear the prime responsibility, this was also a systemic failure in which multiple other players, who might have picked up the omission, failed to do so.

DECISION AND REASONS WITH RESPECT TO INCOMPETENCE

Having failed to find that incompetence had been proven in the care of any *single* patient, the Committee then considered whether, in the aggregate, a pattern of incompetent practice had been demonstrated. It also considered the alternative question of whether the multiple cases introduced by the College, and then conceded to be unproven, actually served to *bolster* confidence in Dr. Vaidyanathan's competence.

In making its determination, the Committee was cognizant of:

1) the College's burden to prove incompetence to the Bernstein standard, which requires that the proof be "clear and convincing and based on cogent evidence";

2) the definition of incompetence, in subsection 52 (1) of the Code, which requires demonstration that, "his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients, of a nature or to an extent that demonstrates that he is unfit to continue practice or that his practice should be restricted";

3) the description of incompetence in Richard Steinecke's, "A Complete Guide to the Regulated Health Professions Act," (in excerpt) that incompetence must be clinical, must relate to a deficiency and must be sufficiently serious to indicate, "that the practitioner cannot be trusted with the care of patients in at least some circumstances……"; and,

4) that incompetence has a temporal component, i.e., that a finding of incompetence must be based on a *present* deficiency and not on one in the remote past.

The Committee found that the College had failed to establish that Dr. Vaidyanathan is incompetent in the aggregate as well as in the individual cases where it found his care to be substandard.

The Committee could discern no pattern of deficiency among the six cases in which it found that at least some aspect of the care failed to meet the standard of the profession. Of the five cases judged to be substandard, the issues included**:** a failure of timely diagnosis of ectopic pregnancy; improper performance of an MEA with serious consequences; removal of normal ovaries without consent; inaccurate contemporaneous record; inappropriate telephone advice to a patient complaining of leg pain and inappropriate prescription of testosterone; and, failure to ensure that a patient undergoing tubal ligation was not pregnant at the time. In the opinion of the Committee, there is no overlap or duplication among the clinical deficiencies and no pattern regarding the occurrences was proven to the requisite standard, despite a painstaking examination of a busy obstetric/gynecologic practice.

In the case involving the bowel perforation following MEA, the Committee was asked to conclude, on the basis of this single surgical procedure, that Dr. Vaidyanathan lacked surgical skill. Contrary to that conclusion were several items of evidence. The testimony of Dr. B was that he knew of no other instance of a complication of MEA in Dr. Vaidyanathan's practice. Dr. Vaidyanathan estimated that he had done the procedure on at least forty previous occasions. The only person (Dr. L) who had had ample opportunity to observe Dr. Vaidyanathan's capability in the operating room testified that he had "very good technical skills." In addition, the Committee had serious reservations about the many instances in which Dr. A opined that Dr. Vaidyanathan's surgical skills fell below standard when his only basis for these opinions was his review of the record. He did not observe, or seek to observe, any surgical procedures performed by Dr. Vaidyanathan. For these reasons, the Committee gives correspondingly little weight to Dr. A's assessment of Dr. Vaidyanathan's surgical skills.

In its submissions, the defence presented a Brief of Continuing Medical Education Documentation for Dr. Vaidyanathan, which enumerated the numerous professional

educational courses in which Dr. Vaidyanathan had participated. These included, among many others, courses entitled, “Severe Pre-eclampsia,” “Medical Mistakes,” “Polycystic Ovary Syndrome – Comprehensive Care of the Patient,” “Scientific Basis for the Selection of Surgical Needles and Sutures,” “Reducing Accidental Injuries During Surgery and “Using and Abusing Oxytocin.” To the Committee, this represented evidence of a serious effort to rectify any perceived areas of deficiency, with direct bearing on Dr. Vaidyanathan’s “present” competence.

The Committee was also concerned about the methodology for selection of cases for analysis on the basis of recorded complications. No evidence was presented at the hearing to support that Dr. Vaidyanathan’s complication rate was in any way abnormal in comparison with his peers. In fact, the hospital statistics that were provided in respect of obstetrical complications/interventions places Dr. Vaidyanathan very much at the median level.

By the very nature of such a review, one would expect to be seeing negative outcomes. In many cases (particularly those that were eventually conceded by the College), it was the Committee’s opinion that Dr. A appeared to work back from these negative outcomes to attribute the cause to Dr. Vaidyanathan’s poor management. Where a potential benign explanation was equally available for Dr. Vaidyanathan’s decisions or judgment, invariably Dr. A posited the negative one, and was rarely swayed from this position even in the face of challenging opinions from opposing experts or authoritative texts, journals and clinical practice guidelines.

Finally, the Committee feels obliged to observe that the College’s case against Dr. Vaidyanathan was based on thirty-nine cases in which its expert originally opined that Dr. Vaidyanathan fell below the standard of care and/or was incompetent. At the outset of the hearing, two of these cases were withdrawn. At the conclusion of the hearing, eleven of the remaining cases were conceded by the College as not having met the burden of proof and, in one further case, the College conceded that its position wasn’t strong. In the majority of the conceded cases, and some of the contested ones, the evidence presented actually led the

Committee to the opinion that Dr. Vaidyanathan's care was very good as opposed to substandard.

In summary, the Committee found the allegation of failing to meet the standard of the profession to be proven in six instances relating to cases #'s 2, 16, 25, 37, 38 and 39 and not proven in the remaining thirty-one cases in which evidence was presented. The Committee also found that the allegation of incompetence was not proven.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Sankar Vaidyanathan, 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(1) 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: 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 and the Complaints Committee of
the College of Physicians and Surgeons of Ontario
pursuant to subsection 36(1) and 26(2) of the **Health Professions Procedural Code**,
being Schedule 2 of the ***Regulated Health Professions Act, 1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. SANKAR VAIDYANATHAN

PANEL MEMBERS: DR. R. MACKENZIE (CHAIR)
E. COLLINS
DR. W. KING
DR. B. TAA (PHD)
DR. J. DOHERTY

Penalty Hearing Date:	August 15, 2006
Penalty Decision Date:	September 20, 2006
Release of Written Reasons on Penalty:	September 20, 2006

PUBLICATION BAN

PENALTY DECISION AND REASONS

The Discipline Committee of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on October 17 to 21, 31, November 2 to 4, 22 to 25, 2005 and January 23 to 25, 2006. At the conclusion of the hearing, the Committee reserved its decision. On July 7, 2006, the Committee delivered in writing its decision and reasons for decision as to finding. The Committee found that Dr. Vaidyanathan committed acts 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 he failed to meet the standard of the profession in six cases.

The Committee heard evidence and submissions on penalty on August 15, 2006 and reserved its decision on penalty.

PENALTY ORDER AND REASONS

The Committee is charged with the responsibility of determining the appropriate penalty for its finding of professional misconduct by Dr. Vaidyanathan in the six cases in which it found that there had been a failure to meet the standard of practice of the profession, i.e. Case 2 - failure to diagnose ectopic pregnancy; Case 16 - failure to obtain consent for removal of ovaries; Case 25 - inaccuracy in record keeping; Case 37 - failure to recognize a serious surgical complication; Case 38 - inappropriate prescription of Androgel and inappropriately advising a patient without examination; and, Case 39 - failure to have a system to ensure lack of pregnancy prior to performing tubal ligation.

In arriving at its decision with respect to penalty, the Committee carefully considered victim impact statements from three patients, Case 39, Case 38 and Case 37 (Exhibits #'s 40, 41 & 42) and a brief (Exhibit #44) containing some seventy-three letters of support for Dr. Vaidyanathan from patients and colleagues. A brief of continuing medical education undertaken by Dr. Vaidyanathan was also provided and considered.

A further exhibit (#43) was introduced. It is an order, made under section 37 of the Health Professions Procedural Code dated February 28, 2005, restricting Dr.

Vaidyanathan from performing any sort of medical practice except surgical assisting. The Committee was informed by his counsel that Dr. Vaidyanathan had voluntarily refrained from surgically assisting since the date of that order and that he had resigned his privileges at Humber River Regional Hospital as of June, 2005.

The Committee heard the testimony of four of Dr. Vaidyanathan's patients, Dr. U (she is also a colleague.), Ms. V, Ms. W and Ms. X. Each was fulsome in her praise of Dr. Vaidyanathan's care, characterizing him variously as a good listener, sincere, compassionate and willing to take time to explain difficult subjects in appropriate language. None expressed any concern respecting the care which she had received and each, despite being aware, in general terms, of the findings of the 2001 and 2006 Discipline Committees, indicated that she would return to him as a patient if he were to resume full or unrestricted practice.

The Committee also heard the testimony of two colleagues, Dr. Y, a primary care physician on the staff of Humber River Regional Hospital, and Dr. Z, a primary care physician on the staff of the Etobicoke campus of the William Osler Health Centre. Dr. Y recalled that the medical group to which he belongs used to refer about fifteen to twenty patients per month to Dr. Vaidyanathan over a six to seven year period. Dr. Z testified that he had referred four to eight patients per month to Dr. Vaidyanathan over a nine to ten year span. Both praised Dr. Vaidyanathan as accessible and accommodating and reported no negative feedback from their patients nor any personal concern with respect to his patient care. Dr. Z testified that his is a highly "ethnic" practice and that Dr. Vaidyanathan's language skills and awareness of his patients' cultural values were decided assets.

Both colleagues testified to an awareness, in general terms, of the findings of the 2001 and 2006 Discipline Committees. Nonetheless, were he to resume full or unrestricted practice, both would again refer patients to Dr. Vaidyanathan.

Counsel for the College submitted that the College is seeking revocation of Dr. Vaidyanathan's certificate of registration to practise medicine or, in the alternative, a permanent restriction prohibiting Dr. Vaidyanathan from practising obstetrics or surgery, combined with monthly supervision of his office practice, the supervisor to report quarterly to the Registrar, a 12-month suspension of his certificate of registration, and a recorded reprimand. College counsel made clear in her submission that revocation was her primary submission and that the alternative submission was very much a less desirable outcome.

Counsel for the physician submitted that an appropriate penalty would be a reprimand and a suspension of 12 months, itself to be suspended because of the nearly 18 months which Dr. Vaidyanathan had already spent out of practice. He submitted that revocation should be linked to incompetence or to intolerable behaviour, neither of which apply in this matter.

The Committee was provided with the decision of the 2001 Discipline Committee which found Dr. Vaidyanathan to be incompetent and to be guilty of professional misconduct by failing to maintain the standard of practice of the profession, by falsifying a record relating to his practice and by engaging 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.

Counsel for the parties in their submissions noted that "revocation" as a penalty, as directed by the Courts, was to be reserved for the worst cases and "repeat offenders".

Counsel for the College submitted that the Committee's findings in this case constituted a repeat offence. Counsel for Dr. Vaidyanathan disagreed vigorously with the College's position. He submitted that there was little similarity between the findings of the two hearings. He reminded the Committee that there was no finding of incompetence made in 2006. Moreover, while all the instances of substandard care found by the 2001 Committee concerned obstetrical patients, none of the cases of obstetrical care presented

in the 2006 cohort was found to fall below the standard practice of the profession. Furthermore, in 2006, no surgical procedures were found to have been conducted in a substandard fashion. In case #37, where a uterine perforation took place, the Committee's criticism was of the *failure to recognize* the complication and not the *occurrence* of the complication.

The Committee was not persuaded by the argument that there were sufficient similarities in the findings of the two hearings to establish a pattern. In a sense, any two cases in which findings of substandard care have been made are similar – at least to the extent that the care in both was substandard. However, the search for common features begs assessment of the strength of the commonality. For example, the suggestion of equivalence between an admitted, after-the-fact falsification of patient records and the misstatement that a patient was in labor when she was not, or, even more, with the failure to record a drug prescription, was not accepted by the Committee. A countering, and perhaps more persuasive, example occurred in Dr. Vaidyanathan's management of uterine rupture. Such a case in 2001 formed a major part of the finding of incompetence. The management of a similar case in the 2006 cohort, while criticized, in some aspects, by the College expert, was found by the Committee to have met, or perhaps *exceeded*, the standard of the profession.

Therefore, the Committee was of the opinion that an insufficient case had been made to consider Dr. Vaidyanathan a "repeat offender" on a basis that would justify revocation of his certificate of registration.

This does not mean that the Committee treats lightly the six cases of substandard practice which it found to constitute professional misconduct. In considering an appropriate penalty, the Committee has taken into account that, by virtue of the section 37 Order, Dr. Vaidyanathan has been restricted since February 28, 2005, from practising any sort of medical practice except surgical assisting, which he voluntarily elected not to do. In effect, a lengthy suspension of more than 18 months has been served by Dr. Vaidyanathan, and the Committee does not consider any further punitive action is

necessary as part of the penalty. The penalty objectives of general and specific deterrence are addressed by what has been in effect a lengthy suspension and the order of a reprimand. The Order that the Committee makes addresses the additional penalty objectives of public protection and rehabilitation.

The Committee gave careful and thorough consideration to Dr. Vaidyanathan's fitness to reenter practice following his 18-month absence. The Committee considered Dr. Vaidyanathan's successful completion of a SAP assessment ordered as part of the 2001 decision, and the extensive brief of continuing education submitted on Dr. Vaidyanathan's behalf. The Committee is therefore comfortable that Dr. Vaidyanathan has demonstrated evidence of having kept up with developments in obstetrics and gynecology and is unlikely to have a significant *knowledge* deficit in the practice of his specialty. Therefore, one option which could be considered would be to limit Dr. Vaidyanathan's practice, similar, in some respects, to that proposed in the College's "alternative" penalty submission. In that scenario, he would counsel obstetrical patients and render prenatal care, treat and advise gynecologic patients, but do only those surgical procedures appropriate to an office setting. The Committee would have no problem with his resuming such a practice immediately, subject to appropriate monitoring for a period of time.

The Committee is, however, *un*comfortable with his immediate resumption of a full obstetrical/gynecological practice. The CPSO policy respecting the need for reassessment/retraining after an extended absence from practice was brought to the Committee's attention. Under that policy, a reassessment must occur if any physician wishes to reenter practice after an absence of three years or if she/he has practised for less than six months in the preceding five years. However, this is a general policy, not specific to surgical disciplines where additional factors beyond currency of knowledge come into play. It is hard to imagine a patient wishing to undergo an operation by a surgeon who has not set foot in an operating room for 18 months, let alone three years. The Committee would therefore be unwilling to permit Dr. Vaidyanathan to return to operative obstetrics and gynecology without a period of "hands-on" retraining.

Counsel for Dr. Vaidyanathan submitted that Dr. Vaidyanathan does not currently have hospital privileges and that any resumption of such privileges would be subject to the customary hospital credentialing process. While accepting the validity of that argument, the Committee would be more assured in its role of protecting the public by stipulating the minimum retraining requirements, rather than relying entirely upon an as yet unknown Credentials Committee or hospital Board.

ORDER

Therefore, the Discipline Committee orders and directs that:

1. Dr. Vaidyanathan is required to attend before the panel to be reprimanded on a date to be fixed by the Hearings Office in conjunction with the parties no later than three months from the date this order becomes final.

2. The Committee directs the Registrar to impose the following terms, conditions and limitations on Dr. Vaidyanathan's certificate of registration:

    i) upon his return to practice, Dr. Vaidyanathan is restricted to performing only procedures appropriate to an office setting and, in an institutional setting, he is restricted to performing as a surgical assistant (meaning that Dr. Vaidyanathan may only assist other surgeons in their cases and cannot be the primary surgeon in any case and is precluded from providing surgical care including any post-operative care).

    ii) Dr. Vaidyanathan shall practise in an office setting under a clinical supervisor, who is acceptable to the College and who has signed an undertaking acceptable to the College, for twelve months following the resumption of practice at his own expense. The clinical supervisor will report quarterly to the College. Dr. Vaidyanathan will be required to meet with the supervisor monthly, at which time the supervisor will review a representative sample of Dr. Vaidyanathan's patient charts (to be chosen by the supervisor), and

discuss them with Dr. Vaidyanathan. Dr. Vaidyanathan is required to follow any recommendations of the clinical supervisor.

3. In the event that Dr. Vaidyanathan wishes to resume the *full* practice of obstetrics/gynecology and have the terms, conditions and limitations in paragraph 2 removed, he must undergo a preceptorship acceptable to the College, at his own expense, for a minimum period of three months, with an obstetrician/gynecologist who is acceptable to the College, who has signed an undertaking acceptable to the College. At the conclusion of the preceptorship, the preceptor must report to the College that Dr. Vaidyanathan is, in all respects, ready to resume the independent, operative practice of obstetrics/gynecology.

4. If the parties cannot agree upon and consider it appropriate for the Committee to specify more specific terms for the preceptorship, the Committee will consider written submissions from the parties in this regard to be filed within thirty days of the date of this Order, and will impose specific terms relating to the preceptorship.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Sankar Vaidyanathan, 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(1) 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 : 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 and the Complaints Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 36(1) and 26(2) of the ***Health Professions Procedural Code,*** being Schedule 2 of the ***Regulated Health Professions Act, 1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. SANKAR VAIDYANATHAN

PANEL MEMBERS: DR. R. MACKENZIE (CHAIR)
E. COLLINS
DR. W. KING
B. TAA (PHD)
DR. J. DOHERTY

Hearing Date: August 15, 2006
Decision Date: November 27, 2006
Release of Written Reasons Date: November 27, 2006

Publication Ban

SUPPLEMENTARY PENALTY DECISION AND REASONS

The Discipline Committee of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on October 17 to 21, 31, November 2 to 4, 22 to 25, 2005 and January 23 to 25, 2006. At the conclusion of the hearing, the Committee reserved its decision. On July 7, 2006, the Committee delivered in writing its decision and reasons for decision as to finding. The Committee found that Dr. Vaidyanathan committed acts 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 he failed to meet the standard of the profession in six cases.

The Committee heard evidence and submissions on penalty on August 15, 2006 and reserved its decision on penalty. The Committee delivered in writing its Penalty Order and Reasons on September 20, 2006. In that Order and Reasons the Committee, among other things, ordered that in the event that Dr. Vaidyanathan wishes to resume the full practice of obstetrics/gynaecology and have the terms, conditions and limitations in paragraph 2 of the Penalty Order removed, he must undergo a preceptorship acceptable to the College, at his own expense, for a minimum of three months and as otherwise specified in the Order. The Penalty Order and Reasons provided that if the parties could not agree upon more specific terms for the preceptorship, the Committee would consider written submissions from the parties to be filed within 30 days of the date of the Penalty Decision and Reasons. The parties were not able to agree upon all the terms with respect to the preceptorship. By Order made October 19, 2006, the period of time for written submissions was extended to November 20, 2006.

The parties are in agreement with respect to a number of areas and are further in agreement that it is not necessary for the Discipline Committee to make any specific order regarding those terms with which they are in agreement. The parties are in agreement that the preceptorship should take place in an academic setting and be similar in nature to a mini-residency or fellowship. During the preceptorship, Dr. Vaidyanathan will be fully supervised and will not be the responsible physician with respect to any patient.

Counsel for the College was also seeking to have included as an express term of the Penalty Decision related to the preceptorship that Dr. Vaidyanathan's surgical obstetrical and gynaecological practice should be monitored for one to two years in the form of a monthly chart review by the preceptor with monthly reports to be provided to the College. Counsel for the member opposed the imposition of this term arguing that the preceptorship, by the nature of the Order made by this Committee, is necessary only until such time as the preceptor concludes that the doctor is capable of independent practice.

After careful consideration, the Committee is not persuaded that it is appropriate to order any specific monthly monitoring or otherwise deal with the circumstances as the preceptorship unfolds. As has been expressly ordered in the Penalty Decision and Reasons herein made September 20, 2006, the preceptorship is for a minimum period of three months. It may be longer because it does not conclude until the preceptor reports to the College that Dr. Vaidyanathan is, *in all respects*, ready to resume the independent, operative practice of obstetrics/gynaecology. The Committee is mindful that it is of paramount concern to ensure the protection of the public. It is impossible for the Committee today to determine what might be required for the doctor to be ready *in all respects* to resume the independent operative practice of obstetrics/gynaecology. The preceptor will be best able to make this assessment.

The Committee therefore confirms the Penalty Order as made September 20, 2006.