Indexed as: Vasic (re)

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

IN THE MATTER OF a Hearing directed by the Executive Committee of the College of Physicians and Surgeons of Ontario, pursuant to Section 36(2) of the ***Health Professions Procedural Code***, being Schedule 2 to the ***Regulated Health Professions Act***, 1991, S.O. 1991, c.18, as amended

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. VLADIMIR VASIC

PANEL MEMBERS: DR. M. DAVIE (CHAIR)
DR. R. SHEPPARD
S. DAVIS
DR. P. HORSHAM
E. COLLINS

Hearing Dates: November 20 & 21, 2006
Decision Date: January 3, 2007
Release of Written Reasons Date: January 3, 2007

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario ("CPSO") heard this matter at Toronto on November 20 and 21, 2006. At the conclusion of the hearing, the Committee reserved its decision.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Vladimir Vasic committed acts of professional misconduct:

1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*("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; and

2. under paragraph 1(3) of O. Reg 856/93, in that the governing body of a health profession in a jurisdiction other than Ontario has made a finding of incompetence or professional misconduct or a similar finding against the member, and the finding is based on facts which would, in the opinion of the College, be grounds for a finding of incompetence as defined in section 52 of the Code or would be an act of professional misconduct as defined in subsection (1).

RESPONSE TO THE ALLEGATIONS

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

THE EVIDENCE

(a) Overview of the Issues

The allegations of professional misconduct in this case arise from the provision of inaccurate information, by Dr. Vasic, on an application for hospital privileges and in response to a subpoena in the state of Ohio; in an application for hospital privileges, appearance before the Medical Licensing Board, and on a renewal application in the state

of Indiana; and on license renewal forms in the province of Ontario. Dr. Vasic was also subject to disciplinary action in Illinois, Ohio and Indiana.

This case raises two primary issues as follows:

1) Did Dr. Vasic provide inaccurate information on his 2004 and 2005 CPSO certificate of registration renewal forms, and, if so, does such conduct constitute professional misconduct?

2) Has a governing body of a health profession outside of Ontario, namely the medical boards of Ohio, Indiana or Illinois, made a finding based on facts, which would constitute professional misconduct in Ontario?

In brief, the evidence deals with a series of linked events. On August 23, 1999, the CPSO found Dr. Vasic to have committed professional misconduct, in that he failed to maintain the standard of practice of the profession; his certificate of registration was suspended for six months.

Prior to this, in December, 1997, a General Hospital in southern Ontario had terminated Dr. Vasic's hospital privileges (see Exhibit 7(b), p.2, para.2 and Exhibit 5(e), p.3, para.2).

On February 11, 2004, the State Medical Board of Ohio revoked Dr. Vasic's license because he had not acknowledged, on job application forms in Indiana and Ohio, his losing hospital privileges at a General Hospital in southern Ontario. He had also failed to acknowledge in the Ohio application that his license to practice in another jurisdiction, namely Ontario, had, by that time, been subject to challenge or proceedings (see Exhibit 5(d) and Exhibit 5(e), p.12, paras.3 and 4 of the Findings of Fact).

On June 15, 2004, the Medical Disciplinary Board of the Department of Professional Regulation of the State of Illinois revoked Dr. Vasic's license as a result of having received information that Dr. Vasic's license to practice medicine in Ontario had been suspended, and that the complaint leading to that suspension had constituted professional misconduct.

On his CPSO certificate of registration renewal forms, dated May 22, 2004 and May 19, 2005, Dr. Vasic gave inaccurate information about his disciplinary history in the United States.

On September 1, 2005, the Medical Licensing Board of Indiana revoked Dr. Vasic's license, also for not acknowledging past or ongoing disciplinary actions against him.

(b) Summary of the Evidence

The Committee heard the testimony of representatives of two of the U.S. medical boards connected to the issues**,** as well as of employees of the College of Physicians and Surgeons of Ontario on behalf of the College. The Committee also heard the testimony of Dr. Vasic, who called no witnesses and filed no exhibits. The College filed various exhibits, including license renewal forms filled in by Dr. Vasic.

Ohio State Medical Board

Ms. A, works in Public Services for the State Medical Board of Ohio, and testified that her position gives her knowledge of the disciplinary process and the documents kept by the State Medical Board of Ohio. College counsel took her through the certified documents in Exhibit 4 and 5.

The July 9, 2003, "Notice of Opportunity", Exhibit 4B, informed Dr. Vasic that the State Medical Board of Ohio intended to review his certificate to practice medicine and surgery on the basis that, in a February, 1999 Application for Appointment to the Medical Staff to a hospital in Indiana, Dr. Vasic answered "no" to whether he had ever had hospital privileges suspended [the "Application"]; and, in April, 2002 Application to the Professional Staff to the County Medical Center in a small town in Ohio, Dr. Vasic had answered "no" to a similar question [the "second Application"]. The Notice of Opportunity alleged that Dr. Vasic had in fact lost his hospital privileges at the General Hospital in Ontario in December, 1997. Further, the Notice of Opportunity alleged that on the second Application, Dr. Vasic had answered "no" with respect to a question asking if his license to practice his profession in any jurisdiction had ever been voluntarily or

involuntarily limited, suspended, revoked, denied, subjected to probationary conditions, or relinquished; or whether proceedings toward any of those events had ever been instituted. The Notice of Opportunity alleged that Dr. Vasic's medical license had, in fact, been suspended by the CPSO on August 23, 1999. As well, the Notice of Opportunity alleged that in the course of responding to a Board subpoena, Dr. Vasic wrote in a May, 2003 letter that a 1999 suspension by Ontario was applicable only if he returned to Ontario.

In Exhibit 5E, the Report and Recommendations of a State Medical Board Hearing Examiner of Ohio, this Discipline Committee learned that the Ohio hearing panel made several findings of fact supporting the allegations set-out in the Notice of Opportunity, and concluded, that "the series of untruths, his unwillingness to accept responsibility for his actions, and the inability of the Board to adequately monitor Dr. Vasic, indicate that Dr. Vasic cannot be trusted to hold a certificate to practice in this state." His license was permanently revoked by Order of the State Medical Board of Ohio on February 11, 2004 (Exhibit 5(d)).

Illinois Department of Financial and Professional Regulation

This Discipline Committee did not hear oral evidence from a representative of the Illinois Department of Financial and Professional Regulation. However, counsel for the College tendered certified copies of documents related to proceedings between that department and Dr. Vasic in 2003 and 2004. Exhibit 10, a letter from the Illinois Department of Financial and Professional Regulation, indicated that a representative would have been willing to testify at the hearing had a later date been available.

According to Exhibit 6(b), on October of 2003, the Medical Disciplinary Board of the Department of Professional Regulation of the State of Illinois sent a Notice of Preliminary Hearing to Dr. Vasic directing him to appear on December 22, 2003 before that board. The Complaint attached to the Notice of Hearing alleged that the department had received information that the CPSO had suspended Dr. Vasic's license to practice medicine in Ontario as a result of a finding of professional misconduct and that this was grounds for a revocation or suspension of his certificate of registration in Illinois.

Dr. Vasic did not appear before the Illinois board. On April 19, 2004, Exhibit 6(c), a 20-day Notice was sent to Dr. Vasic informing him that the board had recommended that his license be revoked and providing him an opportunity for a Motion for Rehearing. The 20-day Notice included a document entitled Findings of Fact, Conclusions of Law and Recommendations of the Director, which found that Dr. Vasic's license had been suspended in Ontario, and which recommended that his license in Illinois be revoked.

According to Exhibit 6(d), although Dr. Vasic failed to appear either in person or by counsel, his license was revoked in Illinois on June 15, 2004, after all the legal notices had been sent to his address on the records.

Indiana Medical Licensing Board

The Committee also heard sworn evidence from Mr. B, a member of the Medical Licensing Board of Indiana. From the witness and the certified documents, the Committee learned that the Indiana Board held two hearings.

According to Exhibit 7(c), a disciplinary hearing was scheduled to be held on May 26, 2005. The hearing had been scheduled in response to a Complaint filed in February, 2005, Exhibit, 7 (d). The respondent failed to appear in person or by counsel at that hearing. The Indianan Board issued a Notice of Proposed Default.

The second hearing was held August 25, 2005. Again, the respondent, Dr. Vasic, failed to appear in person or by counsel. According to Exhibit 7B, Findings of Fact, Ultimate Findings of Fact, Conclusions of Law and Order, the following was determined by The Medical Licensing Board of Indiana; (a) in an appearance before the Indiana Board on August 28, 2003, Dr. Vasic had concealed that he had a pending disciplinary hearing with the Ohio Board; (b) on his June 2003 renewal form to the Indiana Board Dr. Vasic answered "no" to five questions dealing with whether the applicant has had any disciplinary actions taken against him/her, has formal charges pending or has ever lost hospital privileges; (c) he had falsified information on applications for staff privileges and/or memberships at two hospitals or health care facilities [The "Application and second Application"]; (d) this conduct constituted a violation of the Indiana code.

Dr. Vasic's Indiana license was revoked on September 1, 2005.

Dr. Vasic's Testimony

Dr. Vasic's emphasis was on the 1999 disciplinary action by the CPSO. He blamed the CPSO for being obsessed with punishing doctors; the patient who sparked the action for being obese; the CMPA for telling him he did not have to care about anything; the College and his lawyer for not telling him that his name would be on the Internet; the assessor from the College for having insulting requirements; and, the CPSO for encouraging complaints and for making deals.

Under cross examination by College counsel, Dr. Vasic admitted or opined that: (a) he has been registered in Ontario since 1978, and had filled in and signed the 2004 and 2005 CPSO certificate of registration renewal forms; (b) he knows that he has an obligation to inform licensing bodies of address changes; (c) he understood what it meant to have his Ohio license revoked - but argued it was revoked simply because he had told an Ohio official that her license was the one that should be revoked; and (d) he did not know that his Illinois license had been revoked until about a year ago [he believes he did notify the Illinois authorities about a change of address, but the mail office at the local Hospital in Illinois was a mess].

FINDING AND DECISION

The Committee found unanimously that both allegations 1 and 2 were proven by the facts brought out at the hearing.

Allegation 1

In support of allegation 1, the Committee finds Dr. Vasic provided false information on certificate of registration renewal forms in May 2004 and May 2005 to the CPSO; copies of the forms were available to the Committee (Exhibits 2 and 3).

Under oath, Dr. Vasic admitted that he had filled out and signed the 2004 and 2005 CPSO renewal forms, including answering "no" to whether he had ever been disciplined by

another licensing authority and “no” to whether disciplinary action was pending against him.

In February 2004, however, Dr. Vasic’s license had been revoked by Ohio (evidence from Ms. A; Exhibit 5D, E and F). In June of 2004, Dr. Vasic wrote a letter to Ms. C of the CPSO, in which letter he stated that his Ohio license had been revoked in February 2004 (Exhibit 12). Dr. Vasic testified that this letter proved he was not hiding the discipline in Ohio from anyone, but admitted to questions by counsel for the College that he had not disclosed the information on his renewal forms.

In May 2004, disciplinary action was pending against Dr. Vasic in Illinois, resulting in the revocation of his Illinois license in June 2004 (Exhibits 6B and D). Dr. Vasic testified that he was not aware of these proceedings, and only learned of his suspension by Illinois “about a year ago”. The Discipline Committee makes no finding of fact with respect to whether or not Dr. Vasic was aware of the Illinois proceedings at the time he completed his 2004 and 2005 CPSO renewal forms.

In May of 2005, disciplinary action was also pending against Dr. Vasic in the state of Indiana, resulting in revocation effective Sept. 1, 2005 (evidence from Mr. B; Exhibits 7B & C). Dr. Vasic did not deny that he was aware of these proceedings when he completed his May 2005 CPSO renewal form.

Based on Dr. Vasic’s admission regarding his knowledge of the Ohio proceedings and findings, and the fact that he did not deny having knowledge of the Indiana proceedings, the Discipline Committee finds that he provided false information on his May 2004 and May 2005 CPSO renewal forms.

Allegation 2

Allegation 2, that the governing body of a health profession in a jurisdiction other than Ontario has made a finding of professional misconduct on grounds that would also constitute professional misconduct in Ontario, was also supported by the facts.

The Ohio Board relied on facts that would also be grounds for a finding of professional misconduct in Ontario. In particular, it found that Dr. Vasic had published a false, fraudulent, deceptive or misleading statement in not admitting that he had lost hospital privileges at a General Hospital in southern Ontario. Further, in a February 12, 2003 letter, in the course of responding to an Ohio Board subpoena, Dr Vasic falsely stated that his 1999 Ontario suspension "is applicable only if I return to Ontario and I never did." (Exhibits 5E and D).

Allegation 2 is further supported by the Indiana Board's findings: that Dr. Vasic gave false information on his applications to the two other health care facilities; that he did not reveal a pending disciplinary action in Ohio; and that he did not reveal previous disciplinary action in Ontario.

SUMMARY OF FINDINGS

The Committee finds allegation 1 and 2 are proved. Dr. Vasic has committed acts of professional misconduct 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; and, under paragraph 1(3) of O. Reg 856/93, in that the governing body of a health profession in a jurisdiction other than Ontario has made a finding of incompetence or professional misconduct or a similar finding against the member, and the finding is based on facts which would, in the opinion of the College, be grounds for a finding of incompetence as defined in section 52 of the Code or would be an act of professional misconduct as defined in subsection (1).

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

Indexed as: Vasic (Re)

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

IN THE MATTER OF a Hearing directed by the Executive Committee of the College of Physicians and Surgeons of Ontario, pursuant to Section 36(2) of the ***Health Professions Procedural Code***, being Schedule 2 to the ***Regulated Health Professions Act***, 1991, S.O. 1991, c.18, as amended

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. VLADIMIR VASIC

PANEL MEMBERS: DR. M. DAVIE (CHAIR)
DR. R. SHEPPARD
S. DAVIS
DR. P. HORSHAM
E. COLLINS

Penalty Hearing Date: June 14, 2007
Penalty Decision Date: September 6, 2007
Release of Written Reasons Date: September 6, 2007

DECISION AND REASONS FOR PENALTY

The Discipline Committee of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on November 20 & 21, 2006. At the conclusion of the hearing, the Committee reserved its decision. On January 3, 2007, the Committee delivered its written decision and reasons finding Dr. Vasic had committed acts of professional misconduct.

The Committee heard submissions on penalty on June 14, 2007, and reserved its decision.

PENALTY CONSIDERATIONS

After considering the findings in this case, the findings and reasons in similar cases brought to the attention of the Committee, and the need to make a decision that sends a clear and strong message of specific and general deterrence, the Committee determined that a lengthy suspension is the appropriate penalty for Dr. Vasic in the circumstances of this case, together with an order requiring the payment of costs.

The conduct for which Dr. Vasic is to be penalized is the provision to the College of false information on two certificates of registration renewal forms, in 2004 and 2005, and for having been found guilty of professional misconduct by the medical boards of two U.S. jurisdictions for similar acts of dishonesty. Dr. Vasic was dishonest in not informing the College, in response to specific questions asked on its registration renewal forms, that he had been disciplined by one U.S. licensing authority and that disciplinary action was pending before another U.S. licensing authority. The subject of discipline in these two proceedings was the provision of false information in applications for appointments to medical staffs at hospitals in Ohio and Indiana, and in communications with the State medical boards in those states. These findings are described in detail in the Committee's decision and reasons on finding.

With respect to the Ontario renewal application forms, it must be noted that Dr. Vasic had written to the College in June of 2004, informing the College that his Ohio licence

had been revoked in February 2004, but he admitted that he had not disclosed the information on his renewal forms.

It is essential that a physician communicate honestly with his or her governing body. It is necessary to the College's role of protecting the public that physicians provide accurate information about discipline proceedings in other jurisdictions on their certificate of registration renewal forms.

Although the findings of the U.S. medical authorities were not based on patient care and there was no evidence before the Committee that patient care in Ontario was affected by Dr. Vasic's misconduct, it is nevertheless a serious matter requiring a serious penalty when a physician is dishonest with the College. Aggravating factors in this case include a demonstrated lack of remorse by Dr. Vasic when he testified before the Committee, and a lack of insight on his part into the nature of his misconduct. It was also a factor that Dr. Vasic had a previous finding against him in 1999 for committing an act of professional misconduct in respect to his treatment of two patients. Dishonesty was not a factor in that case, and the previous panel had noted Dr. Vasic's "clean prior record with the College, his co-operation in the matter, and his admission of responsibility".

The Committee gave little weight to the submissions made on behalf of Dr. Vasic that he had done and continues to do missionary work internationally, had a number of medical publications to his name, and cares for a patient population made up mostly of former Yugoslavians who depend on him because he speaks their language. No matter how service oriented a physician may be, he must accept the rules in place relating to the governance of the profession of medicine in the public interest.

Counsel for the College filed with the Committee prior decisions of the Discipline Committee involving dishonesty and ungovernability. The Committee is aware that it is not bound to follow the result in a prior Committee decision, as it must with a decision of the Court, but it is also aware that the Courts have stated that it is a fundamental principle of fairness that "like cases must be treated alike", if they cannot be distinguished. The

Committee also is aware that changing or evolving standards or policies may justify a departure from a prior decision of the Committee, for which justification should be provided. In this case changing standards were not raised as an issue. Counsel for each of the parties took us through prior Committee decisions, which they submitted we should or should not be looking to for guidance as to what is appropriate in this case.

College counsel summarized three previous College decisions that involved similar acts of professional misconduct: *Goldenthal* [2002]; *Pandhi* [2001]; and *Tesher* [2002]. The penalties in these cases ranged from a reprimand to a three-month suspension; however, College counsel submitted that there were mitigating factors in those cases that are not present in this case, and that those cases did not contain the aggravating factors that are found in this case. College counsel also referred the Committee to cases in which previous panels had found the member to be ungovernable: *Blum* [1998] and *Leibl* [2001]. There was also a reference to *Li* [2002], which had been quashed by the Divisional Court for reasons unrelated to the Committee's decision. In these cases, the panels had ordered revocation of the physician's certificate of registration.

The *Goldenthal* case also involved a doctor who was dishonest in answers he gave on the questionnaire for the annual renewal of his membership in the College. The doctor had been found by the governing body of a U.S. state to have committed an act of professional misconduct that the Committee concluded would also be an act of professional misconduct had it occurred in Ontario. He was given a reprimand and was ordered to pay costs. The Committee in that case specifically noted as mitigating factors the fact that the doctor had resigned, that he was no longer in practice at the time of the decision, and that he had no record of any further or previous offences in Ontario. Given the significant differences from the facts of this case, the Committee did not place any weight on the *Goldenthal* decision.

In the *Pandhi* case, the doctor failed to notify the College that he had agreed to an Interim Order in New York prohibiting him from practising while disciplinary proceedings were pending, and he gave a false statement on his annual renewal form by not revealing this.

He had also been found by the New York Board to have committed various acts of professional misconduct, including practising with gross negligence, practising with negligence on more than one occasion, incompetence on more than one occasion, committing fraud and moral unfitness, in addition to failing to maintain records. For these acts of professional misconduct, Dr. Pandhi's certificate was suspended for three months. The fact that Dr. Pandhi demonstrated remorse by pleading guilty was considered a mitigating factor by the panel hearing that case.

The *Tesher* case also involved a guilty plea and an agreed statement of facts. In that case, the physician was found to have made a deliberate misrepresentation to the College by not disclosing pending disciplinary actions against him in New York. He was not found guilty of professional misconduct in the New York proceeding, but he did enter into a settlement agreement with the New York authorities in which he did not contest the allegations and agreed to a penalty and certain conditions. The allegations in New York were that he had ordered, prescribed and administered controlled substances in an inappropriate manner over a five-year period. The Committee reprimanded him and ordered that his certificate be suspended for three months although the suspension would be waived if he completed certain courses.

The Committee accepted College counsel's submission that Dr. Vasic's conduct demonstrated a lack of insight. However, the Committee found there was a qualitative difference between Dr. Vasic's conduct and that in the following two cases presented where the member was found to be ungovernable.

In the *Blum* case, the Agreed Statement of Facts revealed that there was a 1990 finding against him in California for administering to himself controlled substances and dangerous drugs; a 1993 finding in Texas for the same kind of offence; and various violations, between 1993 and 1995, of terms and conditions placed on him by the Texas medical licensing authorities. Among the factors that the Committee cited as a reason for ordering revocation was that the College has a mandate to protect the public from dangerous prescribing.

The *Leibl* case involved misconduct by a doctor spanning more than two decades, including using Sodium Amytal and alcohol in his treatment that risked a patient's life. The Committee in that case noted that the doctor had committed "virtually all the physician/patient boundary violations that are described in the literature". The victim read a victim impact statement into the record, which articulated how seriously she had been affected by the doctor's actions. Again, the Committee saw this conduct as qualitatively different from that of Dr. Vasic.

In summary, the Committee concluded that a lengthy suspension but not revocation was appropriate in the circumstances of this case. In the cases cited by the College that involved dishonest conduct similar to Dr. Vasic's, the maximum penalty was a three-month suspension. That said, the Committee viewed Dr. Vasic's misconduct as more serious than the conduct of the physicians in the *Goldenthal*, *Pandhi* and *Tesher* cases, since it involved a number of instances of dishonesty over a lengthy period. Furthermore, unlike in those cases, Dr. Vasic has demonstrated no remorse for or insight into his misconduct. The Committee was therefore of the view that a lengthier suspension than three months was required and that this would serve as a specific deterrent for Dr. Vasic, as well as a general deterrent for others. The Committee also felt that a lengthy suspension was necessary to protect the integrity of the self-governance system and retain the confidence of the public in the profession's ability to self-regulate.

ORDER

The Discipline Committee therefore orders and directs that:

1. The registrar suspend Dr. Vasic's Certificate of Registration for a period of 12 months, three months of which shall be suspended if Dr. Vasic completes, at his own expense, the College's Medical Ethics Course and provides proof thereof to the College. The commencement date for the suspension is September 14, 2007 at 11:59 p.m..

2. Dr. Vasic pay the College costs in the amount of $5,000.00, within 30 days of this order.

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