NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Behnaz Yazdanfar, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names of patients or any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing under subsection 45(2) and 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under section 45 is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Yazdanfar, B. (Re)

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

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) 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. BEHNAZ YAZDANFAR

PANEL MEMBERS:

DR. E. STANTON (CHAIR)
D. GIAMPIETRI
DR. P. POLDRE
R. PATTILLO
DR. A. SIMPSON

Hearing Date:	May 26, 2014
Decision Date:	May 26, 2014
Release of Written Reasons:	June 25, 2014

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on May 26, 2014. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Yazdanfar committed an act of professional misconduct:

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

2. under paragraph 1(1)33 of O. Reg. 856/93, in that she has engaged in conduct or 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.

It is also alleged that Dr. Yazdanfar is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. Yazdanfar admitted the first and second allegations in the Notice of Hearing, that she has failed to maintain the standard of practice of the profession with respect to Patient A and B; and, also with respect to Patient A and B, that she has engaged in conduct or 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. Dr. Yazdanfar also admitted to incompetence with respect to Patient A.

Counsel for the College withdrew the allegation of incompetence with respect to Patient B in the Notice of Hearing.

FACTS AND EVIDENCE

The following Agreed Statement of Facts was filed as an exhibit and presented to the Committee:

1. Dr. Behnaz Yazdanfar ("Dr. Yazdanfar") is a family physician who received her Certificate of Registration authorizing independent practice on June 25, 1996. She is a family physician who, beginning in approximately 2000, focused her practice on cosmetic surgery at the Toronto Cosmetic Clinic ("TCC"), which she owned and operated.

Current Complaints - Patient A

2. In August 2009, the College received a letter of complaint from Patient A about two liposuction procedures performed on her by Dr. Yazdanfar. The first, in February, 2008, was on her abdomen, lower back and love handles/flanks. The second, in April, 2008, was on her inner thighs.

3. Patient A had gone to see Dr. Yazdanfar after seeing her advertisement in the newspaper and then going on-line to the website for the TCC.

4. The College retained Dr. X to provide an independent opinion on the care provided by Dr. Yazdanfar to Patient A. Dr. X concluded that Dr. Yazdanfar failed to meet the standard of practice of the profession and displayed a lack of knowledge, skill and judgment in her performance of large-volume liposuction on Patient A and by failing to appropriately recognize and respond to the complications that arose from the procedure. Dr. X's opinion dated March 3, 2010 is attached at Tab 1 of the Agreed Statement of Facts.

Current Complaints – Patient B

5. In July 2009, the College received a letter of complaint from Patient B regarding a breast augmentation Dr. Yazdanfar performed on her in October, 2007.

6. The College retained Dr. X to provide an independent opinion on the care provided by Dr. Yazdanfar to Patient B. Dr. X concluded that Dr. Yazdanfar failed to meet the standard of practice of the profession and displayed a lack of knowledge, skill and judgment in failing to appropriately respond to the unsatisfactory outcome of the breast augmentation procedure. Dr. X's opinion dated February 28, 2010 is attached at Tab 2 of the Agreed Statement of Facts**.**

ADMISSION

7. Dr. Yazdanfar admits that she is incompetent and failed to maintain the standard of practice of the profession in her care and treatment of Patient A in performing a large-volume liposuction procedure in excess of the published guidelines at the time and in failing to recognize and respond to complications that arose from the procedure, as set out in Dr. X's report at Tab 1 of the Agreed Statement of Facts.

8. Dr. Yazdanfar admits that she failed to maintain the standard of practice of the profession in her care and treatment of Patient B in failing to appropriately respond to the unsatisfactory outcome of the breast augmentation procedure, as set out in Dr. X's report at Tab 2 of the Agreed Statement of Facts**.**

9. Dr. Yazdanfar admits that she engaged in disgraceful, dishonourable or unprofessional conduct in her communications with Patient B and Patient A post-operatively.

FINDINGS

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Yazdanfar's admission and found that she committed an act of professional misconduct in that she has failed to maintain the standard of practice of the profession with respect to Patient A and B; and,

also with respect to Patient A and B, that she has engaged in conduct or 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. The Committee also found her incompetent under subsection 52(1) of the Code in that her care of Patient A displayed a lack of knowledge, skill or judgment and that her practice should be restricted.

The Committee reviewed the opinion of the College's independent expert regarding Dr. Yazdanfar's care of the two patients. In the case of Patient A, the independent expert provided evidence that the standard of care was not met because the total volume of aspirated material far exceeded published guidelines and such an operation should not have been done in a private clinic with no formal hospital link. In addition, Dr. Yazdanfar failed to recognize that inner thigh liposuction has been recognized as a high-risk site for vascular injury. In the case of Patient B, the independent expert stated that the failure to acknowledge a post-operative deformity demonstrated a lack of knowledge, skill and a disregard for the welfare of her patient. Since breast augmentation is considered an aesthetic operation, patients expect a result that they are satisfied with. The expert stated that some sort of additional surgery should have been offered to Patient B given her subsequent concerns.

The Committee noted that Dr. Yazdanfar's admission explicitly acknowledged the validity of the expert's opinions with regard to patients A and B.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The Committee is aware that a joint submission must be accepted unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute.

The Committee considered the established general principles in determining the appropriate penalty. These principles include protection of the public and maintenance of

the public trust, maintenance of the integrity of the profession and the College's ability to govern the profession, a denunciation of the conduct, specific and general deterrence and consideration of the member's potential for rehabilitation.

The Committee was provided with the previous Penalty and Reasons for Penalty of the Discipline Committee imposed on December 21, 2011 (the "First Dr. Yazdanfar Case"), with regard to Dr. Yazdanfar to assist in its deliberation and to understand the background to the joint submission under consideration.

In the First Dr. Yazdanfar Case, the Committee hearing that case held a 67 day hearing which commenced in July 2009, and resulted in Reasons for Decision dated May 4, 2011, and the reasons for penalty outlined above. The First Dr. Yazdanfar Case considered a number of complaints and took a broad look at Dr. Yazdanfar's practice. Among other things, the Committee in the First Dr. Yazdanfar Case undertook a careful review of the circumstances surrounding the death of one of Dr. Yazdanfar's patients, Ms Krista Stryland. In the First Dr. Yazdanfar Case, the Committee found that Dr. Yazdanfar committed an act of professional misconduct, in that she failed to maintain the standard of practice of the profession; she contravened the advertising regulation; and she engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would be reasonably be regarded by members as disgraceful, dishonourable or unprofessional. She was also found to be incompetent. The Committee in the First Dr. Yazdanfar Case rendered a penalty of a two-year suspension of Dr. Yazdanfar's certificate of registration, a reprimand, and the imposition of terms, conditions and limitations on Dr. Yazdanfar's certificate of registration for an indefinite period, including restricting her performance of all surgery except as a surgical assistant in a hospital setting and other restrictions.

The two-year suspension of Dr. Yazdanfar's certificate of registration has now been served but the indefinite terms, conditions and limitations imposed on Dr. Yazdanfar's certificate of registration in the First Dr. Yazdanfar Case remain in force.

At the heart of the matter currently before the Committee are two further complaints from Patients A and B. Both of these complaints were made after the hearing into the First Dr.

Yazdanfar Case had already been commenced and therefore could not be part of that case. Counsel for the College submitted that if the complaints with respect to Patients A and B had been part of the First Dr. Yazdanfar Case, the penalty in that case would have been no different.

Accordingly, the current joint submission is substantially the same as the penalty in the First Dr. Yazdanfar Case save and except that there is no further suspension of her certificate of registration. There is a further reprimand and a restatement of the same indefinite terms, conditions and limitations imposed on Dr. Yazdanfar's certificate of registration. The Committee accepts that the terms of the joint submission are appropriate in the unique circumstances of this case.

Notwithstanding the fact that the penalty in the First Dr. Yazdanfar Case would have been no different if the complaints with respect to Patient A and B had formed a part of the earlier case, it is important as a matter of the public interest, to make findings with respect to the care received by Patients A and B and render the appropriate penalty. It is also important by way of these reasons and a reprimand to admonish Dr. Yazdanfar for her misconduct with respect to Patients A and B.

The Committee was distressed to learn how the conduct with respect to Patients A and B referred to in the Agreed Statement of Facts arose after the death of one of Dr. Yazdanfar's patients, Ms Stryland, one of the subjects of the 2011 hearing. This demonstrated a significant lack of insight and a fundamental disregard of the obligation to learn from tragic outcomes. Learning is a fundamental aspect of professional self-regulation.

Protection of the public is paramount. It will be achieved by the nature of the continued restrictions placed on Dr. Yazdanfar's surgical activity, such that she can no longer perform surgery except as a surgical assistant in a hospital setting, during which she would need to be supervised by an approved member of the College of Physicians and Surgeons of Ontario. Furthermore, public protection is provided by the provision for unannounced inspections of her practice and patient charts, for the purpose of monitoring compliance with the restrictions. Finally, Dr. Yazdanfar must publish the restrictions on

her certificate of registration in any advertisement of her clinic or any clinic owned by her.

A reprimand in this matter is appropriate for the Committee to express to Dr. Yazdanfar its abhorrence of her conduct with respect to Patients A and B, including her failure to learn from the tragic outcome of another patient who preceded the two patients in this matter.

ORDER

Therefore, having stated the findings in paragraphs 1 and 2 of its written order of May 26, 2014, on the matter of penalty and costs, the Committee ordered and directed that:

3. Dr. Yazdanfar appear before the panel to be reprimanded.

4. The Registrar place the following terms, conditions and limitations on Dr. Yazdanfar's certificate of registration for an indefinite period:

   (a) Dr. Yazdanfar is restricted from performing all surgery, except as a surgical assistant in a hospital based setting, provided that a member of the College of Physicians and Surgeons of Ontario who is approved by the College is in attendance and performing the surgery ("all surgery" includes but is not limited to any cosmetic surgical procedures);

   (b) Dr. Yazdanfar's practice is limited to that of a surgical assistant, as described under (a) above.

   (c) Dr. Yazdanfar shall co-operate with unannounced inspections of her practice and patient charts, conducted at her own expense, by a College representative(s), for the purpose of monitoring and enforcing her compliance with these terms, conditions and limitations; and

   (d) Dr. Yazdanfar shall publish the terms, conditions and limitations imposed on her certificate of registration in any advertisement of her clinic where she is referred to, including on her website, and shall post signage of these

restrictions in a form acceptable to the College in the Toronto Cosmetic Clinic or any other clinic owned by her.

5. Dr. Yazdanfar pay to the College costs in the amount of $4,460.00, within 30 days of the date of this Order.

At the conclusion of the hearing, Dr. Yazdanfar waived her right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.