Indexed as Cheng (re)

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

IN THE MATTER OF a Hearing directed by the Complaints Committee and the Executive Committee of the College of Physicians and Surgeons of Ontario pursuant to subsections 26(2) and 36(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. VINCENT CHENG

PANEL MEMBERS: **DR. P. CHART (CHAIR)**
D. EATON-KENT
DR. L. THURLING
S. DAVIS
DR. C. CLAPPERTON

Hearing Date: October 19, 2006
Decision Date: October 19, 2006
Release of Written Reasons Date: November 29, 2006

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") heard this matter at Toronto on October 19, 2006. At the conclusion of the hearing, the Committee stated its finding that the member committed acts of professional misconduct and delivered its penalty order in writing, with written reasons to follow.

ALLEGATIONS

The Notice of Hearing alleged that Dr. Cheng 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.

2. under paragraph 1(1)1 of O. Reg. 856/93 in that he contravened a term, condition or limitation on his certificate of registration.

3. 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.

The Notice of Hearing also alleged that Dr. Cheng is incompetent as defined by subsection 52(1) of the *Health Professions Procedural Code* (the "Code"), being Schedule 2 to the *Regulated Health Professions Act, 1991*, 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.

RESPONSE TO THE ALLEGATIONS

Dr. Cheng admitted to allegations #1 and #3, as set out in the Notice of Hearing. Counsel for the College withdrew allegation #2 and the allegation of incompetence. Counsel for the College advised the Committee that the reason the College had withdrawn the incompetence allegation was that, Dr. Cheng having resigned his membership, the College no longer has jurisdiction over him for incompetence referable to the time he was a member. The College retains jurisdiction in respect of the allegations of professional misconduct by reason of ss. 14(1) of the Code, which provides that a person whose certificate of registration is revoked or who resigns as a member continues to be subject to the jurisdiction of the College for professional misconduct referable to the time when the person was the member.

FACTS AND EVIDENCE

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

PART I – FACTS

1. Dr. Vincent Cheng was a general practitioner who had a family practice in one area and a cosmetic surgery practice in another community in Northern, Ontario. Dr. Cheng resigned membership in the College on September 8, 2006.

a. Failure to Maintain the Standard of Practice of the Profession

2. In the course of an investigation pursuant to s.75(b) of the *Health Professions Procedural Code* into Dr. Cheng's cosmetic surgery practice, the College obtained 25 patient charts from Dr. Cheng's cosmetic surgery practice. Those charts were reviewed for the College by Dr. X, who provided an expert report to the College with respect to the nature of the care provided by Dr. Cheng.

3. Dr. X is a plastic surgeon practising at a Toronto hospital. He holds a Fellowship in Plastic Surgery from the Royal College of Physicians and Surgeons of Canada. He is a Professor of Surgery at a University in Ontario, and Chairman of the Division of Plastic

Surgery at a University in Ontario. A copy of Dr. X's Curriculum Vitae is attached to [the Agreed] Statement of Facts at Tab 1.

4. In order to prepare his expert opinion, Dr. X reviewed the 25 patient charts, and he also met with Dr. Cheng in the presence of counsel.

5. Dr. X provided an expert report to the College dated in August, 2005 containing his opinion regarding the care provided by Dr. Cheng based on reviewing the 25 patient charts. A copy of Dr. X's report is attached to [the Agreed] Statement of Facts at Tab 2.

6. Dr. X reached the following conclusions with respect to Dr. Cheng's care:

> I have been asked to address three specific questions in my report.
>
> 1. Does the care provided to patients by Dr. Cheng meet the standards of practice of the profession?
>
>   Clearly, Dr. Cheng's care falls well below the practice of the profession in numerous parameters as outlined above.
>
> 2. Does Dr. Cheng's care display any or all of the following:
>
>   - lack of knowledge?
>   - lack of skill?
>   - lack of judgment?
>   - disregard for the welfare of patients?
>
>   It is clear that Dr. Cheng's care displays a distinct lack of knowledge. He has no knowledge of anatomy in several areas in which I asked him to describe the anatomy. He has no knowledge of common pathological conditions. He demonstrates complete lack of skill in his execution of common techniques such as liposuction. He has a flagrant disregard for the welfare of his patients and shows complete lack of judgment, not just in his clinical care but also in the fact that he disregarded the restrictions placed on him by the College.
>
> 3. Are you of the opinion that Dr. Cheng's clinical practice, behaviour or conduction [sic] exposes or is likely to expose his patients to harm or injury?
>
>   There is no doubt in my mind that Dr. Cheng's clinical practice in cosmetic surgery poses a significant threat to the safety of patients. His lack of

> knowledge, lack of skill, lack of judgment and disregard for the welfare of his patients in my opinion constitutes a danger to the public.

7. Dr. X detailed in his report the specific concerns he identified in reviewing the patient charts and meeting with Dr. Cheng which led him to his conclusions:

> The overwhelming impression on reviewing the 25 patient charts provided to me was the dire lack of documentation regarding all of these patients. Documentation is important for continuity of care and patient safety and Dr. Cheng falls below the standard of care in this regard. According to Dr. Cheng, he assesses the patients at their initial visit and then subsequently calls them back for a preoperative appointment. He sees all patients, therefore, a couple of times before operating on them. There is, however, no documentation to this effect in the patient's chart. Furthermore, there is no documentation in the charts of the specific deformities that he is examining. As an example, in the case of a breast augmentation, there is no documentation of the shape or size of the existing breast nor is there any documentation of the degree of ptosis, position of the nipple, etc. Dr. Cheng said that he takes digital pictures of all his patients and that that is his documentation for the specific deformity being addressed. These digital pictures, however, are filed by date and are not filed with the main patient chart. I also asked him specifically about the lack of OR notes in the charts. Dr. Cheng uses templates for these OR notes and simply fills in the blanks. However, the majority of the 25 files that I examined did not contain a template and some that did, had simply a blank template. Dr. Cheng acknowledged that it was important to have documentation in the charts. This lack of documentation constitutes a danger to the patient. Vital information that could influence patient outcome is not recorded and it would appear that Dr. Cheng is relying on his own memory to catalog specifics about each patient. This would not be considered acceptable practice.
>
> I asked Dr. Cheng about his normal practice when going on vacation. He says that he routinely does not do surgery for two weeks prior to going away. In a situation where he had to reoperate on a patient that he had previously operated on within two weeks of going away, he would cancel his vacation. When asked, he admitted that he had not had to cancel any vacations and had only reoperated on one patient of the 3000 or so surgeries that he had done. I asked him specifically about the sorts of complications he felt might require reoperation. He mentioned hematoma and so I questioned him about his approach to hematoma. He explained that he would wait three to six weeks before considering draining a hematoma under most circumstances. This is clearly not an acceptable form of practice and would certainly fall below the standard of care. Dr.

Cheng did not seem to be aware of the increased risk of infection or other complications related to failure to drain a hematoma.

. . .

I specifically asked him about his practice for breast augmentation and had him describe how he does the procedure. His description demonstrated a complete lack of knowledge of the anatomy of the chest wall. He routinely places the implants beneath the pectoralis major muscle and yet had no idea what the blood supply of the pectoralis major muscle was or where blood vessels might be encountered. This lack of anatomic knowledge is considered unacceptable and would certainly fall below the standard of care.

Going through the different patient charts, I took the opportunity to assess his normal practice for the various procedures that were documented in these charts. As an example, I asked him about his normal practice for rhinoplasty. He explained that he only does straight forward rhinoplasties and would refer anything more complicated to somebody else. However, when asked about the anatomy of the nose and specifically the relationship of the cartilages of the nose, it was quite obvious that he did not know the anatomy of the nose. Again, this falls significantly below the standard of care.

We discussed the issue of previous myocardial infarction. In more than one of the patients reviewed, there was a past history of myocardial infarction yet there was no detailed history documented as to whether the patient currently had symptoms or what treatment they have had for their myocardial infarction. There was no preoperative EKG in the chart. Dr. Cheng did not feel it important to have an EKG recording in the chart of patients with a previous myocardial history. He maintained that his approach was very simple. If they had a MI within the previous year, he would refuse to operate. If they had angina, he would refuse to operate on them. One of the patients in particular, had a lengthy drug history. When asked, Dr. Cheng admitted that he did not worry what medications they were on as long as their symptoms were controlled. Despite this admission however, there was still no documentation in the chart to indicate that he had inquired about their symptoms. One patient gave a history of atrial fibrillation. There was no investigation whatsoever of this and there is no documentation in the chart as to whether Dr. Cheng even made any more formal inquiry about this other than documenting it in the chart. There was no electrocardiogram in the chart. When I challenged Dr. Cheng on this, he did not think it was important to have a cardiogram as the surgery he was doing is relatively minor and the patient was going to be awake. In my opinion, this constitutes complete disregard of patient safety and certainly falls below the standard of care.

One patient [Patient Q], gave a long and complicated drug history as well as a history of sideroblastic anemia. When asked, Dr. Cheng did not know what sideroblastic anemia was. There was no blood work recorded in the chart and I asked him why this was the case. He responded that the blood work is kept elsewhere and not necessarily together. He blamed his secretary for not placing the blood work in the chart. This lack of documentation as well as Dr. Cheng's ignorance of what sideoblastic anemia in a patient on whom he is going to operate would be well below the standard of care.

In one of the patient charts reviewed, the patient was simply identified by her Christian name. There was no surname in the chart, no preadmission sheet, nor was there any indication of what procedure had been done. Dr. Cheng was able to identify this patient and explained that she was a patient well known to him and he, therefore, did not keep a chart for this reason. He explained that if he had previously operated on a patient, the documentation relating to that operation was kept in a separate chart and a new chart was made up each time the patient came back so that there was no continuity in his documentation. I asked him if he felt it was important to have all the documentation about a patient together and he admitted that this would be ideal but he didn't know logistically how he could go about this. Once again, this practice falls well below the standard of care.

Several of the patients in the charts have had facelifts. I asked Dr. Cheng to describe his technique for a facelift. What he essentially described was a technique of skin excision. I asked him about the anatomy of the face and it was very clear that he had no idea where the vital structures were. Specifically, he did not know where the facial nerve was or where the branches of the facial nerve were. He maintained that because he did a superficial rhytidectomy, that he didn't have to worry about the facial nerve. He did not know, however, at what level the facial nerve was in the various parts of the face. He also did not know where the greater auricular nerve was and in fact said that it was in front of the tragus and was deep, which is incorrect. He did, however, know that the greater auricular nerve is the most common nerve injured in facelift surgery. Dr. Cheng's lack of anatomic knowledge is unacceptable. The facial nerve is relatively superficial and is at risk during a face-lift procedure. A surgeon should have a thorough knowledge of the anatomy of any region on which he/she is operating in order to avoid complications. Dr. Cheng's lack of knowledge falls well below the standard of care.

One patient, identified as [Patient R], had a facelift in what appeared to be less that one hour judging from the notes. I asked Dr. Cheng if this was possible and he indicated that it was. This would certainly not be considered as standard of care.

I asked Dr. Cheng about his surgical training. He told me that he had worked with Dr. Y at a Toronto hospital as a fourth year student and as an intern. When I challenged him that this was simply a standard fourth year clerkship rotation and a standard internship rotation, I suggested to him that in fact he had had no surgical training. He admitted that this was the case and that in fact he has had no surgical training at all. I asked whether he felt it was reasonable for somebody with no surgical training to do the sort of surgery he was doing and he said that he felt it was reasonable in his particular case having done so many procedures with no complications.

. . .

In relation to liposuction, I asked Dr. Cheng what the normal recommendations would be for replacement of fluid following liposuction. He replied that between 500 c.c. and a liter of fluid should be administered to the patient for every liter of fat removed. He indicated that six to eight liters of liposuction was his personal comfort level or safety level. I asked him about the fact that the amount of liposuction did not always appear in the chart and there were several charts among those that are reviewed that did not contain this information. He agreed with me that the two important pieces of information with regard to liposuction patients are the amount of aspirate as well as the amount of IV fluid replacement. He further agreed that if these items of information are missing from the chart that this potentially creates an unsafe situation. Several of the charts reviewed would indicate that this was the case in Dr. Cheng's practice and that he is creating an unsafe situation for these particular patients. I further questioned him about the practice that I had noted among the charts where several of these patients had got on the bedpan during the procedure and I questioned him about his practice in terms of technique for doing liposuction. It would appear that he only preps the stab incision sites and that the rest of the patient is not prepped. When I asked him how he can assess the amount of suction being carried out without placing his hand on the patient, he indicated that he places his left hand on the unprepped part of the patient but feels confident that because the liposuction wand or cannula is sterile, then this constitutes a sterile procedure. Dr. Cheng's understanding of sterility and sterile technique from his answer to this question is woefully lacking. It is clear that these liposuction procedures are not being carried out in a safe and sterile manner. With regard to the level or amount of aspirate, we discussed the patient [Patient S]. This patient was 5'2" in height and weighed 225 pounds. Dr. Cheng removed 10 liters of aspirate and only replaced 2900 c.c.'s. Dr. Cheng defended this on the basis that only 70% of the aspirate represented fat. According to the nursing notes in the chart, the patient used the bedpan several times during the procedure and from my discussion with Dr. Cheng, it is clear that this patient's procedure was not

done in a proper sterile manner and his practice falls well below the standard of care.

Patient [Patient T] has just one sheet in her chart. This refers to an operative procedure where a breast implant was removed and replaced. Dr. Cheng explained that his patient had a congenital chest wall deformity which he had corrected by using a breast implant. The fact that the previous operative reports were not in the chart were explained by the fact that Dr. Cheng keeps separate charts for each procedure. Dr. Cheng was unable to explain the pathophysiology of any chest wall deformities and when specifically asked whether he knew what Poland's syndrome was, admitted that he did not. Poland's is probably the commonest indication for which patients seek this type of surgery secondary to a congenital chest wall deformity. Dr. Cheng was clearly ignorant of any of the conditions that could give rise to this sort of deformity and this lack of knowledge would fall below the standard of care.

b. Disgraceful, Dishonourable and Unprofessional Conduct

i) Breach of Undertaking

8. On September 17, 2004, as a result of proceedings before the Quality Assurance Committee of the College, Dr. Cheng entered into an undertaking with the College. In that undertaking Dr. Cheng undertook, *inter alia*, that he would "not perform any cosmetic surgical procedures involving the head, effective September 17, 2004." A copy of the undertaking dated September 17, 2004 is attached at [to the Agreed Statement of Facts] at Tab 3.

9. Subsequent to signing the undertaking, Dr. Cheng breached the terms of the undertaking by performing cosmetic surgical procedures involving the head. Between the date of signing the undertaking and approximately February 2005, Dr. Cheng performed 15 cosmetic surgical procedures involving the head. The first of these procedures was performed on the same day he signed the undertaking, after signing the undertaking with the College. The procedures performed in breach of the undertaking included mid-face lift, blepharoplasty, liposuction to the cheek, jowel lift, rhinoplasty, and pinning back a patient's ears.

ii) Breach of section 37 Order

10. On August 31, 2005, the Executive Committee of the College issued an Order imposing terms, conditions and limitations on Dr. Cheng's certificate of registration pursuant to s. 37 of the Health Professions Procedural Code, pending the discipline hearing in this matter, because the Committee was of the opinion that the conduct of Dr. Cheng exposed or was likely to expose his patients to harm or injury. The Order provided as follows:

(a) Dr. Cheng is restricted from performing all surgery. For greater certainty, "all surgery" includes, but is not limited to, any cosmetic surgical procedures, and all minor office surgery (whether insured or uninsured including removal of lumps and bumps (e.g. moles, etc.); and

(b) Dr. Cheng shall cooperate with unannounced inspections of his office(s), practice(s) and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.

The Order took effect at 12:01 a.m. on September 2, 2005. A copy of the section 37 Order is attached to [the Agreed] Statement of Facts at Tab 4.

11. After the date the section 37 Order came into effect, and until approximately May 13, 2006, Dr. Cheng breached the section 37 Order by performing 16 surgical procedures. The procedures performed included: breast implants, blepharoplasty, abdominaplasty, and liposuction to the hip, back, waist, abdomen, and chin. The first surgery in breach of the section 37 Order occurred on September 18, 2005, sixteen days after the section 37 Order came into effect.

12. After the date of the section 37 Order, Dr. Cheng on at least two occasions represented to the College that he was not conducting surgery. These representations were untrue.

13. The College conducted a lengthy investigation into whether Dr. Cheng had breached the section 37 Order. That investigation culminated in the College obtaining a search warrant to search Dr. Cheng's office and home. The search warrant was executed on May 15, 2006. At the time of the execution of the search warrant, patient charts in relation to most of the surgeries referred to in paragraph 11 above, were discovered in an upstairs sitting room in Dr. Cheng's home in a plastic storage box mixed in with patient records from the years 2002 and 2003.

PART II - ADMISSION

14. Dr. Cheng admits that he committed professional misconduct in that:

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

(b) he 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, pursuant to paragraph 1(1)33 of O. Reg. 856/93.

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. Cheng's admission and found that he committed acts of professional misconduct under paragraphs1(1)2 and 1(1)33 of O. Reg. 856/93.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Cheng made a joint submission as to an appropriate penalty and costs. They submitted that the Registrar should be directed to revoke Dr. Cheng's certificate of registration, effective immediately; that Dr. Cheng pay to the College its costs in the amount of $2,500; and that the results of the proceeding be

included in the register. The Committee reviewed the evidence and considered the penalty proposed. In considering the penalty, the Committee was aware that the law requires that the joint submission be accepted unless to do so would be contrary to the public interest or would bring the administration of justice into disrepute. The Committee accepted the joint submission for the following reasons.

Revocation of Dr. Cheng's certificate of registration was seen as appropriate to protect the public. Dr. Cheng demonstrated a serious lack of knowledge in several areas and was deficient in his skills and judgement. His lack of screening for other medical conditions prior to surgery posed risks to patients. Also, Dr. Cheng was seriously deficient in his documentation, and relied on his memory. Dr. Cheng was neglectful in record keeping, failing to document basic patient information. He was seriously deficient in technical and procedural practice and demonstrated a lack of attention to patient safety. Dr. Cheng did not have the requisite training to perform cosmetic surgery and subjected his patients to potential harm. In the view of the Committee, he is an unacceptable risk taker having performed thousands of surgeries without proper training, knowledge and skills. Revocation will ensure that Dr. Cheng does not practise and subject any other patients to the risks his deficits pose.

Dr. Cheng demonstrated blatant disregard for the authority of the College when he entered into an undertaking restricting his practice and, subsequently, violated that undertaking. He breached the undertaking by performing fifteen cosmetic surgeries involving the head in the next five months, one of them on the same day he signed the undertaking.

When the Executive Committee subsequently issued an Order imposing terms, conditions and limitations on Dr. Cheng's certificate of registration, pursuant to s.37 of the Code, he breached that Order as well. Although he was prohibited from performing any surgical procedures, he performed sixteen surgeries in the ensuing eight and a half months, the first within sixteen days of the Order.

By breaching the conditions placed on him, Dr. Cheng demonstrated that he does not believe the rules apply to him. Not only did he do surgery when he was prohibited, but he

also lied about it to the College. He was reckless and willing to jeopardize the health and safety of his patients and it is the Committee's view that he would continue to do so if he were allowed to continue to practise.

The Committee considered that Dr. Cheng admitted the allegations against him and gave up his right to a hearing at which the College would have to prove the allegations against him. The Committee was also aware that the counsel for the parties were more familiar with the facts and circumstances of the case than were the members of the Committee.

In summary, with respect to the principles considered in determining the appropriate penalty, specific deterrence is achieved by revocation of Dr. Cheng's licence. General deterrence for the membership at large is satisfied. Dr. Cheng's lack of knowledge, skill, and judgement and complete disregard of the College's sanctions cannot be tolerated and the public's safety will be protected by the penalty order imposed.

Given the pervasive nature of his transgressions and his marked deficiencies leading to revocation, the Committee wishes to make a comment for consideration by the panel of the Discipline Committee on any future application by Dr. Cheng for reinstatement. Dr. Cheng has demonstrated a serious lack of responsibility to patients, a lack of integrity and a lack of honesty in his dealings with the College. This unethical behaviour goes far beyond a deficiency in medical knowledge and skills.

ORDER

Therefore, the Discipline Committee ordered and directed that:

1. The Registrar revoke Dr. Cheng's certificate of registration, effective immediately.

2. Dr. Cheng pay to the College costs in the amount of $2,500.00.

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