

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Liberman, this is notice that the Discipline Committee ordered there shall be a ban on publication of the name or identity and any information that would disclose the name or identity of all patients (other than Ms Stryland) and family members of patients (other than Nick Stryland), whose names or identities are disclosed at the hearing or in any documents filed at the hearing, under subsection 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 or 47... 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: Liberman, B.A. (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. BRUCE ALAN LIBERMAN**

**PANEL MEMBERS:**

**DR. E. STANTON  
D. DOHERTY  
DR. C. CLAPPERTON  
DR. E. ATTIA (PhD)  
DR. B. LENT**

**Hearing Dates: June 14 to 18, June 28, June 30, July 19 to 21 and  
September 17, 2010**

**Decision Date: May 4, 2011**

**Release of Written Reasons: May 4, 2011**

**PUBLICATION BAN**

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee of the College of Physicians and Surgeons (the “Committee”) heard this matter at Toronto on June 14 to 18, 28, 30, July 19 to 21 and September 17, 2010. At the conclusion of the hearing, the Committee reserved its decision on finding.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Bruce Alan Liberman committed acts 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 maintain the standard of practice of the profession; and,
2. under paragraph 1(1)33 of O. Reg. 856/93, in that he 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 Notice of Hearing also alleged that Dr. Liberman is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (“the Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991* (“the RHPA”), 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 to practise or that his practice should be restricted.

### **RESPONSE TO THE ALLEGATIONS**

Dr. Liberman denied the allegations in the Notice of Hearing.

## THE EVIDENCE

### Overview of the Case and the Issues

#### I. Krista Stryland

On September 20, 2007, Krista Stryland, age 32, underwent liposuction surgery performed by Dr. M at the Toronto Cosmetic Clinic (“the clinic”). Dr. Liberman was the anesthesiologist who gave Ms Stryland her anesthetic and transferred her to the recovery room. At some point during the approximately three hours that she was in the recovery room, Ms Stryland became unconscious and required re-intubation. At 15:51 hours, Dr. M called 911, stating that Ms Stryland was “crashing” and, when the paramedics arrived minutes later, they found the patient in a pool of blood with vital signs absent. Following resuscitation efforts by the paramedics and at the nearby hospital, Ms Stryland was pronounced dead at 18:44 hours.

In determining whether Dr. Liberman failed to maintain the standard of practice of the profession and is incompetent, the Committee considered the following issues regarding Ms Stryland’s care:

- i) Did Dr. Liberman turn over care of an unstable patient to the clinic nurses in the Recovery Room?
- ii) Did he fail to aggressively treat her hypovolemia?
- iii) Did he fail in not calling 911, first, when his initial treatment failed and then when she became unconscious?
- iv) Did he fail to chart the initial recovery room vital signs and his intervention prior to re-intubation?

The above issues were also considered with respect to the allegation that Dr. Liberman has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee also looked at the following issues related to whether Dr. Liberman engaged in disgraceful, dishonourable and unprofessional conduct:

- i) Did he remove his September 20, 2007 resuscitation note from the chart and replace it with a note dated the next day?
- ii) Did he place in his September 21, 2007 note misleading information regarding the patient's status at the time the paramedics arrived?

## **II. Patient B**

Schedule A to the Notice of Hearing alleges that Dr. Liberman failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct in his care and treatment of a second patient, Patient B, on September 20, 2007. While some of the evidence heard by the Panel related to what was happening in respect of Patient B, it was heard as part of the narrative of the evidence related to Ms Stryland. No expert evidence (or other direct evidence specific to his situation alone) was presented in relation to his treatment, nor was his case the subject of closing submissions by the College. Since the allegations were not pursued by the College, there was not proof of the allegations to the requisite standard and this allegation is therefore dismissed.

## **III. Other Patients**

Besides the case of Ms Stryland, the Committee also considered whether Dr. Liberman failed to maintain the standard of practice of the profession and whether he was incompetent in his charting with respect to 55 other patients as outlined in an expert's report.

## **Summary of the Evidence**

In addition to receiving various documentary evidence, a DVD of the video recording from the security camera in the back hall at the clinic, and a CD of the 911 call regarding Krista Stryland, the Committee heard from several witnesses. The witnesses included the two paramedics who responded to the 911 call that day; an internist who attended Krista

Stryland in the Emergency Department of the Toronto hospital to which she was transferred; and, the Registered Nurse and the Registered Practical Nurse who worked at the clinic. Three expert witnesses in anesthesia testified at the hearing and the Panel was also provided with a written report from another expert in the same area. A forensic document examiner also gave evidence.

The Committee considered the credibility of each of the witnesses in assessing their evidence by asking:

- Did the evidence make sense?
- Was the evidence reasonable?
- Was the evidence plausible?
- Was there any internal inconsistency in the witness' oral testimony?
- Was there inconsistency with the oral testimony of other witnesses?
- Was there any inconsistency between his or her oral testimony and the documentary evidence?
- Was there any motivation to be other than truthful such as having an interest in the outcome of the proceeding?
- Did the witness have any memory impairment?
- Did the witness tend to exaggerate?

## **Format**

The decision and reasons is presented in the following format:

- i) Oral testimony of each witness, followed by an assessment of credibility.
- ii) Agreed Facts
- iii) Other documentary and video evidence
- iv) Findings and Legal Issues
- v) Summary

**i) Oral Testimony**

**Mr. X**

Mr. X has been a paramedic since 1989 and he is currently classified as a Level 3, the highest skill level for a paramedic. As such, he is authorized to do several advanced medical procedures.

At 15:52 pm on September 20, 2007, he and his partner received a high priority call to go to the Toronto Cosmetic Clinic regarding a patient who was unconscious following a liposuction procedure.

They arrived at the clinic five minutes later and found Ms Stryland a chalky white colour, intubated, with a nurse holding onto a bag-valve mask. The patient had a white compression type stocking on her torso and her lower extremities, and was lying in a pool that appeared to be blood mixed with a saline type fluid, or “very, very, diluted blood”.

Ms Stryland was unconscious, not responsive and had no vital signs. Although she was breathing, it was “agonal”, or ineffective breaths. The cardiac monitor showed an electrical impulse that was slow and with a narrow complex rhythm, but the patient had no carotid pulse. The Fire Department personnel on the scene were instructed to begin chest compressions, and various drugs for a cardiac arrest situation were given to Ms Stryland. The paramedics left the clinic at 16:18 hrs and arrived at the hospital at 16:23 hours.

Mr. X had no interactions with Dr. Liberman at the clinic.

**Credibility of Mr. X**

The Committee found Mr. X credible. His independent recollection accorded with the documentary evidence and the incident report completed by him after attending Ms Stryland contained important details that were consistent with his recollection.

**Mr. Y**

Another paramedic, the partner of Mr. X, testified that he was a Level 2 paramedic, trained to do high level trauma care. He described Ms Stryland as “ashen” and resembling a patient who had lost a lot of blood, and he noted a large amount of fluids that were the colour of “pink lemonade” pooling beneath the patient. His description of the patient and her lack of vital signs and responsiveness was similar to that of his partner.

Mr. Y had no recollection of talking to Dr. Liberman at the clinic.

**Credibility of Mr. Y**

The Committee found Mr. Y credible. He referred to the ambulance call report which is Tab 7 in the joint book of documents (Ex 3B) to refresh his memory. His testimony was also in accord with the incident report that he prepared shortly after the event (Ex 8) and which he also used to refresh his memory while testifying.

**Dr. G**

Dr. G is a trained nephrologist who works as an internist with admitted internal medicine patients at a Toronto hospital. On September 20, 2007, he was called to the Emergency Room to assist with the care of Krista Stryland.

Ms Stryland appeared severely anemic and had liquid drainage that he stated was like “Kool-Aid” oozing from several wounds. She was cold to the touch and had fixed and dilated pupils. The stretcher and floor were awash in serosanguinous material from a puncture wound near the top of the sacrum.

Dr. G testified that Ms Stryland’s hemoglobin, on hospital admission, was 6 grams per liter. A normal value for women is between 120 and 160 and a critical value would be less than 60 grams per liter, or 10 times the value of Ms Stryland’s. He testified that she had virtually no oxygen carrying capacity in her blood.

The normal value for proteins in the blood is between 60 and 80 grams per liter and Ms Stryland’s was 5, the most profoundly low protein he has seen in his professional life.



Proteins exert a force in the circulation called “oncotic pressure” that serves to keep the blood in the capillaries so the blood pressure does not force the circulating blood into the tissues. Dr. G testified that, without proteins, there is no oncotic pressure, fluid from the bloodstream goes into the tissues and the tissues become swollen.

Dr. G also testified that Ms Stryland had no coagulation factors according to her lab results, meaning that there was little to form clots to be able to staunch the blood flow.

With virtually no hemoglobin, no oncotic pressure, and no ability to form clots and staunch the bleeding, the diagnosis of severe anemia, hemorrhagic shock, and disseminated intravascular coagulation, or DIC, was made, meaning Ms Stryland had consumed all her clotting factors and had none left to be able to clot any blood flowing from her wounds.

Ms Stryland had a transient pulse and was given numerous blood products, including clotting factors as well as other procedures to deal with her situation. However, she was pronounced dead at 18:44 hours.

### **Credibility of Dr. G**

The Committee found Dr. G credible and his notes, written shortly after his consultation in the Emergency Department that day, were consistent with his testimony and added to the reliability of his testimony.

### **Ms J**

Ms J has been a licensed Practical Nurse for 10 years and she had been working at the clinic for several months prior to September 20, 2007. She worked as a circulating nurse and another person, Mr. H, worked there assisting in the Operating Room (OR) as well. Ms J believed that Mr. H was an urologist in China and she was not sure if he was licensed in Ontario.

She acknowledged that she is a defendant in a collective lawsuit involving Dr. Liberman, Dr. M and her nurse colleague, Ms Q. She also is involved in an investigation by the College of Nurses.

Although primarily a circulating nurse in the OR, she had other duties including assisting in the recovery room (RR), if needed. She was the circulating nurse during Ms Stryland's surgery and also for the third case of the day. She testified that the primary responsibility for the recovery of patients was Ms Q's, who was in the RR with the first patient of the day when Ms Stryland was in the OR. Ms Q took over the care of Ms Stryland once the first patient was discharged.

Ms J testified that a monitor used in the RR recorded the blood pressure (BP), the pulse and the oxygen saturation (O2 sat) in the blood simultaneously. The monitor took vital signs according to the setting of the time interval and also had a button that could be pushed to record vital signs on demand. The trend for previous recordings was visible on the bottom of the monitor. An alarm sounded if the vital signs were out of range, that is, if the BP was either above 200 (systolic) or below 80 (systolic), but this range was adjustable. She was not sure if the alarm for the O2 sat range was adjustable.

The alarm also had a volume setting. A patient moving their hand too rapidly or tapping their finger would set off the alarm. She did not recall what the alarm setting was for the pulse or the O2 sat. The alarm could be silenced for only two minutes and then it would sound again, according to Ms J.

Ms J testified that Ms Stryland assisted in putting on her own compression garment after surgery, and also stated that she "more or less" moved herself over to the RR stretcher from the OR table. She stated that she and Dr. Liberman took the patient into the RR. On arrival there, Ms Q was preparing for the discharge of the first patient.

Ms J testified that she hooked Ms Stryland up to the monitor and she would have quickly jotted down the time she arrived in the RR and the timeline for her vital signs to be taken.

She said she would then put on the warming blanket and she would have asked the patient to wiggle her toes as well as other little commands to see if she responded or not. She said she would not have a vital signs reading on the monitor at the time of the writing of the timeline across the top of the graph on the RR record.

It would take a minute or two to connect the patient to the monitor and another one or two minutes after that to get a reading. Depending on the patient, it would take three to five minutes to connect the BP cuff and the oximeter, the device attached to a finger monitoring the oxygen and pulse. She testified that once the monitor is connected it takes 30, or maybe 40 seconds to get a reading.

Ms J testified that, during this time, Dr. Liberman was standing beside the patient, that “he stayed until the first vital appeared on the monitor, and once he deemed that the patient was okay, he left”.

Ms J states that she did not make any notations on the chart as she was tending to the patient’s needs and that those needs took precedence over that of documentation. In her words: “Documentation was secondary.” According to Ms J’s testimony during cross examination, the first two vital signs on the RR record were written by Ms Q. She testified that they were not consistent with the vital signs that she saw while in charge of the patient in the RR, which were not concerning to her. She acknowledged that the first two vital signs are not consistent with the last vital sign recorded by Dr. Liberman in the OR, nor with the patient being able to transfer herself or with the patient being talkative, upbeat and chatty.

In her testimony, Ms J reiterated that she was responsible for the first two vital signs at 13:15 and 13:20 and, then shortly after, she said it was a “mix” between herself and Ms Q. In cross-examination, she said “they” did the vital signs on Ms Stryland’s arrival in the RR.

Ms J testified that after the first two vital signs, Ms Q was responsible for the patient. Ms J said that she was responsible for charting for the time she was there and Ms Q for the time Ms Q was there.

Prior to returning from discharging the first patient, Ms Q was concerned about Ms Stryland's vital signs, namely her blood pressure, and spoke to Ms J about it. Ms J recalled that Ms Q said, "That doesn't concern you?" as she pointed towards the monitor and what it was reading at that time.

Ms J testified that she replied that Dr. Liberman was aware of what the vitals were and that he was okay with it. When asked if Dr. Liberman had an acceptable range for blood pressure on arrival in the RR, Ms J said that she believed "he had an acceptable range at about 70" (systolic). She said Ms Stryland's BP was in the 80's at this time and she reiterated in cross-examination that she reassured Ms Q that this was the norm and that Dr. Liberman was aware of it.

The induction of the anesthesia for the third patient would take about five minutes. Following that, the infiltration of the fluid would take place with the solution of normal saline and lidocaine and epinephrine. Ms J testified that the infiltration process for the third patient took about 15 to 20 minutes. Once the last bag of infiltrate was done, she went back to check on Ms Q in the RR. She saw that Ms Stryland's BP was low. Ms Q also voiced that the low BP was a concern to her and she asked her to assist in doing simultaneous BP readings on each arm. She recalled that Ms Stryland's BP was fluctuating between the mid-70's and high to mid 60's and when they did the bilateral readings, they got the same reading. It was the opinion of Ms J that, at that time, Ms Stryland was not responding as someone with low blood pressure would, as she was talkative.

After doing the readings, Ms Q asked Ms J to inform Dr. Liberman and ask him to come into the RR. Ms J testified that she did so and she said that she and Dr. Liberman both walked back to the RR. She said that Dr. Liberman looked at the monitor and told them to

increase her fluids, to place her in reverse Trendelenberg position and to monitor her. Ms J said that she increased the fluids by opening the valve on the IV and the stretcher was put in the head-down position. She stayed with the patient long enough to hear her say that she was hungry and to see that the “vital signs were going up”.

In her testimony, Ms J said that she went back and forth from the RR to the OR. She stated that as she was stepping through the door the next time she went to the RR, she heard Ms Q tell the patient to sit up because she was going to give her something to eat. Just as the patient went to sit up, she collapsed and Ms Q instructed her to get Dr. Liberman. Ms J noted that the patient had a “change in BP” with an increased heart rate and a loss of consciousness.

In her evidence, Ms J said that Dr. Liberman came into the room and assessed Ms Stryland. He took her pulse manually, took a couple more vital signs with the machine, checked the patient’s pupils and then left to go get an intubation tube from the OR. He also asked Ms J to get another IV bag as he wanted to start a second IV.

Her recollection was that Dr. Liberman intubated Ms Stryland with a laryngeal mask, not an endotracheal tube but she was not sure. Ms Q used an Ambu bag to ventilate the patient. At one point, after the IV’s were inserted, Ms Stryland’s BP increased and she gagged on the intubation tube and tried to pull it out.

When the second IV was started, Dr. Liberman wanted to run the IV as a bolus so Ms J went to the OR, got the pressure bag and connected it to the IV solution. She testified that the pressure bag is like a blood pressure cuff - it can be pumped up and it squeezes the bag of IV liquid causing it to flow at a much faster rate than it normally would with gravity.

Ms J testified that, prior to hooking up a third IV, Dr. Liberman asked for a Foley catheter to be inserted into the urethra to empty Ms Stryland’s bladder and Ms Q did that. Ms Stryland’s blood pressure increased at this point. Ms J acknowledged that she was the

one who wrote on the RR record, Foley catheter and 14 French straight, meaning the size and type of catheter and 100cc following the notation. This referred to how much urine was collected after catheterization. She testified that when she did that, she noticed there was no charting of vital signs on the RR chart.

After Ms Stryland's blood pressure went up around the time of the catheter insertion, it dropped again and Dr. Liberman stated he wanted to put in a third IV. Ms J then retrieved the IV and tubing. She believes the patient had 3000 cc of fluid altogether in the RR before she was taken away in the ambulance.

Dr. M came into the RR to ask if she could help and Dr. Liberman told her he was handling it, according to Ms J's testimony. Dr. M noted that there was an excessive amount of drainage and instructed Ms J to put on another compression garment. Upon Dr. M's return a few minutes later, she assisted Ms J in putting another compression garment on Ms Stryland. Ms J said that although the patient's BP had been going up a little, once they changed her position to put on the compression garment, Ms Stryland's BP fell again.

Ms J testified that Dr. Liberman did leave the RR on at least two occasions, once to get the intubation tube and the second time to get the Ambu bag or whatever else was needed.

According to Ms J's evidence, the third surgery of the day stopped as Dr. Liberman was not able to attend the patient, however, as he could not reverse the anesthetic, the patient was still on the OR table.

Ms J testified that "awhile" prior to Emergency Medical Services (EMS) showing up, Ms Q asked for the chart while she was bagging the patient. Ms Q mentioned that the area on the vital signs graph (in the RR record) was blank and Ms J did not recall responding to her. She saw Ms Q filling out the vital signs graph of the RR record, but she didn't see

her completing them. She did that while ventilating the patient with one hand and writing with the other.

The video of the security camera recording was played and Ms J noted that the empty stretcher went from the RR to the OR at 13:08:53 and, although no movement of the stretcher across to the RR is seen, Dr. Liberman is seen leaving the RR at 13:10:23. Ms J acknowledged that this signifies that the patient is in the RR at this time.

She testified that, at 13:13:29, Dr. Liberman is seen on the video going to the washroom and, at 13:14:29, Ms Q is seen discharging the first patient of the day in the wheelchair. Ms J believes she was in the RR during this period.

At 13:15:16, Ms J testified that she is near some boxes in the hallway and, at 13:19, Dr. Liberman emerges from the washroom and goes into the OR.

At 13:20, Ms J noted that Ms Q returns to the RR with an empty wheelchair.

At 13:23:13, Ms J testified that the figure going up the hallway is Ms Q. Ms J identified herself at 13:24:06 in the hallway with a plate and she is seen in the hallway again at 13:25:49.

At 13:31, Ms J noted she is going into the Prep Room, preparing for the next case.

At 13:38, Ms J testified that Dr. M is observed bringing the third patient, Patient B, down the hall to the OR.

Ms Q was identified in the Prep Room and bringing a container with the fat of Ms Stryland to the freezer at 13:42:35. Ms J testified that Ms Q returns down the hallway. Ms J testified that the video shows her going into the RR.

Between 13:45 and 13:51, Ms J testified that she was the one going back and forth from the RR to the OR and she thought she was retrieving whatever was needed for the third case, Patient B. She testified that some of the equipment that is needed is stored in the RR.

Although the OR door is seen to be open at 14:08:36, Ms J testified that it would have nothing to do with the care of Ms Stryland and that it may have been open because the OR was hot.

Ms J identified Dr. Liberman going from the RR to the OR at 14:34 and he is seen leaving the RR at 14:38:23. Ms J identified herself going back and forth at 14:40 as part of her OR circulating.

Following a gap in recording of 18 minutes from 14:47:55 to 15:06, Ms J testified that she is seen in the video. From 15:06 until 15:15, she and Dr. Liberman were the only two figures appearing in the video.

Ms J identified Dr. M in surgical attire entering the RR at 15:17:37 and then leaving the RR shortly afterwards at 15:18:03 and going back to the OR.

At 15:18:43, Ms J testified that the person putting on an apron is the clinic cleaner. As Dr. M had noted some drainage, the cleaner was putting on an apron to clean up the mess and because of universal precautions with body fluids. Ms J explained that the cleaner wears proper attire so she does not transfer body fluids to any other part of the clinic.

Ms J testified that when Dr. M was in the RR at 15:18 she noted the drainage and asked that a second compression garment be put on.

Ms Q was ventilating the patient and she continued to do so until Ms Stryland was transferred from the clinic to the hospital.



On examination of the anesthetic record, Ms J confirmed that the blood pressure recordings in the OR show Ms Stryland's blood pressure never going below 110 systolic. She confirmed that, at 1:15, Ms Stryland had a BP reading of 110 over 70 or 80 in the OR according to Dr. Liberman's OR record, but Ms J recalls it being a little lower than that. However, Ms J was clear in stating that she did not recall Ms Stryland's BP being in the 100's when she was admitted into the RR, but she didn't think it was in an alarming range. Ms J also testified that Ms Stryland was talkative and she would not expect her to be as alert and talkative as she was if she had dangerously low vital signs.

Ms J has no recollection of alarms going off on Ms Stryland's monitor when she was first admitted to the RR as her O2 sat and her BP were fine at that time. Ms J testified that it was not unusual in her experience for there to be a 20 or 30 point drop in BP on admission to the RR.

She agreed that if the patient was stable she could leave the RR for short periods of time, and if the alarm went off she would return promptly. She testified that Ms Stryland was stable in the period in which she was responsible for her care, that no alarms were sounding and that Ms Stryland was not in distress.

Ms J testified that when she returned from the OR to the RR after the third patient had the infiltration fluid infused for liposuction, Ms Q was a "little frustrated or flustered". Ms J testified that "she [Ms Q] is like, this didn't seem right" and Ms Q asked her to assist in doing bilateral BP monitoring. Ms Q then asked for Dr. Liberman to be called in. Ms J reiterated again that the BP was in the mid-70's to high 60's approximately. Ms J stated: "It did dip to the 60's, but not below, not below, not like 50 or anything like that."

Ms J testified that Dr. Liberman was aware of Ms Stryland's vital signs when she first came into the RR and that these were not concerning. Dr. Liberman was never advised that there were concerning vital signs until after the infiltration of Patient B, the third patient.

When Dr. Liberman came into the RR, he assessed the patient, ordered the patient to be put in reverse Trendelenberg position, ordered the IV fluid to be increased and to continue to monitor the patient. Ms J went on to testify in cross examination that Ms Stryland's vital signs were going up and were fine. She said, "I was called back into the operating room, but I had witnessed at least two of her vitals had gone up and been at a stable, or not stable, but at a steady measurement...It went up from where it was. So it was a great improvement."

She does not recall exactly what Ms Stryland's BP was when she returned to the OR but she did tell Dr. Liberman on return to the OR that her BP was going up. When prompted with her testimony from the College hearing regarding Dr. M, Ms J agreed that she testified that the BP at that point was 78 to 81 systolic.

Ms J testified that when Ms Q filled in the vital signs on the RR graph she was ventilating the patient, and if she looked at the display on the monitor she would have seen the most recent vital signs on the trend area at the bottom of the monitor. She agreed that, if Ms Q did that, they would not have been in accord with the timeline that Ms J wrote on the top of the chart. They would have been the last six vital signs that had been recorded for the Ms Stryland they would have been the vital signs at or about the time that the patient crashed. Ms J testified that, if an expert assumed that the vital signs on the RR record corresponded to the timeline at the top of the graph, they would be wrong.

She testified that Dr. Liberman was never asked to see the patient other than the two times she reported.

When taken again by defence counsel through the video recording from the security camera, Ms J notes that she was out of the RR several times and agreed that her functions carried on with "business as usual" as this was not a situation where a patient with critically low BP was setting off alarms on a monitor. She agreed that several staff walk up and down the hall and that no one appears to be distracted by monitor alarms in the first hour of Ms Stryland's admission to the RR.

At 13:45 on the RR record, there is a systolic BP recording of about 55, a diastolic of less than 30 and the O2 sat of 88 percent, all of which suggests a critically ill patient. Ms J agreed that, “They’re basically crashing”. She agrees that nowhere is there anyone reacting to a “crashing” patient according to the security camera video.

At 14:34, Dr. Liberman is seen coming from the RR and Ms J agreed that this was the first time he had been seen on the video since 13:19. As the video does not pick up all movement, Dr. Liberman was not seen going into the RR.

Ms Stryland’s BP at 14:40 was a little over 40 systolic and a little under 30 diastolic and Ms J acknowledged that this is a “crashing patient”. She denied that they were walking around while the patient was “crashing” and denied that this was “business as usual”.

Ms J testified that the reason it looks like “business as usual” and that they are not dealing with the “crash” is that the “crash” did not happen until later.

Ms J said that it was about ten to fifteen minutes after the first time she went to get Dr. Liberman, when she returned to the RR and saw that the patient had collapsed.

Following hearing the news of Ms Stryland’s death, the staff from the clinic went out to dinner to discuss the events of the day. Those attending included Dr. M, Dr. M’s husband (Mr. R), Dr. Liberman, Ms Q, herself and another nurse at the clinic, Ms D.

Ms J testified that Ms Q said that they should be documenting what happened that day with respect to Ms Stryland and Dr. Liberman responded that he would be the one doing the documentation.

### **Credibility of Ms J**

The Committee found Ms J contradicted herself in her testimony regarding who took Ms Stryland’s vital signs on admission to the RR. While she said at one point that she was

caring for Ms Stryland and recorded the first two vital signs, she didn't write them down, and another time she said it was a "mix" between her and Ms Q doing the vital signs. During cross-examination, Ms J said that "I don't recall it being in the hundreds when she came in and "they" did the first vital." If she had done the vital signs with Ms Q, the Committee believes she would have said "we". Video evidence calls into question whether or not she was the one doing the vital signs as she said she did.

In addition to saying that she was taking care of Ms Stryland for the first two vital signs, Ms J said that she had a conversation with Ms Q, who was concerned about Ms Stryland's vital signs, *prior* to the first patient being discharged. When Ms Q pointed to the monitor and asked "that doesn't concern you"?, she told Ms Q that Dr. Liberman was aware of what the vital signs were and he was OK with it. She said that the patient's BP was in the 80's at his point. The Committee questions Ms J's credibility in relation to her report of a conversation between the two nurses and the BP in light of the subsequent evidence in the documentation, testimony and the video recording. These discrepancies will be dealt with in the Committee's findings.

In contrast to Ms Q who said she asked for the chart when EMS arrived, Ms J recalled that her colleague asked for the patient's chart "awhile" prior to the paramedics arrival.

Her testimony about Ms Q writing the vital signs on the RR record, while at the same time ventilating Ms Stryland, is also not consistent with the findings of the forensic document examiner.

Ms J is also facing a hearing with her own regulatory body and legal proceedings, and the Committee is not certain to what extent these may have coloured her version of events. The fact that she admitted to having conversations with Ms Q about the events surrounding Ms Stryland's care suggests that her memory may have been influenced as well by those talks.

**Ms Q**

Ms Q was summoned to testify and for her testimony she sought the protections of *The Canada Evidence Act* and *The Ontario Evidence Act*.

Ms Q received her diploma in nursing in 1996 and graduated from an Ontario university with a Bachelors of Nursing in 2000. She has done advanced training in several areas, including emergency care, cardiac care and pediatrics. Besides working for an agency, she worked in the Emergency Department full time for five years in two different hospitals. She works at various locations in Toronto through a staffing agency.

After receiving a summons to witness, Ms Q attended an interview with the College investigators. She had her lawyer present at the time. She was called by the defence in the hearing for Dr. M and her testimony concluded about a month before her appearance at this hearing.

Ms Q testified that she is involved in an investigation by the College of Nurses into the death of Ms Stryland and she is a defendant in a lawsuit arising out of Ms Stryland's death.

Ms Q was hired at the clinic as a day recovery and circulating nurse and she began employment the day before her care of Ms Stryland. Ms J was still orienting her on September 20, 2007.

Ms J was the circulating nurse for the second patient, Ms Stryland, and Ms Q was in the RR with the first patient of the day. Ms Q testified that she was the circulating nurse in the OR for the third patient, Patient B, after she discharged the first patient of the day.

When shown the RR record, Ms Q testified that on the top of the page was her handwriting, and that the pre-op vital signs, weight, medication, allergies, past medical history, and the escort information were in her handwriting. She filled it out when she took Ms Stryland to the change room prior to her surgery. She wrote the IV fluids and the

amount on the form. Ms J charted the Foley catheter and the amount obtained on the right side of the RR record.

Ms Q said that she wrote the vital signs at the bottom of the RR graph below the timelines across the top of the graph. She testified that she believed that she wrote those notations just prior to transferring Ms Stryland to the hospital, at a time when she was also controlling Ms Stryland's airway and Ms Stryland was in cardiac arrest.

When EMS arrived, she asked for the chart, noticed it was blank and asked Ms J why that was. She testified that Ms J had no answer for her and she thought that there should be some vital signs down so she started to jot them down as quickly as possible prior to transfer. The information was displayed on the vital signs monitor hooked up to the patient and located on her left side. In order to get the information, she had to scroll back the monitor as it automatically takes a set of vital signs every five minutes. It is pre-programmed to do so, but it only displays one set of vital signs at a time.

She thought she scrolled back 20 to 25 minutes and wrote the information down on the RR record. She testified that she believed that she wrote it down in reverse, as the most recent would have been the ones on the monitor when she started to scroll back. She said that she did not take blood pressure recordings at 13:15 and 13:20 as recorded on the RR Record and testified that the information she wrote down does not correspond to the times shown on the document.

Ms Q said that she wrote it with her left hand as that is the only one she had free at the time since she was bagging (ventilating) the patient with her other one. She thought that she was able to hand off the Ambu bag to the paramedic standing there and she was able to try to note a few more things with her right hand such as the IV fluids that were hanging.

She said that she was in the RR when Ms Stryland collapsed and had to be re-intubated, and she believes that this occurred at 14:45, the time that the notations end on the RR record.

Ms Q was shown her interview with the College investigators in August 2008. At that time she had counsel present with her and she affirmed to tell the truth.

She told the investigators that the vital signs on the RR record were done by her and that, after taking the vital signs at 13:15 and at 13:20, she asked Ms J to speak to Dr. Liberman because she was concerned about Ms Stryland's BP.

Ms Q was read the answers she gave to questions asked of her when she was interviewed at the College in August 2008. At 14:45, she said, she sat Ms Stryland up, whereupon her BP dropped dramatically and she became diaphoretic, with a fast heart rate. She asked Ms J to fetch Dr. Liberman. Dr. Liberman asked to have a catheter inserted and he prepared to intubate her as he felt she didn't have a good gag reflex. Ms Q agreed that she gave those answers.

On further review of that interview, Ms Q agreed that she said that she took over the "bagging" of Ms Stryland as her oxygen level was dropping off. At that time, she agreed that she said, "My hands were busy. Obviously, I was not able to write anything down past this point." She agreed that she did not advise the College that she had not done the vital sign charting at the times shown, but instead they were written just before the EMS arrived when she was scrolling back on the monitor and managing the patient's airway.

Ms Q testified that, as the case has progressed, certain things have come to light including the fact that her initial timeline was completely off. When she saw the video at the lawyer's office, she realized that she was not actually in the RR when the timeline was documented in the RR record. She said that she didn't know what time it was when she entered the RR. She depended on her colleague, Ms J, who had been there for the initial recovery of Ms Stryland to determine that timeline and she took the information from

that. She testified that her evidence at the current hearing was what she would have the Committee believe as she has more information now than she did then.

At this point in her testimony, the witness was excused and the Committee heard arguments about Ms Q being declared an adverse witness. When a witness has made a prior statement that is inconsistent with the statement they are making in the witness box on the day of their testimony, the witness may be declared adverse which allows the party calling the witness (in this case counsel for the College) to cross-examine the witness. After hearing the legal arguments, the previous statements by Ms Q, the response of defence counsel and the advice of the Committee's independent legal counsel, Ms Q was declared an adverse witness by the Committee.

College Counsel reviewed with Ms Q the Practice Standards of the College of Nurses of Ontario with regard to documentation. Ms Q agreed that, as a trained and experienced Recovery Room nurse, her experience tells it is critical to make accurate and contemporaneous notes on patient charts. She was read the standard with regard to late entries and agreed that it was sometimes necessary to make a late entry particularly in emergency care, such as when she needs to ventilate a patient. Marking the chart as a late entry would be easy to do, she said. She did not correct the errors in charting when she realized that they were misleading, nor did she tell the College during her interview with the investigators, nor did she tell the coroner. She testified that, at the time, she believed that the timeline was correct.

After seeing the video once, she realized that the timeline was not correct and it helped her to recover her memory that she wrote the vital signs down with her left hand while the ambulance was on its way and she was bagging the patient.

Ms Q agreed that she had more than two conversations with Dr. Liberman about the timeline for the vital signs. She also had conversations with the other staff at the clinic about the events of that day.



Ms Q testified that she was not present when Ms Stryland entered the RR and went on to reiterate that she was assisting Dr. M and Mr. H with the infiltration of the third patient, leaving Ms J at the patient's bedside. When she went to check on Ms J, following the infiltration of the third patient, she found Ms Stryland in distress and she took over her care. She said she returned to Ms Stryland after 14:00 hrs or closer to 14:30 hours. She thus did not have any responsibility with respect to Ms Stryland's care until 14:30 and it was not her responsibility to chart.

In her testimony, Ms Q acknowledged that making a reflective note immediately after a critical incident is a standard of her profession and she did that on September 20, 2007, in the late evening within a few hours of Ms Stryland's passing. She did it following the meeting of all the clinic staff in a restaurant where they had dinner and discussed the events of the day.

She agreed that she said at the dinner meeting that the recovery room record was incomplete and that an additional nursing note should be written. She testified that Dr. Liberman said he would prefer that she not document on the chart and that he would write an end note since Ms Stryland was his patient. She said that she thought it was prudent that she proceeded to write her own note, and she attempted to write down everything she could recall as she did not have the RR record and she was writing from memory.

Later in her testimony, Ms Q said that she took some information from the RR record that night prior to writing the note. When she took down the information, she was under the impression that it was accurate. She testified that the RR record and her reflective note were consistent with each other.

She noted that the times were approximations, except for one specific time and that was the time of the patient's re-intubation – 14:45. The reason she was able to recall this time is because she had not been wearing her watch and, when she put it on, she saw the actual time.

She continues to believe that the time of re-intubation was 14:45. However, later in her testimony, Ms Q said that, although she indicated in her testimony previously that the time of the “crash” of Ms Stryland was 14:45 and at other times she has been less exact in her time, she agreed that she did not have a firm recollection of the exact time.

Ms Q was taken line by line through her reflective note. At 13:20, she returned from discharging the first patient and Ms Stryland had only been in the RR for 10 minutes or so. She also agreed that when she returned from discharging the first patient she saw a concerning BP and Ms J told her not to worry about it as it was not an uncommon experience. However, later in her testimony, she denied she was in the RR when Ms J took the first few readings of the vital signs in the RR. She agreed that she has no first-hand knowledge that the first vital signs were not concerning as Ms J said.

She testified that, when she returned to the RR after the infiltration of Patient B, the third patient, Ms Stryland’s BP was below 70 and she asked Ms J to get Dr. Liberman. She acknowledged that Dr. Liberman came into the RR, assessed the patient, told them to put the patient in the Trendelenberg position and increase her IV fluids. She also said that her testimony at the hearing of Dr. M was correct. Dr. Liberman said to just give her some fluids, put her in a Trendelenberg position and “She will perk up.”

At 14:45, Ms Q wrote in her note that Ms Stryland became restless and agitated and was complaining of thirst. Ms Q wrote that she increased the head of the bed to facilitate fluid sips, and when she did that the patient became increasingly restless and pale with a dramatic decrease in O2 saturation.

She testified that the patient’s heart rate became much faster and the blood pressure decreased. She also noted that there was a blood pool under the patient when she repositioned her. Her note said that she became progressively less responsive and Dr. Liberman was called.

Ms Q agreed that if the video showed Dr. Liberman going back and forth from the OR to the RR from 14:34 to 14:38 that would correspond to the chronology.

She also agreed that the patient was in extremis at this point. She was near death and if she had not been resuscitated and re-intubated she would have died. According to Ms Q, the patient remained in extremis until she left for the hospital.

During this time, Ms Q stayed with the patient providing airway assistance with an Ambu bag. She agreed that she didn't have time to write anything further on the RR record. She also agreed that another binder was placed on Ms Stryland and at 15:30 that was soaked through with blood and the BP dropped from 110 over 60 to 70 over 30. The heart rate increased to 128 beats per minute and spontaneous respirations ceased, and she resumed assisted respirations with the Ambu bag. She testified that she is describing a second collapse of the patient.

When she returned to the clinic five days later for work, she gave Dr. Liberman a copy of her reflective note and he told her she should not have written it and was upset with her. He told her she should destroy it.

College counsel then reviewed with Ms Q some of the findings of the forensic document examiner's report.

- i) He was unable to find any characteristics in the six columns of vital signs that appeared to be made with a left hand.
- ii) He concluded that the person who wrote the information found beside the pre-op vitals at the top of the chart was likely the same person who wrote the vital signs in the six columns at the bottom.
- iii) He also said that there was strong support for the conclusion that certain writing on the chart was made when the recovery room record was not above any other documents in the chart.

- iv) In addition, he found that some of the writing on the RR record is imprinted on other pages of the patient's chart, including the fat extraction sheet, as well as the anesthetic record and the fainting instructions sheet.
- v) The forensic document examiner also concluded that the writing at the bottom of the RR record was written in at least two distinct writing episodes and Ms Q agreed that was not consistent with what she testified earlier as she recalled that her writing occurred in one singular episode.

When suggested to her that the document examiner's conclusions do not match her recovered memory, Ms Q said that her memory is all she has and reiterated that she wrote the vital signs prior to the patient's transfer to the hospital. She denied that it was a fabrication.

The security camera video was played for Ms Q and it is noted that Ms J goes back and forth from the OR to the RR a number of times from 13:41 to 13:48. Ms Q denied that this was consistent with Ms J being the circulating nurse, as she recalled she had been asked to circulate as she was still in orientation at the time. She thinks Ms J was coming in to help her (in the OR). Ms Q denied that she took over care of Ms Stryland when she returned from discharging the first patient, as she did not take over Ms Stryland's care until later.

When it was pointed out that she came down the hallway at 14:05 and entered the RR, there is no indication that she left the RR until the paramedics left with Ms Stryland at 16:13. She said that she took over care after finishing the infiltration of Patient B.

In cross-examination, Ms Q was shown the anesthetic record for the third patient that shows from the vital signs record that the surgery started about 13:30. She agreed that the infiltration process took place after the patient was under anesthetic.

Ms Q said that she was not in the OR when Ms Stryland moved from the OR table to the stretcher that day and her involvement with her was limited to the RR. She said she has no first-hand knowledge of Ms Stryland's level of consciousness in the OR.

She agreed that she has no first hand knowledge of whether or not Ms Stryland was stable when she was moved from the OR to the RR. She also agreed that the anesthetic record shows that the last systolic blood pressure is 110 and this is not a low BP. She testified that the O2 saturations are 99 percent with one of them at 98 and they are all good concentrations.

Ms Q agrees that she was not in the RR when Ms Stryland first arrived in the RR and that when she arrived in the RR, Ms Stryland was already there. She said that Ms J and Dr. Liberman brought Ms Stryland to the RR.

Ms Q recalls going to the RR to make sure Ms J was okay and didn't need any assistance, and she then noted that the BP was below 88 systolic. Ms J told her that she was comfortable with the BP and that it was not unusual for a patient recovering from liposuction to have a drop in BP. She does not believe the BP was in the 60's at that time. Ms Q returned to assist with the surgery for the third patient.

Ms Q said that the first concerning drop in BP occurred at some point when she took over the responsibility for Ms Stryland's care. The patient's BP dropped below 70 systolic and, as far as she knew, there was no prior drop in BP to that level. Ms Q asked Ms J to go to the OR and let the doctors know. She thought that Dr. Liberman came to the RR after that time, assessed the patient and asked her to do a manual BP which she did. She also increased the IV fluid. The patient's BP improved over this time and, to her recollection, it approached 100 systolic. Once the BP reached 100 systolic she didn't think it was necessary for the patient to be in that position as she was increasingly stressed, so she slowly raised the head of the bed.

Ms Q said Ms Stryland wanted to get up and go to the washroom and that when she tried to sit up she developed a fast heart rate, her blood pressure dropped and she lost consciousness. She asked Ms J to get Dr. Liberman right away and he came promptly and assessed the patient. He intubated the patient, instructed her to catheterize the patient, and increase the fluids.

Ms Q was shown the security camera video and reviewed the details in various time periods of the afternoon of September 20, 2007. At 13:15:32, Ms J is taking inventory of supplies delivered to the clinic in the hall. At this time, the RR record shows the BP as 60 over 20 diastolic. She agrees that this is a dangerously low BP and that there is no indication on the video that there is a “crashing” patient in the RR.

At 13:19, she agreed that Dr. Liberman walks past the RR and is not bothered by any alarms in the RR. She also agrees other staff pass the RR and do not seem to be bothered by any alarms in the time period up to 14:26. She agreed that from the activity in the hall it appears to be “business as usual”. At 14:45, the blood pressure is a systolic of 42 on the RR record and a diastolic of less than 30, a heart rate of 141 with an O2 saturation of 85. Ms Q testified that this is a “crashed” patient, the patient at the end of the day.

At 15:06, on the video, Ms J is seen coming from the RR going to the OR and Dr. Liberman goes from the OR to the RR. Both of them go back and forth between the two rooms over the next few minutes, sometimes with items in their hands. Ms Q agreed that it appears that the intubation takes place during the period of 15:10 and 15:16 or 15:17 according to what is suggested by the activity on the video.

Ms Q agreed that alarms must have gone off that day but she has no recollection of them now. She believes that the first concerning BP was after 2:00 pm that day, after the infiltration of the third patient was done.

**Credibility of Ms Q**

Ms Q's testimony is not consistent with other evidence in several major areas. Although she repeatedly said that she was not in the RR when Ms Stryland was admitted there, she is seen leaving the RR about four minutes after Ms Stryland arrives. She returns there about five or six minutes later.

Ms Q also said that she did not know the consciousness level of Ms Stryland at the end of her surgery as she was not there. However, the security camera video clearly shows her entering the OR with Ms J at 13:01 hours, the time corresponding to the end of the surgery when Ms Stryland would be waking up and having a compression garment put on.

Ms Q said that she was the circulating nurse for the third patient of the day, yet she is not seen going between rooms setting up for the next surgery; Ms J is seen doing this. At 13:38:57, Dr. M accompanies the third patient, Patient B to the OR. At 13:39, Ms Q appears to be in the Prep Room and, at 13:42, she is seen in the hall carrying a bag containing Ms Stryland's fat to be placed in the freezer. She returns at 13:43. Ms Q appears from the OR and goes to the RR at 13:46. She is seen in the hall at about 14:05 returning to the RR. The appearances of Ms Q in the hall, at the times corresponding to the beginning of the next surgery and her return to the RR, do not support her claim that she was not the RR nurse for Ms Stryland and did not go into the RR until 14:30. The OR note for the third patient of the day also documents that Ms J was the circulating nurse for the case, not Ms Q.

Ms Q gave evidence that she took over Ms Stryland's care at about 14:30, yet this contradicts her own reflective note written the day in question, her interview with the College, the video recording and other documentary evidence.

The forensic document examiner's findings do not support her version of when and how she wrote the vital signs on the bottom of the RR record graph. In addition, Ms Q was an

experienced Emergency and RR nurse and, as such, the Committee believes it more likely that she did chart contemporaneously.

The Committee therefore did not find Ms Q's testimony credible in several areas that will be further outlined in the Committee's findings.

**Dr. S**

Dr. S has been an anesthesiologist since 1997 and currently is an Assistant Professor in the Department of Anesthesia at an Ontario University. The Committee accepted Dr. S as an expert witness.

Dr. S did a report regarding the Dr. Liberman matter dated May 26<sup>th</sup>, 2009. She was asked to answer the following three questions:

- i) Does the care provided by Dr. Liberman meet the standard of practice of the profession?
- ii) Did Dr. Liberman's care display a lack of knowledge, skill or judgment or disregard for the welfare of his patient?
- iii) Are you of the opinion that Dr. Liberman's clinical practices, behaviour or conduct exposed, or is likely to expose, his patients to harm or injury?

In summary, she had the following opinions:

- i) The care of Dr. Liberman did not meet the standard of practice of the profession in that he failed to recognize hypovolemic shock and treat it.
- ii) She said that it was difficult to determine whether he demonstrated a lack of knowledge or a lack of judgment because she could only comment on what was done, or not done, but clearly, she thought he was deficient in one or a combination of the two.
- iii) With regard to the final question about whether or not his clinical practice, behaviour or conduct exposes, or is likely to expose his patients to harm or



injury, she said she could not answer that question with only one file to review.

Dr. S reviewed the Anesthetic Record of Dr. Liberman and the information recorded there. Recording pre-op vital signs as Dr. Liberman did is important as they provided a baseline. None of the pre-op section of the anesthetic record was a concern for Dr. S. The intra-operative part of the Anesthetic Record was explained and the expert witness had no concerns about this area.

At the bottom of the Anesthetic Record on the left side is a space for the documentation of vital signs on admission to the RR. Dr. S explained that the anesthesiologist must ensure patient's vital signs are stable on admission to the RR in order to delegate the care of the patient to the RR nurse. She testified that, on Dr. Liberman's anesthetic record for Ms Stryland, the vital signs on admission to the RR were not charted and they should have been.

Dr. S read from the Guidelines for the Standard of Care for Anesthesia from the Canadian Anesthesiologist's Society, specifically, that care should not be delegated to the RR nurse until the anesthesiologist is assured that the patient may be safely observed and cared for by the nursing staff. The anesthesiologist or designated alternate is responsible for providing anesthetic related care in the RR. This standard applies to clinics as well as hospitals.

Dr. S testified that vital signs after surgery can vary from the pre-op vital signs, but they should not be outside the range of 20 or 30 percent variance from pre-op vital signs, either higher or lower. In looking at Ms Stryland's pre-op vital signs, her systolic blood pressure should be in the range of 85 systolic or higher post-operatively.

In reviewing the RR record, Dr. S assumed that the vital signs were recorded when they were done and she made that assumption because every day for 15 years she has seen

nurses charting contemporaneously. They keep up with their charts. She testified that it is the standard.

She said the first reading was recorded at 13:15 although she thought the arrival to the RR was at 13:09. The first BP is extremely low at 60 over 28 with a pulse of 68 and an O2 saturation of 85 percent. She said she would be concerned about that and would want to find out why and address it.

Dr. S outlined the causes of low blood pressure or hypotension. She explained that shock means that there is not enough pressure to perfuse the vital organs with blood and oxygen causing damage. If hypotension is due to hypovolemia, then usually the body responds with a higher pulse rate to compensate. Even though Ms Stryland's BP is low at 13:15, the heart rate is only 68 and Dr. S said there were many possible reasons for this. The O2 sat of 85 percent is below normal and for a healthy young patient it should be well over 95. Once the O2 level is below 88, the oxygen delivery is severely impaired.

Dr. S testified that the vital signs for Ms Stryland at 13:15 are not normal and she is not stable. A young patient may not show physical symptoms of hypotension as they are able to compensate and they may look surprisingly normal. Dr. S said that a patient with these vital signs should not have had her care delegated to the RR nurse.

Once the anesthesiologist is involved in another case, it is difficult to deal with problems, as the anesthesiologist can't leave the anesthetized patient, according to Dr. S. In this case, given the status of Ms Stryland, the anesthesiologist should not have started the next case.

With vital signs in this range, Dr. S testified about the next steps if hypovolemia was the working diagnosis. The patient needs more IV fluids and oxygen, and if the vital signs don't come up within a few minutes, then she needs agents to constrict the blood vessels to temporarily increase the pressure until the problem can be fixed. The medications

don't fix the problem but they buy time until the cause can be found and treated. She outlined the physical examination that should be done immediately as well.

Because Ms Stryland's vital signs remain low at 13:20, 13:30 and at 13:45 and Ms Stryland has been administered more oxygen, Dr. S said that her concern would be rising because whatever is being done to deal with the problem is not working.

Dr. S explained that the Trendelenberg position, or the head below the heart position, lets gravity help by putting blood volume to the head, as the brain is the most vital organ. The position usually increases blood pressure but it is a temporary measure to maintain perfusion and it does not fix the underlying problem. Dr. S said that she assumed Dr. Liberman's working diagnosis was hypovolemia because the Trendelenberg position and the increase in IV fluids are treatments for that problem. She testified that as an anesthesiologist she would like to see a response within five to ten minutes, that is, a BP over 80, preferably over 90, or somewhere close to normal for a person of that age and co-morbidities. She outlined other treatments and considerations if this did not work.

Dr. S noted that at 14:15, the patient's BP is about 57 over 25, so it is not better, and slightly worse, than when she came into the RR. Ms Stryland's heart rate has now increased to 102 signifying that her body is doing everything it can to maintain her BP and Dr. S said her level of concern would be getting high. Dr. S testified that the patient is getting worse and she would consider transfer at this point as an hour of different treatments has not helped.

Dr. S said Ms Stryland should have her hemoglobin checked as she may require blood products. In addition, she needs pressure agents that are usually delivered by infusion. Invasive arterial lines are usually used to measure the response to these agents.

Dr. S is of the opinion that Dr. Liberman fell below the standard of care for Ms Stryland in his care of her from the time of her admission to the RR up until 14:45.

Dr. S said that if the BP is low when the patient is in Trendelenberg position, sitting up with the head above the heart requires even more driving (blood) pressure. As she didn't have that, Ms Stryland lost consciousness. This demonstrates that there was not adequate perfusion of the brain and suggests that Ms Stryland has lost a significant amount of blood. Dr. S testified that arrangements should have been made for transfer to a hospital when Ms Stryland was re-intubated.

Dr. S explained that the production of urine depends on how adequately the kidneys are perfused with blood. Between 10:00 am and about 3:00 pm, in five hours, the bladder catheterization of Ms Stryland rendered 100 to 125 ml of urine. Dr. S testified that this amount of urine is not adequate given the amount of fluid that she had been given.

Following intubation, catheterization and more IV fluids, Dr. Liberman's handwritten note indicates that the BP came up to 100 over 55, the O2 sat was 100% with a good tracing and pulse was 108 to 110 beats per minute. Ms Stryland was gagging on her endotracheal tube and making purposeful hand movements. Dr. S said that this indicates that the patient was responding as hoped, however, she still needed to be transferred as she needed further fluid resuscitation and likely blood products.

Dr. S reviewed the rest of Dr. Liberman's handwritten note and the notation that the dressing suddenly became soaked with blood that pooled on the stretcher and did not clot. The significance of this fact is that Ms Stryland has bled out all of her blood, her cells, and all her clotting factors and platelets. Because her fluid is being replaced with just saline with no cells, platelets and clotting factors, a dilutional coagulopathy results and clotting can't happen. Disseminated intravascular coagulation (DIC) is also a possibility with this amount of trauma and the appearance of blood that is not clotting.

Dr. S testified that Dr. Liberman did the right thing with intubation, fluids and treating Ms Stryland with what he had available, however, he fell below the standard of care in not anticipating where this could potentially go and transferring her immediately. If the

patient's collapse didn't happen at 14:45, but happened at 15:10 to 15:15, Dr. S said that it would not alter her opinion with regard to immediate transfer to the hospital.

Dr. S testified that, with regard to Dr. Liberman's knowledge, skill and judgment, it was unclear to her whether he didn't recognize at the time how life-threatening this was or whether he recognized it and thought that his treatment was adequate and appropriate, which are two different things; one is knowledge and one is judgment. Either way, it is a standard of the profession to deal with it appropriately. Dr. S would not have confidence that Dr. Liberman would be able to recognize and deal with another re-intubation situation like this.

During cross-examination, Dr. S agreed that Dr. Liberman's pre-operative and intra-operative care was appropriate and that he responded quickly and appropriately when he was called to the RR by the nurse. She testified that a working diagnosis of hypovolemia was appropriate as well.

When discussing the portion of the anesthetic record dealing with the vital signs on admission to the RR, Dr. S agreed that when the same anesthesiologist does the intra-operative and post-operative care the communication of the vital signs on the bottom of the anesthetic record is obviated. However, she went on to add that all the vital signs recorded over a day can't be remembered, thus it is necessary to record them.

Dr. S testified that her opinion of Dr. Liberman's care of Ms Stryland was based on the RR vital signs and the timelines that were recorded. Those vital signs informed her opinion that the patient was in shock when she arrived in the RR, remained in shock for the next 90 minutes and that hypovolemia should have been suspected and ruled out. Dr. S also said that if the vital signs were different, then she may have a different view of the case, however, the ensuing events were consistent with those vital signs being accurate.

Dr. S pointed out in her testimony that although doctors may exercise their clinical judgment in different ways and it may not mean that they are falling below the standard

of practice, when life-threatening things come into play the amount of variation in practice gets much narrower, until you are right down to an algorithm about how treatment must be done.

In re-examination, Dr. S agreed that it would be concerning if the vital signs on admission to the RR were repeatedly not recorded at the bottom of the anesthetic record over a lengthy period of time in two different clinical settings.

Dr. S said that, once a patient is resuscitated and then subsequently goes to the hospital, the standard of care would suggest that the anesthetist should document the resuscitation as soon as he is no longer involved firsthand in the actual resuscitation, that is, immediately afterwards.

Dr. S reiterated that the ensuing events with Ms Stryland are consistent with the vital signs on the RR being correct. The situation with Ms Stryland was life-threatening with minimal variation in what needed to be done to manage her.

### **Credibility of Dr. S**

The Committee found Dr. S clear and thoughtful in her testimony and found her very credible.

### **Dr. T**

Dr. T graduated from medicine in 1990 and received his specialty in anesthesia in 1996. He practises anesthesia at various hospitals and cosmetic surgery clinics. In light of his extensive qualifications, Dr. T was qualified to give expert evidence in the field of anesthesia.

Dr. T testified that he thought Dr. Liberman met the standard of care in his pre-operative and intra-operative care of Ms Stryland. However, he thought that the doctor fell below the standard of care in his post-operative care with regard to two areas: the treatment, management and transfer of care in the RR; and the documentation of his care, as well as

his ability to resuscitate a patient with respect to management and treatment of a critically ill patient and the documentation of that.

Dr. T thought that Dr. Liberman displayed a lack of knowledge in the following areas:

- i) his inability to formulate a list of potentially life-threatening conditions for a patient with an extremely low BP in the RR, and to quickly rule them out as causes for low BP;
- ii) his inability to recognize that his initial measures of increased IV fluids were not working, and further measures would be required;
- iii) his lack of applied knowledge of using inotropes and vasopressors in the face of continually low blood pressure; and
- iv) his inability to recognize a patient who was critically ill or in shock, either due to severe hypovolemia and/or ongoing bleeding and hemorrhage.

With respect to judgment, Dr. T testified that Dr. Liberman displayed a lack of judgment in the following areas:

- i) his lack of timely use of inotropes and vasopressors when initial measures of management of an extremely low BP in the RR failed to bring about a sustained rise in BP in Ms Stryland; and
- ii) his inability to use his judgment to quickly transfer a critically ill patient to a hospital facility after his initial interventions did not correct Ms Stryland's extremely low BP.

Dr. T thought that Dr. Liberman displayed a lack of skill when he did not use his observational skills to accurately assess Ms Stryland in the following areas:

- i) his omission of reviewing the RR nurse's notes and trends of vital signs of the patient which clearly showed the patient deteriorating into shock, most likely from hypovolemia secondary to ongoing bleeding and hemorrhage;

- ii) his inadequate assessment of Ms Stryland's volume status in the RR including assessing the presence of orthostatic hypotension, the level of the patient's jugular venous pressure, the amount of urine output, and the capillary refill; and
- iii) his inability to recognize a patient going into hemorrhagic shock.

Dr. T thought that Dr. Liberman's clinical practice, behaviour or conduct exposes or is likely to expose his patients to harm or injury for the following reasons:

- i) his lack of knowledge of reasons and diagnosis for sustained low blood pressure in a patient post-surgery;
- ii) his lack of knowledge to appropriately treat ongoing hypotension in the post-operative period;
- iii) his lack of applied clinical knowledge of the use of inotropes and vasopressors in the face of ongoing hypotension and in the acute resuscitation situation;
- iv) his lack of skill to recognize a patient with severe hypovolemia, most likely secondary to ongoing bleeding and hemorrhage;
- v) his lack of documentation of the vital signs and level of consciousness upon arrival to the RR;
- vi) his lack of judgment regarding when it is appropriate to transfer and/or delegate care to the RR nurse of a patient who had extremely low BP and low oxygenation on arrival to the RR; and
- vii) his lack of judgment to quickly identify, assess and transfer an unstable and critically ill patient to a hospital in a timely manner.

Dr. T described the procedure for liposuction and noted that when liposuction is done there is blood, the tumescent solution or infiltration solution, and serum sucked out in addition to the fat. Reading from Ms Stryland's medical chart, Dr. T noted that 6075 cc's of liposuction fluid was aspirated and the amount of fat in that was 2725 cc. He is involved in 20 to 50 liposuction cases a year and has never been involved in a case where six litres of fluid was aspirated. The risk of complications increases with the amount of volume removed and he said that five liters or more leads to a higher risk of that



happening. He pointed out that an anesthesiologist should know the risks of every surgery that he provides anesthetic for.

The pre-operative and intra-operative records were reviewed and Dr. T was of the view that Dr. Liberman's care and documentation in this area met the standard.

With regard to the transfer of a patient to the RR, Dr. T said that the anesthesiologist can delegate care of a patient to a RR nurse only when the patient is stable, and part of that includes the documentation of the initial vital signs on arrival in the RR on the bottom of the anesthetic record. If the patient is unstable, it behooves the doctor to find out why instead of delegating care to the nurse.

Dr. T said that he would expect the BP to be no more than a variance of 10 to 15 % from the pre-operative vital signs and, in Ms Stryland's case, that would therefore mean a systolic pressure of 90 to 95. If it was lower than that, and it had been stable intra-operatively, he would assess the patient and he outlined what he would do.

Looking at the RR record, Dr. T assumed that the first BP recorded at 13:15 was recorded by the nurse on admission to the RR. Ms Stryland's BP was extremely low at 60 over 25 and her O2 sat of 85 is also a concern as they are out of the 15 % variation range. Ms Stryland's BP is almost 50% lower than her pre-operative one, he notes. A severely low BP can cause significant damage to the patient's organs, Dr. T said. Similarly, an O2 sat of 85% over a sustained period of time can lead to heart or brain damage.

Dr. T noted that Ms Stryland's heart rate was curiously not elevated at 13:15 as it would be expected to be with a low BP, and he would want to find out why it is low. He outlined what he would do to assess that and the possible reasons for the heart rate being lower than expected given the low BP.

Dr. T testified that he had seen young patients with a BP this low alert and talkative and explained the situation where this may happen and what may be expected. He said that young people can lose up to 40% of their blood volume and still maintain consciousness.

At 13:15, 13:20, 13:30, and 13:45, over the course of half an hour, Dr. T notes that the heart rate increased from 68 to 78, and although the patient was on 10 litres of O<sub>2</sub>, her O<sub>2</sub> sat was only 88 at 13:45 which suggests that this was not an adequate amount of oxygen for this patient. According to the nurse's notes, it does not appear that Dr. Liberman assessed the patient to see why in a fairly straightforward liposuction case, she had ongoing hypotension.

Dr. T did not think that Ms Stryland was stable enough to have her care delegated to the nurse in the RR and Dr. Liberman didn't meet the standard of care.

Dr. T said that he was not sure Dr. Liberman recognized the gravity of the situation. Dr. Liberman did not document any concern about a low blood pressure, and if he didn't recognize it, his care fell below the standard.

Dr. T said that it appeared that the nurse had contacted Dr. Liberman at least twice between 13:15 and 14:45 to report Ms Stryland's vital signs. It appeared that all that was done was that the patient was given an IV fluid bolus and put in the Trendelenberg position. No other measures were taken and Dr. T was of the view that Dr. Liberman did not properly assess the patient or consider other diagnoses besides hypotension due to inadequate fluid resuscitation. He didn't do a full assessment of the patient to find out why this patient continued to have ongoing hypotension in the RR.

The Trendelenberg position is a temporizing measure and the patient should not be in the position for more than 20 to 30 minutes. Dr. T testified that it is not a definitive treatment.

In looking at the RR record, Dr. T testified that it appeared that 3000 cc's of fluids were given in the post-operative period by the RR nurse and if there was a rise in BP it was not charted. The BP continues to fall over the course of an hour and a half to the last recorded BP being 40 over 25 with a heart rate of 141 and an O2 sat of 85% at 14:45. He testified that the extra fluid did not help. With three liters of fluid, (3000 cc) the patient's BP should be well within normal limits. He said he would refer the patient to the hospital, as she needs investigation and treatment that is unavailable at a cosmetic clinic. He would be concerned about ongoing bleeding if the BP falls back down after giving fluids, and he would let the surgeon know immediately that he was concerned, as the surgeon needs to assess the patient as well. If there are no signs of obvious bleeding, then the patient needs to be referred immediately to the hospital and he would call 911.

In Dr. T's opinion, Dr. Liberman did not meet the standard of care as he didn't recognize the gravity of the situation or how serious the hypotension was. There was no documentation on his anesthetic record or the RR record that he was thinking anything else other than minimal dehydration or inadequate volume replacement for a diagnosis of hypotension. He didn't think of life-threatening problems. He didn't assess the patient or seem concerned about a patient who was becoming tachycardic and lowering her BP over the course of roughly 90 minutes. He didn't seem to put much stock in the patient's vital signs and put more stock in her level of consciousness to the point that at 14:45 the patient became unconscious suddenly.

Dr. T reviewed Ms Q's personal log and compared it to the RR record. He noted that the doctor was notified at 13:45 that the patient had a low BP according to Ms Q's note. He said that when Ms Q noted at 14:45 that the patient became restless and confused at a time when her BP was 40 systolic and 25 diastolic with a heart rate of 141, it indicated a bad sign, that the brain is now being poorly perfused. Ms Stryland wants to get up and she is thirsty according to the notes and these signs show she is severely hypovolemic, probably from hemorrhaging. She has had some boluses of fluid that have not helped. At this time, the nurse noted a blood pool under the patient during repositioning. It sounds like the bleeding is much more than what is expected, Dr. T testified, and the patient is

now in shock. Her cardiovascular and nervous systems are poorly perfused and compromised. She requires emergency help and it is at this point that the nurse asks Dr. Liberman for help.

Dr. T testified that the steps Dr. Liberman took at this point in time, including intubation, extra oxygen and manual ventilation, two extra intravenous lines and fluids, as well as catheterization were technically appropriate. Dr. Liberman managed the situation well, he said, except for one major thing. The patient became unconscious 90 minutes after coming into the RR, which is very, very uncommon after normal straightforward liposuction. At this point, he or his designate should have called 911, Dr. T opined. She needed to go to the closest hospital immediately for diagnosis about what was happening, and for definitive management. Blood is not available at cosmetic clinics, Dr. T stated, and the picture suggested that is what Ms Stryland needed. The fact that Dr. Liberman's note written the next day said Ms Stryland's BP rose to 100 over 55 and her O2 sat was 100%, and she was gagging on the endotracheal tube, did not alter Dr. T's opinion that 911 should have been called when she was re-intubated. It would be expected that the BP would increase with intubation as it is quite stimulating to the body. Dr. Liberman didn't remove the endotracheal tube as he presumably didn't think Ms Stryland's level of consciousness was such that she could protect her airway.

The catheterization revealed 125 cc of urine in the bladder accumulated during an almost five hour surgery period. Dr. T testified that this is a small amount of urine production and is very worrisome as it means that the kidney is responding by trying to retain fluid to maintain as much fluid as possible for the patient.

Dr. T testified about the "golden hour", a description used by critical care physicians, including anesthesiologists, for the management of patients. The theory is that if you can aggressively treat these patients within 60 minutes or one hour, usually in the hospital, the chances for survival are the greatest. There is much anecdotal evidence in the literature to support this view. Dr. T testified that the patient needs to be transferred as soon as possible to increase her chance of survival.

Dr. Liberman's note commented that, suddenly at 15:35 to 15:40, the patient's BP dropped again to roughly 70 over 30 and her pulse increased to 128 beats per minute and the dressing became suddenly soaked with blood which pooled under the stretcher and did not clot. Dr. T said that the significance was that the patient has probably gone into DIC, disseminated intravascular coagulopathy, which was a poor sign. Because all the coagulation factors were used up, Ms Stryland had massive bleeding.

In his testimony, Dr. T said that 50 minutes into the "golden hour" following the re-intubation at 14:45, the patient is worse. The likelihood of survival is now much worse because she is bleeding from everywhere.

Dr. T said that the significance of the paramedics finding the patient chalky white with no vital signs shows that Ms Stryland has been bleeding a significant amount of time. The bleeding had been going on a long time and had been missed. In his opinion, Dr. T thought that the fact that the patient was in this condition means that the post-surgical care was not appropriate. By focusing on just one diagnosis, that the patient was dry due to inadequate rehydration of fluids, Dr Liberman missed the major problem. These are common things for anesthesiologists to think about, he said, and it should have been recognized.

Dr. Liberman didn't document at all any measures he did in the RR with Ms Stryland and that fell below the standard for management and documentation for an anesthesiologist. He should have done a quick note about what happened, including any emergency care prior to the paramedics coming to ensure continuity of care in the Emergency Department. His note was written 24 hours later. This does not meet the standard for documentation in a timely manner in Dr. T's opinion.

In addition, if Ms Stryland crashed at 14:45 he should have called 911 within a few minutes of that time.

Dr. T opined that Dr. Liberman exposed this patient to harm and would expose future patients to harm as he did not recognize something as basic as ongoing bleeding.

Dr. T read Dr. M's operative report for Ms Stryland that stated that the patient was transferred to the RR in awake and stable condition. Dr. T said that information was not consistent with the documents of the nurse's RR notes, and Ms Q's notes. Dr. T said that it is uncommon for a patient to be stable in the OR one moment and then five minutes later in the RR, unstable, unless there is something life-threatening that happened in the interim, and it is the doctor's job to sort that out as well as why there was a discrepancy between the vital signs and the clinical picture.

Dr. T agreed that if the vital signs were wrongly recorded on the RR record, that would explain the discrepancy on the vital signs. However, he also stated that he would not put that as one of his highest possibilities as he could not see much gain for the nurse to be writing vital signs erroneously on a document used for patient care and possibly for legal purposes. Dr. T admitted that he assumed that the vital signs on the RR record were charted contemporaneously.

Dr. T agreed that Dr. Liberman should have filled in the vital signs on admission to the RR on the anesthetic record according to the Guidelines of the Practice of Anesthesia. It would be the minimum expectation. Dr. T was taken to an Anesthetic Record that he completed for Dr. Liberman when Dr. T gave the doctor an anesthetic in June 2007. Dr. T's own anesthetic record contained some errors, according to his testimony, that were a breach of the standards that he said reasonable and prudent physicians do breach from time to time.

### **Credibility of Dr. T**

The Committee found Dr. T credible. Although he had made some errors in his charting of an anesthetic he gave Dr. Liberman in 2007, they did not affect his acceptance as an expert witness by the Committee, nor in the Committee's view did it affect its consideration of what constitutes the standard of practice. In addition, his testimony was

consistent with Dr. S's testimony with regards to the diagnosis and management of post-operative hypotension.

**Dr. V**

Dr. V is an anesthesiologist with considerable experience. He currently works at a Toronto hospital and has a cross appointment in the Pharmacology Department and the Department of Anesthesia at an Ontario University. He was qualified as an expert witness.

Dr. V was given several documents to examine as well as the testimony of the two nurses, the expert reports and the medical reports from the Toronto Cosmetic Clinic, and the medical records from the Toronto hospital to which Ms Stryland was transferred. He was also asked to assume that Ms Stryland was stable upon admission to the RR.

Because Ms Stryland's vital signs were stable in the OR, and because Ms Stryland moved herself from the OR table to the stretcher and was talking, he found it difficult to see how the patient could do those things and have the low BP as noted on the RR record.

He agreed that the vital signs in the RR should not vary outside of 20 to 30% of the pre-operative recordings.

Dr. V testified that Dr. Liberman met the standard of care with respect to his treatment of Ms Stryland's drop in BP. His failure to chart the vital signs on admission to the RR was a minor omission if the patient is awake and stable with no evidence of blood loss.

He did not believe that the paramedics should be called when a patient lost consciousness or "fainted". He said the anesthesiologist should look for a cause and make a judgment and then decide whether or not to call 911.

Dr. V acknowledged that he had Dr. Liberman's note written the day after the death of Ms Stryland and the RR record, but he did not have Ms Q's reflective note at the time he was formulating his opinion. He did receive her note later.

Dr. V was asked to assume that when Ms Stryland was admitted to the RR, she was stable and that she remained stable until the nurses advised Dr. Liberman of concerns at 15:06. He was asked to not rely on the RR information to make his report and to rely on his instructions to deal with the last hour on Ms Stryland's time in the RR. He was not told that there is video evidence of Dr. Liberman going between the RR and OR between 14:34 and 14:38, that blood pooling was noted, and that Ms Q's note said the re-intubation took place at 14:45. The first time blood pooling was noted, according to Dr. V's information, at 15:35 to 15:40, based on Dr. Liberman's note written the next day.

### **Credibility of Dr. V**

The Committee did not place much weight on Dr. V's evidence. When Dr. Liberman's counsel retained Dr. V to opine on the care Dr. Liberman provided Ms Stryland, Dr. V was asked to make various assumptions which resulted in Dr. V concentrating on a time frame very late in Ms Stryland's post operative course at the clinic that day. It is the opinion of the Committee that there were assumptions made by Dr. V which were not supported by the evidence, as we will discuss later. In addition, while Dr. V received various documents to review, he did not receive a copy of the entire medical record related to Ms Stryland's operative procedure, nor did he receive a copy of Ms Q's reflective note prior to preparing his expert opinion report.

### **Mr. P**

Mr. P is a very experienced forensic document examiner with years of experience. He examined the chart of Ms Stryland from the Toronto Cosmetic Clinic.



After outlining the methodology of the various tests he conducted on the pages of the chart, he summarized his evidence. Most of the pertinent evidence is contained in the above testimony of Ms Q.

In addition to those findings, Mr. P also found that there was evidence of a note dated September 20, 2010, which was missing from Ms Stryland's chart, which had writing characteristics of Dr. Liberman. The handwriting from the missing note had been indented on pages that would have been below it in the chart when it was originally written. What Dr. Liberman wrote the next day was different. The missing note contained the following words and although they were not completely aligned horizontally, there was a linear element to them. It is impossible to duplicate the exact spacing here although an attempt has been made to give a visual sense of it.

\* \* \*

20 / 9 / 2007

STRYLAND

Krista

Pulse ↓

20/M

approx

At approx 1435 unresponsive  
 and pt pulse palpable ~ 72-84/Minute  
 Carotid started Rt  
 pt intubated 2nd iv started  
 ...ater inserted 3rd iv

O2 Sat  
 paramedics called  
 assisted

\* \* \*

Besides the words on the missing document shown above, Mr. P found indentations corresponding to 60 or 68 over 28 written near the pulse 72-84. As he was not sure of the number, he did not include it in his written reproduction of the missing document.

The above examination of a missing document and the points summarized in Ms Q's testimony were the most relevant points of Mr. P's evidence.

## **ii) Documentary Evidence**

The Committee reviewed numerous documents, including Ms Stryland's chart, from the Toronto Cosmetic Clinic, particularly the Anesthetic Record and Recovery Room record with the highlights of those records following. Other documents examined included the Anesthetic Record for Patient B, the third patient of the day, and the reports of the nurses, paramedics and expert witnesses. Most of the pertinent material has been summarized under the testimony of the witnesses.

### **Anesthetic Record**

Vital sign recordings from Krista Stryland's operative period, recorded from 10:02 to 13:15, range from 110 – 130 systolic to 70-80 diastolic BP. Her heart rate ranges from about 72 to 90 and her O2 sat is 98 to 99. According to the document, about 5900 cc's of fluid were removed during liposuction.

### **Recovery Room Record**

Vital signs are recorded as follows on the RR record:

<b>Time</b>	<b>BP</b>	<b>Pulse</b>	<b>Oxygen Saturation (O2 sat)</b>	<b>O2 Administration</b>
13:15	60/ 28	68	85%	none
13:20	65/30	70	86%	none
13:30	60/30	76	93%	5 liters/minute
13:45	55/25	78	88%	10 liters/minute

14:15	57/25	102	91%	10 liters/minute
14:45	43/28	141	85%	RA (Room Air)

There is documentation of a 14 French Foley catheter being inserted with 100 cc of urine collected on insertion.

Ringer's Lactate in the amount of 3000 cc's is recorded.

Pre-op vital signs are 114/72 BP and Pulse of 72 and Respirations of 20 with an O2 sat of 99%.

### **Personal Log of Ms Q (Reflective Note) of September, 2010, 23:45 hrs**

The times and the vital signs on this document are closely aligned with those on the RR record. Ms Q notes that all times are approximations except for the time of 14:45. The following are some of the highlights of this document:

13:15	the nurse documented that the "Anesthesia/MD" aware of the BP of 66/30 and O2 sat of 88%
13:30	Patient was awake, alert and conversing with the RPN and had sips of water
13:45	Patient awake conversing. BP 60-70 over 30-40 and heart rate 60-70. Asymptomatic. MD aware. Patient placed in Trendelenberg position and IV continued to bolus.
13:45-14:45	BP unchanged. Patient remained awake and easily rousable during the period. Patient was kept NPO (nothing by mouth) due to position. Patient told that fluids would be given when BP improved.
14:45	Patient became restless/agitated and complained of thirst. When sat up to have a sip of fluid, she became more restless, pale with a dramatic

decrease in O2 sat. Patient became tachycardic and hypotension worsened. Blood pool noted under patient with repositioning during this time. Patient became progressively less responsive. Anesthesia called to bedside. Patient given O2, 10 liters by facemask. Following assessment by anesthesia patient was intubated. Assisted ventilation with a BVM . Anesthesia inserted 2 more IV' and patient given 3 liters of Ringer's Lactate under pressure. BP increased.

- 15:20 Patient resisting attempts to ventilate and biting down on endotracheal tube. Making purposeful movements with right hand. Patient experiencing spontaneous respirations and given 100% oxygen. BP increased from 85/48 to 110/60 and heart rate 100.
- 15:30 Second abdominal binder placed on patient by MD and RPN to provided additional pressure to area of bleeding.
- 15:35 second dressing and binder soaked through with blood. BP dropped from 110/60 to 70/30 and Heart rate 128. Spontaneous respirations ceased and resumed assisted ventilations.
- 15:40 911 called.
- 15:55 BP increased to 100/55 and pulse 110 with some spontaneous breathing assisted with Ambu bag
- 16:00 Patient moved to EMS stretcher and after transfer, vital signs were absent. No palpable pulses and CPR initiated.

At the end of the reflective note, Ms Q notes some of the treatment of Ms Stryland in the hospital.

### **Dr. Liberman's Resuscitation Note of September 21, 2007, at 11:00**

The following is a précis of the salient points in the doctor's note.

Dr. Liberman's documents that, at approximately 14:45 on September 20, 2007, he was notified of a sudden change in the status of Ms Stryland. She became unconscious, with a low BP and increased heart rate.

On examination, he found the patient to have a carotid pulse of 150 and respirations of 10-12 per minute with a weak gag reflex, and not responding to verbal stimuli.

He intubated her and gave her 100% Oxygen with assisted ventilation. After IV boluses in three IV's, the patient's BP was 100/55 and O2 sat 100% with a pulse of 108-110.

He said that another binder was placed on top of the first as there was some bleeding but it was not *excessive in amount* [emphasis added].

Over the next 35 to 40 minutes, the patient had a BP of 85-110 systolic and 48-60 diastolic with a pulse of 96 –108.

From 14:50 to 15:30, the patient received 3-4 liters of Ringer's Lactate.

Suddenly, at 15:35 –15:40, the patient's BP dropped to 70/30 and pulse increased to 128 and the dressing was suddenly soaked with blood that pooled on the stretcher and did not clot.

Ringer's Lactate IV was bolused through all three IV's

On arrival of the paramedics at 1600 hours, patient's BP was 100/55 (approximately), pulse 110 min and spontaneous respirations of 24 minute. O2 sat was 100% and patient

was gagging on the endotracheal tube. On moving to the EMS stretcher, pulse decreased to 30 minute and CPR commenced.

### **iii) Agreed Facts**

Two agreed statements of fact were submitted to the Committee. One of them (Exhibit 4) related to agreed facts with respect to a video security camera system that was in use in the clinic. The video from that system and the Agreed Statement of Facts concerning it are addressed in the section below.

The second Agreed Statement of Facts (Exhibit 6) related to the opinion of Dr. Z, an anesthetist who was appointed medical investigator pursuant to s. 75(a) of the Health Professions Procedural Code. Dr. Z reviewed some 55 charts from 2 clinics pertaining to cosmetic medical procedures performed by Dr. Liberman in 2006, 2007 and 2008. Dr. Z's report is very thorough comprising more than 200 pages that comment on each of the clients and his opinion with respect to it. The Committee very carefully reviewed and considered all of Exhibit 6.

### **The Video from the Security Camera**

The following facts were agreed and set out in Exhibit 4.

#### **PART I—FACTS**

1. In early 2007, a digital video recorder system (the "DVR System") was installed by a Toronto communication technology company at the Toronto Cosmetic Clinic (the "TCC") for security purposes. Approximately 10 cameras were installed in various places including outside the TCC, in the TCC's waiting area, in the hallways and in the server room.

2. One of the approximately 10 cameras was installed above one of the TCC exits ("Camera I"). This camera is set to record movement in the hallway between the TCC's operating room and recovery room.

3. The DVR System is an unmanned surveillance system, which runs automatically. It consists of three parts: the cameras, the computer ("DVR Server"), and the program. The cameras are connected to the DVR Server.
4. The only people with access to the DVR System, allowing it to be turned on and off and to save recordings, are Mr. R and the communication technology company technicians.
5. The cameras are motion sensitive. Accordingly, if they detect a motion they record the motion. Not every motion is detected by the cameras and, as such, it is possible for the cameras to miss a motion.
6. The cameras record movement all the time. However, there is limited volume on the DVR Server. The camera will continue to record, even once the DVR Server is full. Once the DVR Server is full, new information will get recorded over old information. No information recorded at the TCC is archived or backed up.
7. Recordings can be saved. To do so, one needs to choose which camera or cameras are to be saved, a range of dates, and a range of times.
8. On or about October 11, 2007, Mr. R and Dr. M saved onto the hard drive of the DVR Server a recording from Camera 1. This recording covered the motion detected in the hallway between the operating room and recovery room from approximately 7 a.m. to approximately 9 p.m. on September 20, 2007 (the "September 20, 2007 Security Camera Recording").
9. According to Mr. R, gaps in the September 20, 2007 Security Camera Recording are as a result of there being no motion, or the camera failing to pick up motion.
10. In the September 20, 2007 Security Camera Recording, there are frames where an individual suddenly appears or suddenly disappears. According to Mr. R, this is due to either a busy central processing unit which can cause "jerk"-like movements, or the failure of the camera to detect a motion.



11. The DVR System records the date and time while recording. The date and time is visible on the screen of the recording. The date and time recorded in the frames is the accurate date and time of the events recorded.

12. In approximately November 2008, copies of the September 20, 2007 Security Camera Recording were downloaded from the DVR Server and copied onto a memory stick. Other copies of this recording were made from the copy stored on the memory stick.

13. According to Mr. R, in or about February and March 2009, the TCC had a problem with the DVR Server. In order to service the problem, the communication technology company first formatted and restored the hard drive. This process resulted in erasing everything on the hard drive. Due to continuing problems, the communication technology company had to replace the hard drive. According Mr. R [sic], pursuant to the company's policy, the original hard drive was destroyed.

\* \* \*

The security camera recorded activity in the hall at the back of the clinic that was shaped like a 'T'. The camera was located near an exit door at the base of the 'T' and faced a long hall. At the far end of the hall, the top of the 'T', was the connecting hall between the operating room and the recovery room.

The Committee examined in detail the video recording of the security camera on September 20, 2007 and noticed that it seemed to record all activity taking place in front of it. However, at the far end of the hall, the top of the 'T', activity sometimes was not recorded, or a person would suddenly appear as if "out of nowhere".

The Committee accepted that the video was accurate with respect to the times of the recording.

The following outlines some of the information contained in the video that the Committee found most compelling in coming to its decision:

- in general, there was a lot of activity in the back hall and between the RR and OR at all times during the working day
- Dr. Liberman is easily recognizable as he has dark shoes, is the only staff without a hat, and also does not wear a mask
- during the first surgery of the day, the following times recorded this activity:

9:21:11	the empty stretcher was taken from the RR to the OR
9:22:29 - 9:22:36	the stretcher with a patient was taken from the OR to the RR - 7 seconds to cross the top of the 'T'
9:22:43	Dr. Liberman is seen leaving the RR and going to the OR, 7 seconds after taking the patient to the RR.
9:22:54	Dr. Liberman goes back to the RR from the OR
9:23:19	Dr. Liberman leaves the RR and returns to the OR - 25 seconds later
10:09	Ms Stryland is seen walking to the OR
10:35 to 13:08	Dr. Liberman is seen walking around and out of the OR over 15 times, sometimes appearing to be carrying a plate, other times moving boxes from the hall to the OR and sometimes going to the prep room or the RR.
13:08:53	an empty stretcher goes from the RR to the OR - no stretcher movement from OR to RR is seen
13:10:24	Dr. Liberman is seen leaving the RR - less than one and a half minutes from when the empty stretcher is taken from the RR to the OR.
13:10:28	Ms J is seen leaving the OR and goes to the RR—4 seconds after Dr. Liberman left the RR.

13:11:07	Ms J goes from RR to OR—39 seconds after she went in and 33 seconds after Dr. Liberman left.
13:11:18	Ms J walks from OR to RR.
13:14:26	Ms Q is seen with patient in a wheelchair, taking first patient to be discharged.
13:20:36	Ms Q returns from discharging patient and takes empty wheelchair into RR.
14:34	Dr. Liberman is seen going into the OR (There were no images of him when he left the OR)
14:38	Dr. Liberman is shown again going to the OR (There were no images of him leaving the OR)
14:47:55 - 15:06:02	a gap in recording - a period of 18 minutes and 7 seconds - the Committee noted that this gap in recording was one of the longest in the day as there was frequent activity in the hall.
15:06:54 - 16:13:26	Dr. Liberman goes back and forth between OR and RR many times
15:18:22	the cleaner is seen exiting the RR and walking quickly up the hallway
15:18:43	the cleaner returns to the RR while putting on an apron as she is walking
15:28:24	the cleaner going into the RR while carrying something
16:13	Paramedics are seen taking Ms Stryland out the back door of the clinic, along with Ms Q and Fire Department personnel.

#### **iv) FINDINGS AND REASONS FOR FINDINGS**

In considering the case, the Committee recognizes that it must make its findings based on a balance of probabilities with evidence that is clear, cogent and convincing. In many areas the evidence was contradicted, unclear and not credible. The Committee looked at all the evidence carefully and examined which is most credible, cogent and convincing and which is accepted.

## **I. Krista Stryland**

### **Failing to Maintain the Standard of Practice of the Profession**

#### **i) Did Dr. Liberman turn over the care of an unstable patient to the nurses in the Recovery Room?**

After examining the video recording in detail, the Committee made several findings, some of which refuted evidence given in testimony. The parties agreed that the times shown on the video are accurate and the Committee accepted that fact. In the Agreed Statement of Facts, Mr. R, the husband of Dr. M, whose company managed the security video, stated that any gaps in the video are the result of there being no motion or the motion not being detected by the camera.

Dr. Liberman's anesthetic record indicates that Ms Stryland's surgery was finished at 13:15 hrs. The empty stretcher is seen on the video being pushed from the RR to the OR at 13:08:53. Although there are no images on the video of movement of the stretcher from the OR to the RR, it is assumed that when Dr. Liberman is seen leaving the RR at 13:10:24, less than one and a half minutes after the stretcher went into the OR, Ms Stryland has already been moved to the RR. Ms J confirmed Ms Stryland's arrival in the RR at this time when she testified about movement on the security camera.

According to Ms J's testimony, it took her three to five minutes to connect the monitor and do the first vital signs reading. If Dr. Liberman is seen leaving the RR within a minute and a half of the stretcher going to the OR, then it does not seem likely that he remained in the RR to ascertain the vital signs as Ms J said he did. Nor could he have recorded them.

When the Committee examined the video recording of the first patient of the day, it was noted that, at 9:21:11, the empty stretcher was taken from the RR to the OR. This time the camera picked up the stretcher movement from the OR to the RR and it took seven

seconds to cross the small hall between the two rooms, from 9:22:29 to 9:22:36. Dr. Liberman is seen leaving the RR and goes to the OR at 9:22:43, seven seconds after taking the patient to the RR. He returns to the RR at 9:22:54 and leaves again at 9:23:19, 25 seconds later. The patient has only been in the RR for about one minute. He returned to the RR at 9:24, again within two minutes of arrival and with not enough time for the vital signs to be taken according to Ms J's evidence.

The Committee concludes from this evidence that Dr. Liberman did not stay with the patient long enough to know what the vital signs were, and thus, could not record them. He was not able to determine whether the patient was stable either.

In examining whether or not Ms Stryland was stable on admission to the RR, the Committee carefully reviewed the testimony of the two nurses.

Ms J, the RPN, said that she and Dr. Liberman moved Ms Stryland to the RR and that she quickly wrote the times across the top of the RR vital signs graph, with the first time being 13:15 hours. She connected the monitor and took the first vital signs but didn't record them as she was busy doing other things for the patient such as getting a warming blanket, checking her level of consciousness by having her do little commands such as wiggle her toes.

Ms J testified that she was responsible for the first two vital signs in the RR recorded at 13:15 and 13:20. Shortly after this statement, she said it was a "mix" between herself and Ms Q. Later in cross-examination, she said that she did not recall Ms Stryland's BP being in the hundreds and "they" did the first vital sign. The Committee believes that if she did the vital signs with Ms Q, she would have said "we", rather than "they". Ms J contradicted herself more than once with regard to whether she or Ms Q did the first vital signs in the RR and this raised questions about her credibility.

Again, the video gives some evidence that, in the initial few minutes that Ms Stryland was in the RR, Ms J was less engaged with the patient than she would have the

Committee believe. If Ms Stryland arrived in the RR at about 13:10, Ms J is seen leaving the OR at 13:10:28, four seconds *after* Dr. Liberman left the RR. Although she is seen going into the OR earlier with Ms Q, just prior to the transfer of the patient to the RR, there is no evidence she is the one accompanying the stretcher to the RR. The video did not pick that up, nor did it pick up her movement back to the OR from the RR if that is what happened. She then returns to the OR at 13:11, less than a minute later, and then back again. At 13:15, Ms J is seen checking boxes in the hall-way, five minutes after the patient arrived in the RR and during the time that Ms Q has been seen leaving the RR to discharge the first patient, and during the time period when Dr. Liberman is in the washroom. It appears to us that no one is actually with Ms Stryland in this time period, five minutes after she arrives in the RR. Although Ms J said patient care came first and documentation was secondary, the Committee cannot conclude she was doing either at this point in time.

The forensic document examiner was unable to determine who wrote the times across the top of the RR record. It may have been Ms J as she testified she did. However, Ms Q is the one who recorded the vital signs and the Committee believes that she is likely the one who took them, although she may have had some assistance from Ms J when Ms Stryland first arrived in the RR.

The Committee does not believe that Ms J was the one who was responsible for the first two vital signs on admission, as she says she was, for the following reasons:

- It was not her job. She was a circulating nurse and, as such, she had to prepare for the next case that was slated to start soon. She said that Ms Q had the “primary responsibility with respect to the recovery of patients.”
- As Dr. S testified, for 15 years she has seen RR nurses recording vital signs contemporaneously, and the panel believes that the one who wrote them, Ms Q, is the one who did them. Ms J said it was a “mix” of her and Ms Q and then later said “they”, and the Committee believes she meant Ms Q did the vital signs.

- The video evidence of when Dr. Liberman left the RR contradicts Ms J's testimony that he waited at the bedside while she did the vital signs.
- The appearance of Ms J in the hall a few times in the first five minutes that Ms Stryland is in the RR, supports the Committee's view that she had other duties and probably considered Ms Q, the Registered Nurse hired for that job, as the one in charge of monitoring, despite testimony to the contrary.
- Ms J is seen numerous times in the hall between 13:15 and 13:51 supporting her testimony that she was the circulating nurse for the third case. During some of this time period, Ms Q is in the prep room completing the measurements of fat and infiltrate for Ms Stryland's aspirate. She is then seen transferring the fat to the freezer. The video does not indicate that she was setting up the OR for the next case of the day.
- Ms Q was in the RR for at least the first four minutes of Ms Stryland's arrival there and returned about six minutes after she discharged the first patient.
- Ms Q told the College investigators in her interview that she took the BP readings for Ms Stryland at 13:15 and 13:20.

Ms J's testimony is not internally or externally consistent. Given the video evidence and documentation, it is not plausible. Because Ms J did not appear to have done a contemporaneous note about the event, her memory may have suffered. However, she also is facing legal action and a hearing with her regulatory body, and her own interests may have coloured her story.

Ms Q's credibility suffers as well. Ms Q testified more than once that she was not in the RR when Ms Stryland was admitted as she was busy discharging the first patient. The first patient was seen dressed, in a wheelchair and being helped into the washroom by Ms

Q, about a half hour before Ms Stryland arrives in the RR, indicating that this patient probably required little attention subsequently. Ms Q is not seen on the video discharging the patient until 13:14:26, a full four minutes after Dr. Liberman is seen leaving the RR, at the presumed time that Ms Stryland was admitted there.

Ms Q said that she was the one who was doing the circulating duties that day for the third patient until the initial infiltration was done about 15 or 20 minutes into the surgery. She didn't take over Ms Stryland's care until then, she said. However, she is not listed on the operative note as the circulating nurse for the third patient, Ms J is. In fact, there are two operative notes for this patient, and Ms J is listed on both of them. Ms Q's activities shown in the video from the time the third patient went to the OR also suggests she was actually in the RR.

It is not disputed that the handwriting on the RR record vital signs belongs to Ms Q. Although she said she did not do the vital signs at the times recorded, and they were done later with her left hand while ventilating the patient and corresponded to Ms Stryland's last vitals on the monitor later in the day, the Committee did not find this story credible. Ms Q wrote a reflective note the day of Ms Stryland's passing and her documentation in that note was consistent with the RR record and with what transpired later in the condition of Ms Stryland. That she would suddenly remember doing this charting while bagging the patient after seeing a video at the lawyer's office seems incredible.

Ms Q knew that there had been discussion about the events of the day when the staff went out to dinner and the Committee believes she was doing her best to document what she recalled. Given Dr. Liberman stated he would be the one to write a note, she no doubt wanted to ensure that her recollections were accurately recorded for the scrutiny that she no doubt knew would follow. Her own reflective note and her initial statements to the College investigators hold more weight in the Panel's view. The forensic document examiner was able to say that the RR record vital signs were not done with a left hand, and they were done in at least two separate writing episodes. His forensic finding contradicts her story and supports the Committee's view that the RR record is accurate.



The nurses' evidence was contradictory on this point too. In her testimony, Ms J twice said that Ms Q wrote down the vital signs "awhile before the paramedics arrived". Ms Q said that she wrote the information while the paramedics were there as she started writing first with her left hand and then was able to give the bag to the paramedic to ventilate and she finished with her right hand. On another occasion, she said she wrote it all with her left hand while ventilating the patient. She was emphatic that she documented the vital signs in one single writing episode, contrary to the findings of the forensic document examiner.

The Committee places weight on Dr. S's comment that for 15 years she has been observing RR nurses charting the vital signs as they do them. Ms Q was a very experienced nurse who was used to charting in the RR and Emergency Departments and she understood the importance of keeping vital sign charting completed contemporaneously.

The Committee believes that Ms Q was in fact the one responsible for Ms Stryland's care in the RR that day and that the charting was done contemporaneously for the following reasons:

- the handwriting is hers on the RR record.
- the RR duties were Ms Q's and she was the nurse with the most experience and qualifications in this area.
- the forensic handwriting specialist considered her writing had been done on at least two occasions (and possibly more), supporting the Committee's view that she was the RR nurse.
- the various levels of O2 administered along the timeline on the RR graph do not fit with Ms Q scrolling back on the monitor to document the last few vital signs of

Ms Stryland that day. Her explanation does not account for those varying entries at each time. Ms J was not sure if the O2 Sat was recorded on the trend line of the monitor, but the amount of O2 administered would not be recorded there. Her explanation does not account for that variance.

- her reflective note, completed the same day as Ms Stryland's death, is consistent with her being responsible for Ms Stryland's care and charting contemporaneously.
- in her sworn interview with the College her account is consistent with her being responsible for Ms Stryland's care and charting contemporaneously.
- Dr. S's testimony about RR nurses doing their charting contemporaneously also adds weight to the Committee's view.
- she was busy ventilating the patient after 14:45 and could not do the charting as she was fully occupied, thus the charting could not be completed. When Ms Q said she asked Ms J why the charting was not done, the Committee believes she meant the charting from 14:45 onwards while her "hands were busy" as she said during her interview with the College.

Ms Q's evidence was contradictory with Ms J's, with documentation, with the forensic handwriting analysis, with her own previous documentation in her reflective note and her sworn interview with the College and with the expert's testimony about what RR nurses do. The Committee did not find Ms Q credible with regard to not being in the RR when Ms Stryland arrived, and we did not find Ms Q credible on the point of when the vital sign recording was done either. However, she is also facing a hearing with her regulatory body as well as legal action, and the Committee concluded that, for whatever reason, she was less than forthright with the Committee.

The defence's position was that the RR record and the vital signs were simply wrong and the patient was in fact stable in the RR. However, the Committee did not reach that conclusion. The Committee placed weight on the two expert witness's testimony that the ensuing events with Ms Stryland were consistent with the vital signs in the RR being accurate.

In summary, the Committee concludes:

Ms Q was the one who was responsible for Ms Stryland's care that day, and that the RR charting was done contemporaneously and is accurate.

Dr. Liberman did not stay in the RR long enough to find out what the vital signs on admission to the RR were, much less record them.

The initial RR BP of 60 over 30 and the O2 of 85% is not one of a stable patient, according to the expert witnesses.

Dr. Liberman did delegate care of an unstable patient to the RR nurses in the Committee's view. This initial act set the stage for what was to follow.

**ii) Did Dr. Liberman fail to aggressively treat Ms Stryland's hypovolemia?**

The anesthetic record of Dr. Liberman documents stable vital signs for Ms Stryland throughout her surgery. The Committee notes that the record shows Ms Stryland's initial vital signs recorded a few minutes after 10:00 hrs and noted again at 10:10 and 10:15 hrs. However, Ms Stryland is seen on the video walking down the hall to the OR at 10:09:14, and the Committee is unable to account for the discrepancy in the times. It presumably took Dr. Liberman a few minutes to attach the monitor once the patient was on the OR table and take a first reading. If the OR timepiece did not align with the security camera clock, then it would be expected that her last vital signs in the OR when she was finished her surgery would be recorded about nine or ten minutes before she left the OR, that is,

about 13:00 hrs. Her last ones were documented at 13:15 hrs, a full five minutes after Ms Stryland is presumed to arrive in the RR. Thus, Ms Stryland has recordings on the anesthetic record both ten minutes before she arrives in the OR and five minutes after she has left the OR.

The last entry on the Anesthetic record shows the patient's systolic pressure dipping slightly on the last recording to 110. The pulse appears to be marked with an exclamation mark. When Ms J was asked if she had any reason to disbelieve the anesthetic record, she responded that she disagreed with the last recorded systolic BP and said "to my recollection, her blood pressure was a little bit lower than 110."

Similarly, in the case of the third patient of the day, Patient B, the anesthetic record shows vital signs documented at 13:30. However, Patient B is seen walking down the hall towards the OR at 13:38:57, almost nine minutes after the vital signs are first recorded on the anesthetic record. Dr. Liberman's charting for him ends at 16:20 or 16:25. The last systolic BP is recorded at 16:20 but the last diastolic BP is recorded at 16:25 along with the heart rate, and no systolic blood pressure is recorded at this time. Vital signs are recorded at five minute intervals throughout the time Patient B was in the OR. The Committee heard that Patient B's surgery was aborted because Dr. Liberman was unable to attend to him due to the crisis with Ms Stryland. If Dr. Liberman could not attend long enough to reverse the anesthetic for Patient B, then how could he record the vital signs every five minutes? The Committee is puzzled by the evidence and is unable to draw any firm conclusion, except to call into question the reliability of the vital signs recorded on the anesthetic record. The times are off significantly and the Committee is not certain that the vital signs are recorded accurately either. Dr. Liberman could not have been consistently in the OR to record the vital signs of the last patient when they are recorded. In addition, he is out of the OR over 15 times during Ms Stryland's surgery and questions about his vigilance to her condition in the operating room remain. Unfortunately, the Committee did not hear from Dr. Liberman on these points and is unable to draw a firm conclusion about the accuracy and reliability of the vital sign recordings on the

Anesthetic Record. Whether or not the hypotension indicating a lack of circulating volume actually began in the OR is not certain in the Committee's view.

There is a large disparity between the initial vital signs in the RR and those last recorded in the OR. The Committee considers those in the RR to be accurate for the reasons noted above in regard to the nurse charting them and the finding that they were noted contemporaneously. Dr. T, one of the expert witnesses, gave evidence that it behooved Dr. Liberman to assess the patient and find out why the BP and O2 sat on admission to the RR were so much lower than those recorded in the OR.

Although the Committee makes the finding that Dr. Liberman did not remain in the RR long enough after Ms Stryland was transferred there from the OR to ascertain whether or not Ms Stryland was stable, the Committee heard evidence from the nurses that he knew within the first five or ten minutes or so about her vital signs. The Committee is not certain of when the nurses first told Dr. Liberman of the low BP and O2 sat of Ms Stryland, however, there is repeated evidence that he was told within the first half-hour. Ms Q's statement that Dr. Liberman was not told of Ms Stryland's concerning BP until well after 14:00 hours was the single piece of testimony to the contrary and the Committee did not believe her statement. There was contradictory evidence on this point and, although the Committee tried to make sense of it and ascertain when Dr. Liberman was told of the low BP and O2 sat, the fact remains that the Committee believes it was his responsibility to ensure the patient's stability on arrival in the RR. He did not do that.

According to the nurses' testimony, their first conversation about the vital signs occurred soon after Ms Stryland arrived in the RR. Ms J said that Ms Q had concerns about Ms Stryland's vital signs prior to returning from discharging the first patient. Another time she said Ms Q noted her concerns after she took over Ms Stryland's care, following discharge of the first patient. Ms Q was pointing to the monitor and asking Ms J if the vital signs concerned her. Ms J told her that Dr. Liberman was aware of the vital signs and then went on to explain to her that Dr. Liberman's guideline for an acceptable BP on arrival in the RR was about 70.

Ms J said that Ms Stryland's BP was in the 80's and "This is the drop that we've seen and it's usual of 20 to 30 points."

Similarly, Ms Q said that when she returned from discharging the first patient she had a conversation with Ms J about the patient's vital signs and Ms J told her that it was not an uncommon occurrence. She said this conversation took place prior to the infiltration of the third patient when she went to the RR to check on Ms J and she noticed the BP below 88 systolic. She didn't believe the BP was in the 60's at this time.

The Committee puts weight on this evidence. Although there are discrepancies in the verbal testimony that both nurses gave with regard to the level of the drop in BP, and exactly when the conversation took place (either before or after the discharge of the first patient), both acknowledge that Ms Q, an experienced RR and Emergency Room nurse, was concerned about Ms Stryland's BP within minutes of her arrival in the RR. In her reflective note and in her interview with the College, Ms Q stated that she notified the doctor early in Ms Stryland's admission to the RR.

Ms Q told the College in her interview that Dr. Liberman assessed the patient about 10 minutes after she took over care of Ms Stryland at 13:15 or 13:20. The video does not show Dr. Liberman entering or leaving the RR at this time. Dr. Liberman was in the washroom from 13:14 to 13:19 and when he comes out, he goes into the OR. According to her reflective note, at 13:45 the patient was put in a Trendelenberg position and extra IV fluids given.

Dr. S noted that the RR record shows that, at 13:30, the patient was given O<sub>2</sub> at 5 liters. This fact was also recorded in Ms Q's reflective note and indicates that she was aware of the low BP and O<sub>2</sub> sat and was treating it appropriately with oxygen. The nurses' conversation also indicates that they were aware of the low BP. Despite this evidence, the Committee concludes that Dr. Liberman was not treating the hypovolemia aggressively at

that point. If he did not know about it, it was his responsibility to obtain and record the vital signs on admission to the RR.

Testimony and evidence varied about when Ms Stryland had her first bolus of IV fluid, whether it was 13:45 or closer to 14:15.

Ms Q's reflective note written that day indicates at 13:45 that the patient was awake and conversing and that her BP was systolic 60-70 and diastolic 30-40. Her heart rate was 60-70 and she was asymptomatic. She noted that the doctor was aware and she was continuing to monitor. She was placed in the Trendelenberg position and IV Ringer's Lactate was continued to bolus.

Ms J testified that the BP did go up with these interventions and she reported that to Dr. Liberman when she returned to the OR. Ms Q gave evidence that the BP rose to above 100 systolic when additional fluids were prescribed, although this is not charted on the RR record. No other treatment was ordered.

Ms Q's reflective note varies from the testimony of the nurses about the time of the bolus of IV and the Trendelenberg position being used. In their evidence, that treatment took place a little later. The Committee cannot conclude at exactly what time the patient was given a bolus of IV and put in the Trendelenberg position, however, it does conclude that it was between 13:45, as noted by Ms Q in her reflective note, and 14:15 for the following reasons:

The second conversation about the vital signs took place after the infiltration of Patient B, according to both nurses. Although the nurses varied in their testimony of who was doing what at the time, they were consistent in their evidence about when they proceeded to assess whether or not the vital signs were being recorded properly on the monitor about this time.

In Ms J's evidence she said that she was assisting in the OR for the third case and returned to the RR after the infiltration, that took 15 to 20 minutes, to find Ms Q "frustrated and flustered" and concerned about the BP which didn't seem right. Ms J assisted her in doing a bilateral or simultaneous BP on each arm as requested by Ms Q. Ms J said that Ms Q was not sure the BP was correct because the patient's reaction was not that of someone with a low BP, in that Ms Stryland was awake and alert. Ms J saw Ms Q's personal BP cuff on the counter and presumed she had done a manual BP as well. According to Ms J, Ms Stryland's BP readings at this time were fluctuating between the mid-70's to high 60's (systolic). She also said that *even prior to this discussion*, the patient's BP was in the mid-70's to high 60's. Readings in this range are approaching those on the RR record, whether the time was 13:45 or 14:15.

In Ms Q's testimony, about ten minutes after the third surgery started, she took another set of vital signs using another monitor and then did a manual reading, at which time the BP was below 70 systolic. She asked Ms J to get one of the physicians into the room as she was concerned about what she was seeing and this was not "business as usual" anymore. Later in cross-examination, Ms Q stated that this was the first time that she asked Ms J to notify the doctors of the patient's low BP. This testimony, that the doctors were first notified of Ms Stryland's low BP sometime after 14:00 hours, is in contrast to Ms Q's reflective note written the evening that Ms Stryland died. It also contradicts her reports to the College investigators and Ms J's testimony. Given Ms Q's reflective note was written closer in time to when Ms Stryland died, and because the Committee places weight on the RR record, the Committee was persuaded that Dr. Liberman knew about the patient's hypotension before this time. The Committee accepts the nurses' testimony about rechecking the BP manually around 14:00 hours and that Dr. Liberman was informed. Although their testimony varied in some other ways, this part of their testimony was consistent and was accepted by the Committee.

Whatever was being done to deal with the problem was not working according to Dr. S. Putting the patient in the Trendelenberg position is a temporizing measure and does not solve the problem. Dr. S assumed Dr. Liberman's working diagnosis was hypovolemia



because he used the positioning of the patient and the increase in IV fluids to deal with the problem. Both expert anesthesiologists testified that if the vital signs did not go up and stay up, other treatments should have been considered. Dr. S said that at 14:15 when the BP was 57 over 25 and the heart rate was 102, she would be very concerned and would be considering transfer. She also testified that the patient needed to have her hemoglobin checked and to have blood products.

Both Dr. T and Dr. S testified that they would be performing a physical examination to help determine the cause of the hypotension. Given that the likely cause is hypovolemia, or low circulating volume, the Committee heard from Dr. T various ways to check the volume status of the patient. There is no evidence that Dr. Liberman did any such assessments.

Dr. T noted that Dr. Liberman seemed to not put much stock in the patient's vital signs and relied on Ms Stryland's level of consciousness as an assessment of her stability.

Two of the expert witnesses acknowledged that young people may be alert and talkative while exhibiting the low blood pressures noted on the RR chart. Dr. V, the third expert witness, also agreed that some people can be alert, awake and asymptomatic with a BP of 66 over 30.

Dr. Liberman's failure to understand the gravity of Ms Stryland's medical condition led to his inappropriate transfer of her care to the nurses and his premature commencement of Patient B case. As noted by the experts, the doctor had a patient under anesthesia and another one with hypotension to manage.

Dr. Liberman did not take the extra steps to assess the situation further and develop a more comprehensive list of possible diagnoses. According to the expert witness, the only working diagnosis he had was that Ms Stryland was behind in fluid volume and would "perk up" once she had some more fluid.

The Committee placed weight on the following comments of the expert witnesses in assessing whether or not Dr. Liberman failed to aggressively treat Ms Stryland's hypovolemia:

Dr. Liberman's only response of placing Ms Stryland in the Trendelenberg position and ordering a bolus of IV fluid should have shown a sustained rise in the BP within 5 to 10 minutes if the problem was solely due to the patient being "dry" or having inadequate fluid replacement. Dr. S said that the increased BP should be over 80 and preferably over 90 in this patient. All of the experts said that if there was no sustained increase in BP from fluids or other treatments, then inotropes or vasopressors should be considered.

Dr. S made the point that when the patient is in a life-threatening situation the choices in terms of how to treat a patient get narrower, to the point where you get to an algorithm as to what must be done. There was minimal variation in what had to be done and in her view, Dr. Liberman failed in that regard, indicating his lack of knowledge and/or judgment.

Dr. T also thought that Dr. Liberman failed in recognizing the severity of the situation, and the fact that his measures were not working and he didn't expand his concerns that maybe the patient had ongoing bleeding. These failures fell below the standard of practice required of an anesthesiologist and displayed his lack of both knowledge and judgment. Ms Stryland should have been transferred to the nearest hospital for investigation and treatment when his initial interventions did not produce sustained results.

Dr. S opined that Dr. Liberman fell below the standard of care in failing to recognize and treat hypovolemic shock. In her opinion, the doctor's treatment from the time Ms Stryland arrived in the RR until the time of re-intubation was below the standard of the profession. As noted above, Dr. S would have had a high level of concern by 14:15 and would have considered transfer to a hospital, given the lack of facilities at the clinic.

The Committee concludes that Dr. Liberman failed to aggressively treat Ms Stryland's hypovolemia in the first hour of her time in the RR. Both experts, Dr. S and Dr. T would have been considering transfer to the hospital when the initial measures were not sustaining the BP and, in fact, the patient's vital signs were deteriorating.

Ms Q's reflective note indicates that the patient collapsed and became unconscious at 14:45, the only time she was sure of, according to her note written later that evening. Later in her testimony, she rescinded this certainty about the time of collapse when pressed by the defense counsel. The 14:45 entry on the RR record shows Ms Stryland's BP of approximately 40/20, HR 141, and O2 of 85% with R.A. (room air) written underneath it. There are no further entries after 14:45.

Mr. P's forensic investigation revealed that there was missing material from Ms Stryland's chart in Dr. Liberman's handwriting containing the words "...At approx...1435 and pt... unresponsive" suggesting that his contemporaneous note documented the patient collapsing at about the time Ms Q said she did. This note also contains the words "reintubated".

Dr. Liberman's own handwritten note completed the day after Ms Stryland's death states that at 14:45 hours, he was notified of a sudden change in the patient's status with a decreased level of consciousness, low BP and rapid heart rate. He intubated the patient and gave her manual ventilation.

At 14:34, Dr. Liberman is seen leaving the RR and returning to the OR. At 14:38, he is seen leaving the OR heading to the RR and returning to the OR within a few minutes. The times the doctor is shown on the video going back and forth to the RR is consistent with Ms Q's reflective note about when Ms Stryland "crashed" and needed to be re-intubated, as well as with the doctor's missing note from the chart and his own note done the next day.

From 14:47:55 to 15:06:02, there is a gap in the video recording of almost 19 minutes. When the video shows activity again, the time is 15:06 and the defence counsel put forth the suggestion that the collapse of Ms Stryland did not occur until this time period, after 15:06 as that is when Dr. Liberman and Ms J make numerous trips between the OR and RR, often carrying items in their hands.

The Committee concludes that the time of Ms Stryland's collapse was about 14:35 to 14:45 because:

- Dr. Liberman's missing note from Ms Stryland's chart suggests that at 14:35 the patient became unresponsive.
- The video shows Dr. Liberman leaving the RR at 14:34 and returning again shortly thereafter
- Ms Q's reflective note stated that she was certain that the time of Ms Stryland's collapse as being 14:45
- The RR vital sign charting ends at 14:45 when Ms Q's "hands were busy" with ventilating the patient, as she said in her interview with the College.

Defence counsel suggests that the re-intubation must have occurred later than 14:45 because of the activity shown after 15:06. However, as noted, the triggering of filming of the security camera is unreliable. It seemed unusual to the Committee that there was a gap in the video recording at precisely the time period in question. Other gaps in the video during the working day were rarely this long. Nonetheless, the Committee cannot conclude that because there is activity after a gap of 18 minutes that there was nothing going on in the preceding time period. There was much evidence to counter that notion.

Defence counsel argued that alarms must have been going off if Ms Stryland's vital signs were as low as those recorded on the RR. They also pointed out that the staff did not

appear to be rushing to deal with a patient in distress at any time as may be expected if alarms were sounding. The Committee agrees with defence counsel that for most of the afternoon, from video appearances, it is “business as usual”.

The Committee notes that neither nurse could recall when any monitor alarms went off that day, although they must have gone off, they said. A patient’s hand movement could trigger the alarm according to Ms J’s testimony. Testimony was given that the alarm volume could be turned down and the alarm could be silenced. The limits of the vital signs could be altered so the alarm would not ring. The Committee also viewed on the video that at 18:34 a man, previously unseen on the video, arrived in a business suit carrying a briefcase with tools. He appears to check a vital sign monitor that Dr. M brought out from the RR. The Committee was unable to determine whether he was a serviceman or not and whether the alarm on the monitor was defective. Given the many reasons why alarms may not go off, or if they did, why they may be ignored, the Committee is unable to make any conclusion about whether or not alarms were sounding when it appeared to be “business as usual.”

The nurses outlined the treatment of Ms Stryland in the time period following her collapse and the Committee has no reason to doubt their testimony in this regard. Ms Stryland was intubated, had two more IV’s started and bolus infusions as well as had her bladder catheterized. The small amount of urine in Ms Stryland’s bladder of 100 to 125 cc’s for five hours of surgery and post-operative care is not adequate in the view of Dr. S and Dr. T. Both of them indicated that this finding suggests that Ms Stryland’s circulating volume was inadequate and had been for the preceding five hours, and that her body was attempting to hold onto fluid to compensate.

According to Ms Q’s reflective note, at 15:35, after Ms Stryland’s BP came up to 110/60 with the forgoing interventions, her BP dropped to 70/30 and her heart rate increased to 128. Her respirations ceased and she required ventilatory assistance again. Ms Q testified that just prior to this taking place, Dr. Liberman told Dr. M that the patient did not need

to go to the hospital immediately but perhaps should go there after she was stabilized for overnight observation.

In his handwritten resuscitation note, Dr. Liberman noted that at approximately 15:35-15:40, the patient's BP dropped and her heart rate rose as described in Ms Q's note. He observed that the dressing was suddenly soaked with blood that "pooled on the stretcher and did not clot". This observation was significant, Dr. S testifies, because it can be inferred that Ms Stryland had bled out her blood, cells and her clotting factors and platelets. Because her fluid losses had been replaced with only saline, she had a dilutional coagulopathy. This observation is significant and suggests that Ms Stryland had been bleeding for some time as she had used up her clotting factors.

The paramedics described Ms Stryland as having no vital signs when they arrived and as being very chalky in colour, lying in a pool of very, very diluted blood. Dr. Liberman's note written the next day indicated Ms Stryland had a BP of 100/55, heart rate of 110 and O2 sat of 100% at this time. This is clearly contradictory to the evidence that the paramedics began resuscitation for cardiac arrest when they arrived. Following their initial resuscitation efforts, Ms Stryland was transferred to the hospital. The blood work taken shortly after her arrival at the hospital and reviewed by Dr. G in his testimony revealed that Ms Stryland had severe anemia, hemorrhagic shock and disseminated intravascular coagulation (DIC). Dr. G said that she had bled so much that she required various blood products and had virtually no oxygen carrying capacity in her blood. These findings are inconsistent with Dr. Liberman's documentation of the last vital signs.

The Committee concludes that Dr. Liberman was not aggressive enough in his treatment of Ms Stryland's hypovolemia throughout the afternoon and his deficiencies in this regard led to catastrophic consequences. His note written the next day indicates his distortions about what was actually going on given the vital signs he noted when the paramedics arrived. The Committee questions his motivation in writing clearly erroneous vital signs of a patient at a time when she had none. Questions about judgment noted by the experts are highlighted here as well.

In summary, there are several points at which Dr. Liberman should have intervened in a more aggressive way, according to the expert testimony:

- the initial vital signs on admission to the RR should have been ascertained, and as they were markedly different from those he recorded in the OR, Dr. Liberman should have assessed the reason for that discrepancy.
- there is no evidence that Dr. Liberman tried to assess why there was a discrepancy between the vital signs and the clinical picture of an alert, talking patient.
- the patient spent the next 90 minutes after admission to the RR in shock and it should have been addressed and remedied
- although the patient was able to increase her BP to almost 100 systolic with Ringer's Lactate boluses and the Trendelenberg position, this was not indicative of adequate volume status, especially in young people, and an anesthesiologist should have recognized this. He should have recognized that his treatment was not working and Ms Stryland's vital signs were, in fact, worsening.
- at 14:15, after 60 minutes in the RR, Ms Stryland's BP was 55/20 and her heart rate was 102 beats per minute. Despite Ms Stryland's own physiological attempts to increase her heart rate, her blood pressure did not rise. She should have been considered for transfer to hospital by this point.
- the low volume of urine output indicates that Ms Stryland had a low circulating volume for hours and it should have been addressed earlier
- at about 14:45, the patient decompensated due to her severe hypovolemia and became unconscious with a low BP, fast heart rate and diaphoresis. Her need for

blood products should have been recognized at this point. Her BP of 40/25, and her heart rate of 141 and the O2 sat of 85% is indicative of shock

- Ms Stryland required assistance to breathe for almost 60 minutes before the paramedics were called. Hypovolemic shock requiring ventilation should be managed at the hospital where there is a full laboratory and transfusion capabilities, according to both expert witnesses called by the College.
- Dr. Liberman failed to use inotropes and vasopressors, drugs to increase Ms Stryland's blood pressure
- the Paramedic's record states that Ms Stryland was given 12,000 cc of Ringer's Lactate although only 6000 cc is noted on the chart. Despite all the fluid, the patient was still in shock and a patient requiring even half of that volume to maintain an adequate BP should have repeated checks of their hemoglobin as transfusion will inevitably be required. This should have been anticipated as volume requirements continued.

Defence counsel suggested that the video gives the appearance that it is "business as usual" at the clinic until 15:06 when the collapse of Ms Stryland occurred. The Committee agrees that it appears to be "business as usual" all afternoon, but in fact the lack of attention to Ms Stryland's increasingly dire straits is the reason that is so. Even when she collapsed, the treatment was far from adequate.

In light of the comments summarized above, the Committee finds that Dr. Liberman failed to maintain the standard of the profession in that he failed to aggressively treat the hypovolemia of Ms Stryland. This omission would reasonably be regarded by members as disgraceful, dishonourable and unprofessional.



**iii) Did Dr. Liberman fail in not calling 911, first when his initial treatment failed and then when Ms Stryland became unconscious?**

Dr. S in her testimony said that, by 14:15, she would have developed a high level of concern and would consider making a transfer to the hospital, given the lack of facilities at the clinic. When the patient is in a life-threatening situation, the choices of what must be done to treat the patient get narrower to a point where it comes to an algorithm as to what must be done. Besides noting that she would call 911 at 14:15, Dr. S said that whenever the collapse of Ms Stryland occurred, 911 should have been called immediately in order to transfer her to hospital. In her view, Ms Stryland's situation became a life threatening one and there was little variation in what had to be done to manage her. She thought that Dr. Liberman failed in this regard, indicating his lack of knowledge and judgment.

Dr. T also thought that regardless of when the collapse occurred, Ms Stryland should have been transferred to the hospital. He referred to the "golden hour" in the management of patients in critical conditions. He said that if the patient can be treated aggressively in the first 60 minutes of a life-threatening injury or crisis, then the chances for survival are greatest. At the time that Dr. Liberman notes that Ms Stryland's dressing suddenly became soaked with blood, which pooled under the stretcher and did not clot, it was roughly 50 minutes into the "golden hour".

A patient becoming unconscious about 90 minutes after coming into the RR after liposuction is very uncommon, according to Dr. T. Two systems, her cardiovascular and her central nervous system, are now compromised to the point that they need emergency measures to keep her alive. At this point, Dr. T opined, 911 should have been called.

Dr. Liberman needed to send the patient to the hospital to diagnose what was happening because nothing is available at the clinic to find out why she was possibly bleeding. Dr. T went on to say that the patient needed blood as she has had a significant amount of

bleeding, to the point that it is noted that there is blood pooling under the patient at 14:45. Blood is not available at the clinic and that is what she needed.

Dr. T also noted that, after re-intubation, it would be expected that the BP would rise as intubation is stimulating to the body. Such a rise would not be sustained and should not be reassuring. He went on to say that, “Something led her to this position, to the point that she required more help than Dr. Liberman could offer at a cosmetic clinic”.

Although Dr. V thought that, when Ms Stryland first crashed and needed intubation, it was premature to call 911, he erroneously believed that this was Dr. Liberman’s first intervention with this patient that afternoon. However, he did state that when blood pooling was observed, 911 should have been called within five to ten minutes. If that is the case, it suggests that 911 should have been called at 14:45, when Ms Q noted the blood pooling. According to Dr. Liberman’s note, the blood pooling was not noted until 15:35 and 911 was not called for an additional sixteen minutes.

All the experts agreed that calling 911 at 15:51 was too late.

The Committee concludes that Dr. Liberman’s failure to call 911 when his initial treatment failed, and later when Ms Stryland became unconscious, indicates a failure to maintain the standard of the profession, and as such he has committed an act of professional misconduct. This omission, having regard to all the circumstances, would be regarded by the members as disgraceful, dishonourable and unprofessional.

**iv) Did Dr. Liberman fail to chart the initial Recovery Room vital signs and his intervention prior to re-intubation?**

All of the experts who testified at the hearing agreed that the standard of practice of anesthesiologists is to document a patient’s initial vital signs upon transfer to the RR.

As noted above, the Committee finds that Dr. Liberman failed to chart the initial RR vital signs. The Committee does not believe that he knew what they were initially either, as he didn't stay in the RR long enough to find out. Although Dr. Liberman's counsel has argued that the RR record is inaccurate, Dr. Liberman does not appear to have ascertained Ms Stryland's vital signs on admission to the RR and thus does not have grounds to make this assertion. He failed to maintain the standard of care with regard to charting the vital signs in the RR prior to delegating care to the nurses. There was also no evidence that Dr. Liberman charted his intervention prior to intubation and this also falls below the standard of care.

Dr. Liberman's final resuscitation note was written the day after the crisis with Ms Stryland. In Dr. V's view, the final resuscitation note should have been written immediately once his involvement ends and the patient is transferred to the hospital.

Dr. Liberman committed an act of professional misconduct in that he failed to maintain the standard of the profession in his failure to chart the initial RR vital signs and his intervention prior to intubation.

### **Disgraceful, Dishonourable or Unprofessional Conduct**

- i) **Did Dr. Liberman remove his September 20, 2007 resuscitation note from the chart and replace it with a note dated the next day?**
- ii) **Did Dr. Liberman place in his September 21, 2007 note misleading information regarding the patient's status at the time the paramedics arrived?**

Dr. Liberman also committed an act of professional misconduct by engaging in behaviour that was disgraceful, dishonourable and unprofessional when he removed his September

20, 2007, resuscitation note from the chart of Ms Stryland and replaced it with a note written the next day. The forensic document examiner was clear that the writing features of the missing document in the chart were consistent with that of Dr. Liberman. He also committed an act of professional misconduct with regard to his misleading statements on that replacement resuscitation note as well.

Dr. Liberman said in his note that the blood loss was not excessive in amount prior to the sudden loss of blood at 15:35. However, the cleaner is shown on the video heading into the RR while putting on an apron at 15:18, presumably to clean blood off the floor. Ms J testified that she was putting on an apron because of universal precautions (related to body fluids). Dr. Liberman's notation is not consistent with what is appearing on the video and with the comments of the experts. Ms Stryland suddenly bled out a massive amount of blood that did not clot at 15:35 because she no longer had any coagulation factors left. In other words, Ms Stryland had been bleeding in such an amount in the preceding time period that she consumed all of her coagulation factors. It was of such an amount that, when she got to the hospital, her hemoglobin was the lowest the internist had ever seen, 10 times lower than the usual critical level. She had virtually no capacity to carry oxygen.

Those misleading statements on his resuscitation note, dated September 21, 2007, regarded the patient's status when the paramedics arrived. In his note, he said that Ms Stryland's BP was near normal at 100/55 and her O2 sat was 100%. This clearly was not the case, in light of what her hemoglobin was at the hospital 15 to 20 minutes later. The Committee believed the reports of the paramedics who said that Ms Stryland was "vital signs absent" with agonal or ineffective breathing when they arrived, and that they began measures to deal with a cardiac arrest.

### **Incompetence**

The experts testifying on behalf of the College were most helpful in assisting the Committee in this area. Dr. S opined that it was not clear whether Dr. Liberman didn't

recognize how life-threatening Ms Stryland's condition was, or whether he recognized it and thought his treatment was adequate and appropriate. One signifies a lack of knowledge while the other indicates a lack of judgment. Nonetheless, the standard of the profession is that Dr. Liberman should be able to recognize shock and deal with it appropriately.

Both experts thought that Dr. Liberman failed to maintain the standard of practice and displayed a lack of knowledge, skill or judgment based on his inability to observe what had happened, his inability to recognize that his management of fluids prior to re-intubation was not working, and his failure to recognize the gravity and severity of the situation of a critically ill patient that needed hospital care.

Dr. T thought that Dr. Liberman's behaviour likely exposes or is likely to expose patients to harm or injury because he could not recognize the severity of Ms Stryland's condition. Dr. T said that the fact that Ms Stryland required re-intubation indicates that he was deficient in his care prior to that. He too believed that Dr. Liberman exposed Ms Stryland to harm and may expose future patients to harm because he was not able to recognize something as basic as ongoing bleeding.

Dr. T's testimony sums up this point well. After rating Dr. Liberman's deficiency of knowledge, skill and judgment as a 9 on a scale of 1 to 10 with 10 being the lowest, he noted that:

"It's simple enough to just put someone to sleep, maintain them asleep, and then drop them off in the recovery room. These events are rare, but they do happen, and that's why we're trained as specialists in anesthesia to deal with these critical events in a timely fashion. And that's based on our observational skills, based on our knowledge, based on our judgment, and our management based on all of that, so that we can treat this patient appropriately and in an aggressive manner so that she can survive."

It was not enough that Dr. Liberman was deemed to meet the standard of care with regard to his pre-operative and intra-operative care. The Committee found that he was deficient in his post-operative care and his charting. Dr. Liberman 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”). His lack of knowledge, skill and judgment demonstrates that he is unfit to continue to practise or his practice should be restricted.

### **III. Other Patients**

#### **i) Did Dr. Liberman’s Fail to Maintain the Standard of Practice in his Charting Pertaining to the 55 charts?**

Dr. Z, an anesthesiologist, recognized by both parties as qualified to give opinions regarding Dr. Liberman’s anesthetic care and charting, received some 56 charts and reviewed 55 charts of Dr. Liberman’s anesthetic practice. The charts spanned the years from 2006 to 2008 and pertained to anesthetics given at two cosmetic clinics, including the Toronto Cosmetic Clinic.

Dr. Z opined that Dr. Liberman met the standard of care with respect to the 55 charts with the exception of one major area. Dr. Liberman did not chart the vital signs, that is, the BP, heart rate, and O2 sat of the initial RR recording on the anesthetic record in all of the cases he reviewed. He also failed to document the ASA in four cases.

The lack of charting of ASA rating was related to young healthy patients, who received competent anesthetic care and no additional risk was posed. He thought that the failure to document the ASA was an oversight and given the small number of patients for which it was not documented. It did meet the standard overall, he thought.

Dr. Z noted that Dr. Liberman's own documentation of the vital signs would confirm that the patients were stable prior to transfer of care and that the transfer of care occurred directly between the anesthesiologist and the RR nurse. Because the vital signs were stable and normal and because the RR nurse documented them, this deficit did not put any patients at risk. However, the lack of documentation indicates that the standard of care was not met and assumptions must be therefore made about the stability of the patient in order to delegate their care to the RR nurse.

Dr. Z concluded that his clinical practice meets the standard of care of the profession with the exception of the charting of vital signs in the RR. While Dr. Liberman's care met the standard of practice in "stable" post-op patients (with the exception of the documentation issues), Dr. Z's review did not assess Dr. Liberman's ability or competency in dealing with emergency situations.

The Committee finds that Dr. Liberman has committed an act of professional misconduct in that he has failed to maintain the standard of the profession with regard to charting the patient's vital signs on admission to the RR. As noted above, the Notice of Hearing also alleges that Dr. Liberman was incompetent in the charting with respect to the 55 patients. While the Committee has concerns regarding Dr Liberman's competence which are discussed elsewhere in these Reasons, it finds that the charting issues in respect of these 55 patients are not such as to rise to the level of incompetence even though in some instances they do not meet the standard of practice of the profession.

### **Adverse Inference to be drawn against Dr. Liberman**

College counsel submitted that an adverse inference should be drawn against Dr. Liberman.

As Justice Sopinka noted in *The Law of Evidence in Canada*, Third Edition, at para.6.449, an adverse inference can be drawn in civil cases when, “in the absence of an explanation, a party litigant does not testify, or fails to provide affidavit evidence on an application, or fails to call a witness who would have knowledge of the facts and would be assumed to be willing to assist the party. In the same vein, an adverse inference may be drawn against a party who does not call a material witness over whom he or she has exclusive control and does not explain it away. Such failure amounts to an implied admission that the evidence of the absent witness would be contrary to the party’s case, or at least would not support it.”

The College has established its *prima facie* case. This Committee found sufficient evidence to find Dr. Liberman has committed acts of professional misconduct and he is incompetent. According to Justice Sopinka, an adverse inference should be drawn only after that has been done.

Dr. Liberman had evidence that he alone could have brought before this tribunal and he failed to do that. His testimony would have been helpful in the following areas:

- What were Ms Stryland’s vital signs during the anesthetic period and why did Ms J’s recollection of the last one not match his recording?
- Why were his vital sign recordings on the Anesthetic Record for Ms Stryland and Patient B, the third patient, not aligned with the times as noted above?
- Why did his vital sign recordings vary so much with the initial one in the RR?
- If he had evidence that he knew what Ms Stryland’s vital signs were on admission to the RR and/or he had recorded them elsewhere, Dr. Liberman was open to testify to that effect. Why didn’t he?



- If the RR record was so much in error, then why did he not record that on his resuscitation note done the next day or make an effort to have it corrected before the chart was sent to the coroner?
- Why did he not treat Ms Stryland's hypotension more aggressively?
- Why did he start the next case if he had a patient who was hypotensive?
- Why didn't he call 911 much earlier in Ms Stryland's post-anesthetic period as the expert witnesses said he should?
- Why didn't he call 911 when Ms Stryland's vital signs remained low after treatment with extra IV fluids and the Trendelenberg position?

Dr. Liberman did not testify about these areas. His counsel argued that Ms Q's new version of when she wrote the RR vital signs and the fact that they were in error provided the Committee with a reason to disregard those records. Dr. Liberman was in the RR during at least some of the period when Ms Stryland was in crisis and requiring re-intubation and ventilation. He knew what transpired and when. Why did he not testify about the RR charting? The fact that he didn't testify leads to the conclusion that his evidence would not have supported Ms Q's story of when and how she recorded the RR vital signs.

Nor did Dr. Liberman testify about the omissions on the approximately 55 charts that were reviewed by Dr. Z or about the missing documentation from Ms Stryland's chart in his handwriting.

The Committee considers that it is appropriate in this case to draw the inference that the evidence of Dr. Liberman would be contrary to his case or, at the least, would not support it. That having been said, it is also the Committee's view that the allegations against Dr.

Liberman have been proven to the requisite standard without relying upon any adverse inference that may be drawn.

**v) SUMMARY**

In summary, the Committee finds that on a balance of probabilities, Dr. Liberman failed to maintain the standard of the profession, has engaged in disgraceful, dishonourable, and unprofessional conduct, and displayed a lack of knowledge, skill and judgment in his care and treatment of Ms Stryland. In his charting, he also failed to meet the standard of the profession. The Committee concludes that Dr. Liberman committed acts of professional misconduct and is incompetent.

The Committee directs the Hearings Office to schedule a penalty hearing at the earliest possible date.

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Liberman, this is notice that the Discipline Committee ordered there shall be a ban on publication of the name or identity and any information that would disclose the name or identity of all patients (other than Krista Stryland) and family members of patients (other than Nick Stryland), whose names or identities are disclosed at the hearing or in any documents filed at the hearing, under subsection 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 or 47... 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: Liberman, B.A. (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. BRUCE ALAN LIBERMAN**

**PANEL MEMBERS:**

**DR. E. STANTON  
D. DOHERTY  
DR. C. CLAPPERTON  
DR. E. ATTIA (PhD)  
DR. B. LENT**

**Penalty Hearing Dates:** September 1, 26-28, October 31, & November 11,  
2011

**Penalty Decision Date:** March 21, 2012

**Release of Written Reasons:** March 21, 2012

**PUBLICATION BAN**

## **PENALTY AND REASONS FOR PENALTY**

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on June 14 to 18, 28, 30, July 19 to 21 and September 17, 2010. At the conclusion of the hearing, the Committee reserved its decision. The Committee delivered its written decision and reasons on May 4, 2011.

The Committee found that Dr. Bruce Alan Liberman has committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession, and in that he 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, dishonorable or unprofessional.

The Committee also found that Dr. Liberman is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (“the Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991* (the “RHPA”), 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 to practise or that his practice should be restricted.

These findings relate primarily to Dr. Liberman’s care and treatment of Krista Stryland following her liposuction surgery on September 20, 2007.

The Committee heard evidence and submissions on penalty on September 1, 26 to 28, October 31, and November 11, 2011, and reserved its decision.

## **SUBMISSIONS ON PENALTY**

### **A. College’s Position**

The College is seeking revocation of Dr. Liberman’s certificate of registration, a reprimand and costs in the amount of \$62,050.

The College submits that revocation is warranted because of Dr. Liberman's serious and repeated acts of professional misconduct in his care of Ms Stryland, his profound lack of judgement, his incompetence, his dishonesty, and his lack of insight. The College submits that revocation is necessary in order to maintain public confidence in the medical profession, and to achieve general and specific deterrence. The College argues that even if remediation were an appropriate sanction (which the College does not accept), Dr. Liberman has failed to put forth a realistic and specific remediation plan.

## **B. Defence Position**

Counsel for Dr. Liberman argues that a reprimand, an assessment of Dr. Liberman's anaesthesiology practice, and an undertaking by Dr. Liberman to complete all remediation recommendations and bear the associated costs would be an appropriate penalty. Although defence counsel submits that a six month suspension would be appropriate, he maintains that this should be considered having been fulfilled given that Dr. Liberman has suffered significantly as a result of extensive media attention and personal and professional life changes. An interim suspension order imposed on December 15, 2009, curtailed his professional activities. He has not practised since May 2011 following a voluntary undertaking with the College.

The Discipline Committee heard from several witnesses, as well as Dr. Liberman. Several documents and legal authorities were also presented for consideration by the Panel.

## **C. Witnesses**

### **Dr. S**

Dr. S had previously been qualified as an expert in anaesthesiology during the findings phase of Dr. Liberman's hearing. She was called again during the penalty phase of the hearing to give evidence in relation to remediation in the context of anaesthesiology. She has been a member of a residency training committee for anaesthesiology since 2001 and was program director from 2003 until 2009 at an Ontario teaching center. As such, she

was involved in the setting of objectives for training anaesthesiology residents, assessments of competence, evaluations of each rotation, and development of curriculum. In addition, she has been involved in remediation of residents who were not meeting their competencies as well as assessing and training mid-career doctors.

In order to be a good candidate for remediation, Dr. S testified that the doctor must have insight into his/her practice and professionalism. She testified they need to be able to critically look at what they are doing and where they can improve with humility, honesty and willingness.

Dr. S's opinion is that Dr. Liberman is not a good candidate for remediation. She described Dr. Liberman's lack of judgement and treatment of Ms Stryland as "a grievous error." She stated that Dr. Liberman did not display only one instance of bad judgement. Over the three hour period, there were multiple poor judgements made by Dr. Liberman and multiple demonstrations of a lack of knowledge. She testified that while technical skills are easier to teach, judgement is difficult to teach, especially with events that are rare.

Dr. S listed the following examples of instances where Dr. Liberman made poor judgements in the care of Krista Stryland:

- leaving Ms Stryland in the recovery room in an unstable condition;
- starting on the next case before he was sure that she was stable;
- responding inadequately when he was told she was hypotensive;
- providing inadequate treatment;
- failing to consider various options regarding possible diagnoses;
- lack of ongoing assessment of how she was responding;
- his insistence that Ms Stryland would be fine;
- failing to stop or abort the surgery in which he was providing the anaesthetic at the time when it was clear Ms Stryland was not fine;

- his insistence that every sign of shock had to be present in order for shock to be diagnosed (from his 2009 letter to the College);
- his reliance on signs that were unreliable;
- failing to entertain the possibility that Ms Stryland could decompensate and his failure to avert possible decompensation;
- failing to make appropriate plans in case Ms Stryland did not get better;
- failing to transfer care of Ms Stryland to a hospital, even though he had many opportunities to do so; and,
- failing to transfer with her to the hospital and provide an adequate report and handover to the hospital staff.

Dr. S testified that by nature it is difficult to remediate one's response to a rare event and it is also difficult to teach judgment.

Upon reviewing the letter Dr. Liberman wrote to the College on October 14, 2009, two years after Ms Stryland's death, Dr. S's view was that Dr. Liberman did not show insight or take any responsibility for his actions. She explained that when something goes wrong or not as planned, one has to have the ability to look at what happened critically and assess oneself, either on one's own or with department morbidity and mortality rounds, and really debrief and find out where one could have done something different. Dr. Liberman wrote in his letter, "Although the exact cause of Ms Stryland's low blood pressure and ultimate demise remains unknown to me..." Dr. S was of the view that two years after the event, Dr. Liberman should have had an understanding of how this healthy patient died. Dr. Liberman should have sought help if he was unable to figure it out. Dr. S testified that doctors are constantly learning, and if a doctor is going to continue to practise he needs to be able to critically assess his own practice and see where the deficiencies lie.

Dr. S was also of the view that a two-month physician re-entry program in anaesthesiology would not be suitable to remediate Dr. Liberman. She explained that



when she assesses physicians trained elsewhere in mid-career, the minimum is a three to six month assessment period. She indicated that it takes a long time to assess people and find out where their weaknesses lie and whether they have met all of the competencies. She was also not aware of the use of physician re-entry programs being used for doctors who have been found to fall below the standard of practice.

During cross examination, Dr. S admitted that she had no idea whether or not the Stryland case was representative of the level of anaesthesiology practised and the care provided by Dr. Liberman generally. She testified that it is difficult to determine whether the failure to recognize and aggressively treat Ms Stryland's hypovolemic shock was due to lack of knowledge or judgement. She also was unable to say whether Dr. Liberman's clinical practice, behaviour or conduct exposes or is likely to expose his patients to harm or injury.

Dr. S testified that although hypovolemic shock was not a rare event, progression ending in death is rare. After listing many rare events that occur during and after surgery, Dr. S testified that although rare complications may not be the fault of the anaesthesiologist, it is the anaesthesiologist's responsibility to treat them.

Dr. S also made clear that it was the anaesthesiologist's role to try and ensure that the patient lives through any rare event or complication, whether it occurs in the operating room or the recovery room. In the recovery room, the anaesthesiologist is the most responsible physician, although the surgeon would be involved if there was a surgery related complication.

#### **Dr. F**

Dr. F was called to testify by Dr. Liberman. He is an anaesthesiologist associated with a teaching hospital and university in Ontario. He has participated in the committee charged with the written examinations for the RCPSC and was Chair of the Department of Anaesthesiology at his hospital for eight years. After a review of his extensive C.V., Dr. F was qualified as an expert in anaesthesiology and the evaluation and remediation of

other anaesthesiologists. Dr. F was retained to provide an opinion as to whether Dr. Liberman is remediable and, if he found him to be remediable, to suggest a remediation program.

Dr. F reviewed the decision of the Discipline Committee and interviewed Dr. Liberman for an hour and a half. Dr. F is of the opinion that Dr. Liberman is remediable. He proposed that Dr. Liberman undergo a remediation program consisting of a period of assessment of his practice that would take at least three months. It was Dr. F's opinion that if Dr. Liberman then re-entered practice, he should do so on a probationary basis with a requirement to report clinical activities and adverse outcomes to the College.

In the interview with the physician, Dr. F reviewed Dr. Liberman's knowledge in the management of some common and rare events which occur in anaesthesia both intra-operatively and in the post operative period, including hypotension, hypertension, shock and cardiac arrhythmias. Dr. F testified that he was impressed with the toolbox that Dr. Liberman brought to ambulatory clinics.

He testified that Dr. Liberman was accepting of this Panel's decision and seemed to have insight. He testified that Dr. Liberman convinced him that "if he had it to do again, he would do it differently." He would have sent the patient to the nearest hospital much earlier when she failed to respond to intravenous bolus, and would certainly have sent her after she required intubation. Dr. F also stated that Dr. Liberman was amenable to remediation.

Dr. F testified that Ms Stryland's case should be viewed as a continuum. He did not think that it represented a lot of separate judgements by Dr. Liberman. He went on to say that it was important to recognize that this case was not normal post-operative hypotension, which is common in a lot of patients, but it was serious hypotension leading to irreparable or irreversible changes, such as shock. This patient needed to be transferred to the closest hospital where there were many doctors and where there were facilities to give blood, resuscitate, and do lab tests.

Dr. F agreed that insight is important for remediation: “you do need an acceptance that you do need remediation.” He testified that he believed Dr. Liberman has this insight. Dr. Liberman admitted to him that he should have done things differently and realizes that he overlooked and minimized the hypotension and did not realize how serious the problem was for the patient.

Dr. F also testified that one has to have determination: “you have to change the way you practice and, and he convinced me that he was willing to do that.” He indicated that Dr. Liberman was committed to remediation. Dr. F also testified that Dr. Liberman had the basic knowledge base to be remediable.

Dr. F acknowledged that the findings of the Discipline Committee were serious. In his view, however, Dr. Liberman’s deficiency in the treatment of Krista Stryland was essentially a failure to manage hypotension properly. Dr. Liberman had a fixation that this was not serious hypotension. In Dr. F’s view, the Stryland case was an isolated case. In his view, it was a continuum as opposed to a lot of separate judgements. He proposed a period of assessment to closely monitor Dr. Liberman’s practice and to also see how he works in simulation regarding rare events. He would then propose a remedial program in an acute care hospital. If Dr. Liberman were then deemed fine to re-enter practice, he would have to be on probation for a minimum of a year or maybe two years. Further, because in all likelihood he would re-enter practice in an ambulatory care centre where he would be the only physician present, he would need to make periodic summaries of his practice, number of patients and what he did to the College. He would also have to report complications to the College and undertake appropriate continuing medical education each year, particularly in perioperative and post-operative rare events.

In testifying about Dr. Liberman’s remediation plan, Dr. F stated that during the probation period a hospital setting would be important because there would be peers. He said that it is extremely difficult for an anaesthesiologist to practise alone in an ambulatory patient setting as the patients tend to be healthy and the incidence of rare complications is low. No one reviews the doctor’s care in an ambulatory care setting,

while practising with one's peers provides a cross-fertilization of ideas and methods, with help available.

Dr. F testified that if this Committee's prime concern is that Dr. Liberman is deficient in his knowledge and his ability to handle emergency situations, Dr. Liberman could practise as a surgical assistant in a hospital, where he would be directly under the supervision of a surgeon.

Dr. F agreed that the removal of the September 20, 2007, resuscitation note from the chart, and its replacement with another one the next day containing misleading statements about Ms Stryland's medical condition, reflected negatively on Dr. Liberman's integrity and honesty, attributes that are necessary in a physician.

Dr. F testified that he did not review the findings of the Discipline Committee in detail with Dr. Liberman. He based his opinion on Dr. Liberman saying that he accepted the decision. Dr. F agreed that if Dr. Liberman said that the Discipline Committee "got it all wrong" this would show that he did not have insight. Dr. F said that if Dr. Liberman maintains he has done nothing wrong, then his own opinion would change and he would conclude the physician was not remediable.

#### **Dr. V**

Dr. V was previously qualified as an expert in anaesthesiology during the findings phase of this hearing. He has worked as an anaesthesiologist in a teaching hospital and was involved in the teaching of residents. For the penalty phase of the hearing, Dr. V was retained to opine on two issues: (1) whether Dr. Liberman was remediable for going back to clinical practice; and (2) if so, what sort of program could be set-up.

Dr. V interviewed Dr. Liberman for an hour and a half. He also read the decision of the Discipline Committee.

Dr. V's opinion was that Dr. Liberman was remediable and a program could be set-up to achieve his remediation. Dr. V testified that Dr. Liberman had the requisite intellectual capacity – the anaesthetic knowledge and skill to practise. It was his opinion that Dr. Liberman had insight into his deficiencies. He testified that Dr. Liberman recognized that there were certain aspects in the handling of this case where he lacked the abilities to manage Ms Stryland's care. Dr. V testified that Dr. Liberman said he could have managed the patient better, in retrospect. Dr. V testified that insight does not require acceptance or agreement with every single factual finding made in the Committee's decision.

Dr. V was of the opinion that this was one isolated event. He testified that after 25 years of clinical practice, one case does not mean that someone is incapable of remediation.

Dr. V presented a plan for Dr. Liberman's remediation that he thought would address the doctor's deficiencies. The plan involved two or three months working in a hospital with a trauma centre where cases of hypovolemic shock are common.

In cross-examination, Dr. V testified that in order to fix a problem it is important to acknowledge that there is a problem. He said that he did not go over the findings of the Discipline Committee in detail with Dr. Liberman when they met, nor did he recall the doctor specifically telling him that he accepted them. However, he recalled that Dr. Liberman was distraught and distressed by the findings. He said that, in his view, insight would reflect Dr. Liberman's acknowledgement that the case could have been better managed and there were certain aspects that he could have improved upon.

Dr. V testified that if Dr. Liberman had said to him, "I didn't do anything wrong in Krista Stryland's care; there's no problems in what I did," he would have reached a different conclusion about insight. He would have concluded that the doctor did not have insight. He agreed that insight is important to remediation.

Dr. V testified that the misleading statements in the resuscitation note are serious findings of professional misconduct and raise concerns about Dr. Liberman's integrity. Dr. V agreed that integrity is an essential element for a physician. He agreed that while a doctor could be remediated on a technical matter, integrity would be a different issue.

### **Dr. Bruce Alan Liberman**

Dr. Liberman completed medical school in 1981 and completed his residency in anaesthesia in 1985. He testified that he successfully completed his oral and written examinations for the RCPSC in anaesthesia. He was a staff physician in Toronto and worked in various hospitals. From 1998, he worked primarily in dental and cosmetic clinics with some work in hospitals until 2004.

He testified that he used the FRCP designation until he recently realized that he was not entitled to because he did not pay his annual fee and complete and report the required continuing medical education every year.

Dr. Liberman outlined his recent continuing medical education, testifying that he has read journals about anaesthesia for liposuction. In addition, he reported that after Ms Stryland's case, he did a literature search on liposuction and read "voraciously" about it. He had read parts of Kline's textbook on tumescent liposuction prior to Ms Stryland's case, but after, he testified that he read the entire book at least twice. He also acknowledged, when asked, that he read about hypovolemia and hypovolemic shock.

Dr. Liberman testified that he still has some unanswered questions about what went on with the Krista Stryland case.

Numerous emergency and urgent conditions were reviewed with Dr. Liberman and he reported that he had experience with many of them, although not at private clinics. He testified that none of the patients with complications experienced a poor outcome. Dr. Liberman said that two or three times a year a patient would be sent to hospital from a private clinic due to a complication.

In response to questions by his counsel, Dr. Liberman said that he accepted the findings of the Discipline Committee, although he did not agree with all of the findings. He said that he recognizes that they are serious findings. He said, "I have insight to the fact that they may result in my never practising medicine again." He stated that he had made mistakes and could improve his practice. He stated that there are things he could have and should have done differently and better in Ms Stryland's care.

In examination in chief, Dr. Liberman acknowledged that it was not appropriate to transfer the care of an unstable patient to the recovery room nurse. He agreed it was not appropriate to leave a patient with critically low blood pressure in the recovery room for 90 minutes. In hindsight, Dr. Liberman said he thought 911 should have been called sooner. He testified that the vital signs and interventions in the recovery room should have been promptly noted. Although he acknowledged these things, he did not expressly accept responsibility for any of these deficiencies in Ms Stryland's case.

Dr. Liberman testified that he thought remediation was required and expressed his willingness to undergo an assessment and to remediate any deficiencies as a pre-condition to returning to practice.

Dr. Liberman testified that he reviewed Dr. Z's report and immediately changed his practice, subsequently documenting the initial vital signs of his patients when their care was transferred to the recovery room nurses.

Prior to the interim suspension of his licence in December 2009, Dr. Liberman was working four and a half to five days a week. He ceased practice immediately as required. Subsequently, the court overturned that suspension. Dr. Liberman testified that he was able to resume work for a day a week and eventually to a day and a half a week. He indicated that he could not work more because referring physicians and surgeons declined to use his services because of the media attention. He said the media attention has also cost him his relationship with his sister and only niece. Dr. Liberman testified that friends

and tennis partners have not responded to his e-mails and phone calls. He stated, "My life has ceased and it became an existence." He has not practised since May of 2011.

During cross-examination, Dr. Liberman testified that he did not agree with the factual findings of the Discipline Committee, specifically:

- a) he does not agree with the finding that he did not stay in the recovery room long enough to find out what Ms Stryland's vital signs were upon her admission from the operating room;
- b) he does not believe the recovery room record was accurate, despite the Committee's finding that it was;
- c) he does not agree with the Discipline Committee's finding that Ms Stryland's initial recovery room blood pressure was 60 over 30 with an oxygen saturation of 85 percent;
- d) he does not agree with the Committee's finding that Ms Stryland was unstable when her care was delegated to the care of the recovery room nurses;
- e) he does not believe that he was ever notified of a hypotension that was the level charted in the recovery room record;
- f) he does not believe that Ms Stryland collapsed between 14:35 to 14:45 as the Committee found;
- g) the Committee found that Ms Stryland's vital signs were absent when the paramedics arrived. Dr. Liberman thought she had vital signs when the first of the emergency personnel arrived and, therefore, does not accept that finding of the Committee;
- h) he denies removing his original resuscitation note from the chart of Ms Stryland;
- i) with regard to the misleading statements that the Committee found he made in the note written the next day, Dr. Liberman said that they were written to the best of his knowledge. He went on to say that he was not sure if any of the statements were misleading, but there was certainly no attempt to mislead anyone. He finally



admitted that he did not accept that the statements in his resuscitation note written the next day were misleading as found by the Committee.

Dr. Liberman testified that he agreed 911 should have been called sooner. But he also testified that it was Dr. Yazdanfar's responsibility to call 911. He eventually conceded that with the knowledge he has now he should have called 911 earlier.

### **Dr. W**

Dr. W practises oral maxillofacial surgery in Toronto. He has worked with Dr. Liberman on thousands of cases. He gave examples of instances where Dr. Liberman saved lives because of his skills in intubating patients who were in emergency situations. He also testified about Dr. Liberman's ability to interact with patients and his high level of competency, integrity and good attitude. He had not read the findings of the Discipline Committee in Dr. Liberman's case. He stated in cross examination that he doubted that some of the findings the Committee made could happen. He testified he would be glad to work with Dr. Liberman again. In speaking to Dr. Liberman after the decision of the Discipline Committee was rendered, Dr. W testified that he did not think that Dr. Liberman accepted the findings of the Committee, as Dr. Liberman said to him that, "They have the story wrong."

### **Dr. K**

Dr. K is an otolaryngologist who also performs cosmetic surgery. He testified as a character witness for Dr. Liberman. He testified that Dr. Liberman has provided anaesthesia for about twelve to fifteen procedures over the last three years involving his patients. He found Dr. Liberman to be competent and calming to the patients. He has no knowledge of him falsifying records and he stated he would work with him again.

## **GENERAL PRINCIPLES OF PENALTY DECISIONS**

There is a well-established set of guiding principles applicable to determining the appropriate penalty. These include protection of the public, general deterrence, specific deterrence, rehabilitation, and maintenance of the reputation and integrity of the

profession and the College's ability to govern the profession. The Committee considered these principles carefully during its deliberations.

## **FACTORS CONSIDERED BY THE DISCIPLINE COMMITTEE**

### *1) Nature of the Finding of Misconduct and Incompetence*

The tragic nature of this case is outlined in these reasons and in this Committee's decision of May 4, 2011. Counsel for Dr. Liberman argues that this is a case about Dr. Liberman's care of a single patient on a single day and, therefore, a penalty of revocation is too severe. In the Committee's view, however, there are several notable features to this case.

The Committee was struck by the multiplicity of bad judgments made by Dr. Liberman during the time in which Ms Stryland was trusted to his care. Dr. Liberman's care of Ms Stryland played out over hours. The Committee agrees with the opinion of Dr. S that Dr. Liberman made multiple bad judgements and demonstrated a lack of knowledge over that time.

The context of Ms Stryland's death is important. She was minutes away from a large Toronto hospital. Once finally called, the paramedics arrived within a few short minutes. This case did not involve a calamity occurring in an outpost or remote setting with a doctor who did not have experience in severe hypotension and its management. Anaesthesiologists are trained for this type of complication. The Committee heard from experts that hypotension is common, although the progression to death is rare.

Dr. Liberman removed his September 20, 2007 resuscitation note from Ms Stryland's chart and replaced it with a note written the next day. The replacement resuscitation note contained misleading statements about Ms Stryland's vital signs and O2 saturation levels at the time the paramedics arrived at the clinic. In contrast to his description of her condition, the paramedics initiated treatment for cardiac arrest. Dr. Liberman's comment that Ms Stryland's blood loss had not been excessive prior to her sudden loss of blood at 3:35 pm was clearly misleading as well.

Dr. Liberman tried to cover up what occurred. This speaks to a lack of integrity and professionalism. Despite forensic evidence confirming that the original resuscitation note was removed from the chart, the overwhelming evidence of the paramedics who began treatment for cardiac arrest, and Dr. G's account of Ms Stryland's condition at the hospital indicating Ms Stryland had the lowest haemoglobin level he had ever seen (ten times below the generally accepted critical level), it is astounding to this Committee that Dr. Liberman's position is that his charting of the vital signs was not intended to mislead anyone. The Committee was not presented with any viable explanation as to why the blood pressure and O2 saturation levels were recorded as normal, when they clearly could not have been so. When dishonesty regarding patient care is combined with incompetence and a low standard of care, this Committee has a high level of concern regarding the protection of the public.

When patients have surgery, they trust their care to an anaesthesiologist who often is not of their choosing. They expect that he or she will be competent and careful. Their life is held in this doctor's hands for a period of time. Dr. Liberman not only betrayed the trust that Ms Stryland no doubt placed in him, but he was also dishonest. He distorted the truth of her condition after the fact. In the Committee's view, this was a self-serving attempt to cover-up his failings.

## 2) Victim considerations

The Committee carefully considered the letters from Krista Stryland's family. Their poignant message brought home the enormity of their loss.

Nick Stryland's letter highlighted the impact of Krista's death for their son:

*"The way [my son] changed when I told him his mother had died was so painful to watch as a father. To explain that she was gone, that he would never again feel her hold him, never again hear her voice, was terrible. It was so difficult to explain that his mother had so needlessly been taken from him, and to try to convey to him that it wasn't his fault."*

And further:

*“There are many times when I see him sitting off by himself, and in those times I see an inner sadness in him. There is nothing I can do as a father at these times. It is terrible to watch.”*

### *3) Previous Findings*

There have been no previous findings of the Discipline Committee against Dr. Liberman. Having heard all of the evidence, the Committee agrees with defence counsel that the [\*\*\*] complaint is not relevant. It occurred over a decade ago and the circumstances were different. No findings were made against Dr. Liberman in that case. The Committee did not place any weight on the [\*\*\*] complaint.

### *4) Impact of Proceedings on the Member*

Defence counsel argued that the penalty should take into account the devastating impact of the proceedings and the extensive media attention on Dr. Liberman’s personal and professional life. Dr. Liberman has been disowned by family and friends and the interim suspension imposed December 2009 had the ultimate effect of markedly curtailing his work as an anaesthetist. He has not practised since May 2011. The Committee acknowledges that these events have had a significant impact on Dr. Liberman, both personally and professionally.

Dr. Liberman’s counsel argued that if revocation is imposed and Dr. Liberman is not permitted to practise medicine for at least one more year, it will be virtually impossible for him to resume practice thereafter. The Committee does not believe that this is necessarily true. Dr. Liberman will have an opportunity to reapply at the appropriate time. His suitability to return to practice at that time will be a matter for future consideration. The Committee acknowledges that should Dr. Liberman be granted the privilege to return to practice in the future, he may face impediments to rebuilding his career. The Committee is not prepared, however, to place the public at risk out of concern for the practical difficulties that Dr. Liberman may experience in the future should he attempt to return to practice.

*5) Dr. Liberman's Responsibility and Insight*

When considering Dr. Liberman's remediation prospects at present, the Committee took careful consideration of Dr. Liberman's current understanding of his deficiencies and his role in the events surrounding Ms Stryland's death.

It appeared to this Committee that Dr. Liberman accepted no responsibility for any of the findings of the Discipline Committee. When asked about each of the Committee's findings, his response was to disagree with the Committee's findings. His only concession is that although his view is that Dr. Yazdanfar should have called 911 sooner, "with knowledge he has now" he agrees that he should have called 911.

The Committee is, frankly, surprised that Dr. Liberman has not been more rigorous in examining his role in the events surrounding Ms Stryland's death. In his letter to the College two years after the tragedy, he said, "Although the exact cause of Ms Stryland's low blood pressure and ultimate demise remains unknown to me..." He testified in the penalty phase of the hearing that he still has a number of unanswered questions in his mind about what went wrong with Ms Stryland's case. That he still has questions after days of testimony and analysis by various experts and witnesses is concerning.

When questioned in a general way about whether he made mistakes and whether or not he had room to improve his level of care, he agreed. These generalities, however, did not inspire confidence in the Committee that he had any understanding of his own deficiencies. It appeared to this Committee that he distanced himself from any suggestion that his actions played a role in Ms Stryland's death.

Both parties agreed that the video evidence was accurate. The evidence was incontrovertible that Dr. Liberman stayed in the recovery room only seven seconds when he helped to transport Ms Stryland from the operating room. This was not long enough to know if Ms Stryland had stable vital signs. The Committee notes that he did the same with the first patient of the day as well. Yet, he continues to deny that he did not stay in the recovery room long enough to know what Ms Stryland's vital signs were. Despite

evidence to the contrary, he denies that he handed over the care of an unstable patient. That he maintains this denial in the face of very compelling evidence indicates to this Committee that he does not have the requisite level of insight to make him a good candidate for remediation at this time.

Dr. Liberman disagrees with the finding of the Committee that the recovery room record was accurate and denies being notified of hypotension at the level noted on the chart before 14:00. In fact, Dr. Liberman testified, "...but my position is that I was not aware of a very sick patient in the recovery room." Dr. Liberman had primary responsibility for Ms Stryland in the recovery room and *it was his job to know what her condition was*, irrespective of when he was notified about hypotension. The Committee heard little evidence that indicated Dr. Liberman was reflective on his own actions.

Dr. Liberman also disagreed with the finding that he removed a note from the chart and replaced it with another one which was misleading. The Committee finds it concerning that Dr. Liberman does not take responsibility for this incontrovertible finding.

In order to have insight into behaviour, the Committee believes the doctor first needs to take responsibility for it. Dr. Liberman has not taken responsibility for any of the Committee's findings, despite incontrovertible evidence on many points. We conclude that he has limited, if any, insight. Despite repeated opportunities to elaborate on what he understands about his actions and how he failed Ms Stryland, Dr. Liberman chose to deflect attention away from his part in the events of that day. Even his studying in the years after Ms Stryland's death seems to have centred more on the surgery than the anaesthesia.

Drs. S, F and V all agreed that if Dr. Liberman is still denying that he did anything wrong then he lacks insight. If he does not have insight, then he cannot be remediated. Dr. Liberman's general admissions along with the other evidence suggest that he is parroting what he thinks the Committee wants to hear, without the humility and honesty of a rigorous evaluation of his actions.

### *6. Remediation as an Option*

Counsel for Dr. Liberman suggests that remediation is the right course for his client. Defence counsel argues that because Drs. F and V interviewed Dr. Liberman, they are in a better position to ascertain his amenability to remediation. Drs. S, F and V all agreed, however, that Dr. Liberman does not have insight if he maintains that he did not do anything wrong. They all agreed that insight is necessary for the doctor to be a good candidate for remediation.

Dr. F testified that if Dr. Liberman said the Discipline Committee got it all wrong and he did not do what they said he did, then that would show he did not have insight. He went on to say, “I could understand that maybe at times, okay, when he initially got the decision, he might have been of that opinion, but if that is his opinion today, I would think that he is not remediable.”

Dr. Liberman’s counsel argues that Dr. S’s opinion that Dr. Liberman does not have sufficient insight is based in significant part on an erroneous assumption. Dr. Liberman’s letter to the College in 2009 listed the various signs and symptoms of hypovolemic shock. Dr. S had concerns about Dr. Liberman’s basic level of knowledge, since she thought he was saying that all signs and symptoms needed to be present for a diagnosis of hypovolemic shock. The Committee believes Dr. S did misinterpret Dr. Liberman’s comments in the letter. The Committee does not believe, however, that this erroneous assumption formed a significant part of her opinion regarding Dr. Liberman’s suitability for remediation.

Dr. Liberman has demonstrated that he is not able to accept even the most compelling evidence and admit his role in Ms Stryland’s demise. Although he seemed to be willing to educate himself after the incident, it would appear that he focussed on the surgeon’s role rather than his own role. If he cannot be rigorous about examining his own actions when a patient has died, even after days of evidence and findings by this Committee, then the Committee has concerns that he would not do so when the scrutiny was less intense.

Despite the overwhelming evidence that led to the conclusions that the Committee reached, Dr. Liberman shows little insight into his failings. When someone is going to be remediated, they need to be able to look at their actions in an open-minded way. Dr. Liberman seems to be so entrenched in his view that he does not seem to be able to examine his own actions. Remediation requires humility and open-mindedness about one's deficiencies and the Committee is not confident that Dr. Liberman possesses those qualities that would enable him to change his practices and not be a risk to his patients. The Committee never heard any testimony from Dr. Liberman as to why he thinks he needs remediation.

Dr. Liberman testified that he has successfully dealt with hundreds of "rare events" in the thousands of patients he has treated over his 25 years in practice with no adverse outcomes. His counsel argues that there is no basis to conclude that the doctor is unable to appropriately deal with complications. The findings in this case suggest otherwise. If the physician has dealt with so many complications, it raises the question of why he could not deal with the complications in Ms Stryland's case appropriately. In addition, Dr. Liberman has been practising at clinics for the last several years where the patients are mostly healthy, and, thus, he has not been as challenged as he would have been if he had practised in a hospital setting.

It is notable as well that Dr. Liberman has not practised in a hospital for a few years. Further, he has not maintained his "Fellow" status with the Royal College of Physicians and Surgeons of Canada and has failed to adhere to its requirements for annual continuing medical education. In addition, although Dr. Liberman wants to practise again and requests the opportunity for remediation, the Committee notes that he has actually done very little to maintain his competency since Ms Stryland's death.

The Committee cannot conclude that remediation is a viable option for Dr. Liberman at this time. Besides the concerns expressed above, he did not present a detailed plan for how his remediation would be implemented. His plan did not identify his deficiencies nor address how they would be remedied. In addition, he did not present conditional



acceptance into a hospital anaesthesiology department for further training (which had been suggested by Dr. V).

### *7. Dr. Liberman's Character*

Dr. W and Dr. K spoke to Dr. Liberman's character. Both stated they would not hesitate to work with him again. They testified that they found him to be honest and possess integrity. The Committee did not place a lot of weight on Dr. W's opinion regarding Dr. Liberman's character, because he had not read the Committee's decision, including our findings regarding Dr. Liberman's integrity. Dr. K's experience with Dr. Liberman was confined to only fifteen contacts when Dr. Liberman provided anaesthetic to his patients. The Committee did not find this to be sufficient to place any significant weight on his impression of Dr. Liberman's character.

The Committee found Dr. Liberman to be dishonest. Dr. Liberman wrote erroneous statements on his resuscitation note. Dr. Liberman testified that his report, which stated that Ms Stryland's blood pressure and O2 saturation levels were normal at the time the paramedics arrived, was not designed to mislead anyone. The Committee was surprised to hear Dr. Liberman testify that the note was not written to mislead anyone. The overwhelming conclusion was that the vital signs could not have been anything approaching normal whether he was recording a few minutes before the paramedics arrived or after. Ms Stryland had no vital signs at that time. Dr. Liberman also stated in his resuscitation note that Ms Stryland's blood loss was "not excessive in amount" prior to her sudden blood loss at 3:35 pm. The Committee found this statement inconsistent with the evidence. The Committee does not believe Dr. Liberman's testimony that the note was not intended to be misleading. The note was misleading and this should have been obvious to Dr. Liberman at the time he prepared it.

The Committee was also puzzled with another aspect of Dr. Liberman's actions, or rather inactions, on the day Krista Stryland died. Just as he has distanced himself from taking any responsibility for his part in her death, and just as he tried on several occasions to deflect attention away from his shortcomings, the Committee cannot help but wonder if,

in fact, he became detached from the scenario unfolding with Krista Stryland during the time leading up to her death. Between 2:35 pm and 2:45 pm, Ms Stryland collapsed and required intubation. At 3:18 pm, the cleaner went into the recovery room to mop up body fluids, presumably blood. Dr. Liberman, however, did not call 911. It was over an hour after Ms Stryland collapsed and needed intubation and manual ventilation that 911 was called. The Committee finds this incomprehensible. Although Dr. Liberman had primary responsibility for the patient while she was in the recovery room, he never called for help. He did not take appropriate steps in those three hours, and more-so, in the critical hour after she collapsed. He testified that he sent patients to hospital two or three times a year from his clinical practice when complications arose, so he was familiar with the option to do so. The ambulance and a nearby hospital were minutes away with the facilities to help Ms Stryland. The Committee does not understand how Dr. Liberman could witness the calamity unfolding before him and not call 911 as life was ebbing away from Ms Stryland.

Dr. Liberman's counsel asked him about "rare events." Dr. Liberman responded that he had experience with many emergencies in his years in practice. Unfortunately, although Dr. Liberman has past experience with complications, the steps he took to save Ms Stryland's life were woefully inadequate.

#### *8. Revocation as a Penalty Option*

The Committee has decided to revoke Dr. Liberman's certificate of registration. Before deciding that revocation was the appropriate penalty in this case, the Committee carefully considered the legal precedents submitted by the parties.

Counsel for Dr. Liberman submitted that, with the exception of cases involving a criminal conviction and sexual misconduct, revocation has never been imposed in cases which address the care and conduct provided to a single patient. He argues that revocation would be unduly harsh, unprecedented and excessive in these circumstances.

Defence counsel relies in part on the Divisional Court's decision in *Gale v CPSO*, [2003] O.J. No. 3948. Dr. Gale was an anaesthetist who was involved in the death of a patient at a pain management clinic. The Discipline Committee at first instance found him to be incompetent and to have committed acts of professional misconduct for failing to maintain the standard of practice, prescribing drugs for an improper purpose and engaging in conduct that members would regard as disgraceful, dishonourable and unprofessional. The Committee revoked his certificate of registration. Dr. Gale appealed. The Divisional Court found that the Committee had made errors with respect to the evidence on the issue of the prescription of opioids and referred the findings of incompetence and professional misconduct back to the Discipline Committee of the CPSO for reconsideration. Since the penalty had been imposed based on findings on all allegations, the Divisional Court found that the penalty must also be set aside and remitted the issue of penalty back to the Committee for consideration. In so ordering, the Divisional Court also stated as follows at paragraph 125:

“Even if we had not set aside any of the findings of guilt, we would have set aside the penalty. As we have set aside some of the findings of guilt, but not all, we are remitting the penalty to the College for reconsideration. In doing so, we express our view that, even if Dr. Gale had been guilty of all of the offences of which he was convicted, the penalty of revocation, the capital punishment of a professional, was excessive to the point of being unduly harsh.”

Upon rehearing, the College proceeded only with the allegation that Dr. Gale had committed an act of professional misconduct, in that he had failed to maintain the standard of practice of the profession. The parties proceeded by way of an agreed statement of fact (with reference to the reasons of the Divisional Court) and presented a joint submission with respect to penalty, which was accepted by the Committee. In summary, the penalty provided that Dr. Gale's practice would be assessed at his own expense through a Specialty Assessment Program by the Quality Assurance Committee (“QAC”) of the College and that he comply with any recommendations, terms, limitations or conditions recommended by QAC. The Committee considered the fact that

Dr. Gale had effectively already been deprived of his medical license for a period of almost two and half years, which it considered a severe penalty.

Defence counsel submitted that the Dr. Liberman and Dr. Gale cases were similar in the sense that both cases involved findings of professional misconduct and resulted in the death of a patient. According to the defence, however, there were significant differences in the cases which support a lesser penalty for Dr. Liberman than that imposed in the *Gale* decision. Dr. Liberman's counsel argued that Dr. Gale showed no empathy for the patient, while Dr. Liberman has expressed remorse and empathy for Ms Stryland and her family. Defence counsel further submitted that Dr. Gale showed no insight into his contribution to the patient's death. Dr. Liberman, he argued, has acknowledged that things could and should have been done differently in Ms Stryland's care, and has admitted that he made mistakes and that the findings made by the Discipline Committee constitute substandard care.

It is noted that in *Gale*, the Divisional Court found at paragraph 124 that:

“In the circumstances revealed by this evidence, it appears unreasonable to demand of Dr. Gale that he admit responsibility for the death of [XZ] and to penalize him for not doing so. It seems quite improbable that a reasonably timed intervention on his part could have affected the outcome. As noted above, that does not excuse his failure to act when he should have realized that Dr. Dignan was in error as to the pulse, but, in asking for an admission of responsibility for her death, the Committee demanded too much of him.”

It is the Committee's view that there are significant differences in the two cases. Dr. Gale was not the primary physician in that case during the resuscitation, while Dr. Liberman was the physician in charge in Ms Stryland's care. Further, as discussed above, it is this Committee's view that Dr. Liberman has not, in fact, taken any responsibility and has not demonstrated genuine insight into what he could have done differently.

The defence also argued that Dr. Gale's case involved multiple findings related to his care of multiple patients, while Dr. Liberman's case involves care provided to a single patient and Dr. Liberman's twenty-five year history of anaesthesia practice is otherwise unblemished. The Committee finds that this is a distinction without a difference.

Although Dr. Liberman's case involves the care of one patient over the course of several hours, nonetheless, the care was significantly below the standard one would expect and Dr. Liberman made multiple bad judgments. The Committee also found that Dr. Liberman was dishonest and this is a distinguishing factor from the *Gale* case.

This Committee concludes that the factual circumstances in *Gale* are quite different from Dr. Liberman's case. Dr. Gale was not the primary physician in the care of the patient who died. According to the Court, he probably arrived at the scene of the resuscitation at a time when the patient already had little chance of survival. The time period of the events in issue in *Gale* was fairly short, whereas the opportunity for intervention in Ms Stryland's case was longer.

In the case of Krista Stryland, Dr. Liberman was the doctor in charge of the patient in the recovery room. As such, Ms Stryland's life was in his hands. Although the bleeding and hypovolemic shock that Ms Stryland suffered had its genesis with the surgical procedure that she underwent, the Committee heard from the experts that it is the anaesthesiologist's role to deal with complications arising out of surgery, along with the surgeon. This Committee finds that Dr. Liberman's actions contributed to the death of Ms Stryland, including his lack of attention to her condition on arrival in the recovery room and afterwards. The Committee notes that according to the video of activity at the clinic, Dr. Liberman left the operating room over fifteen times during the course of Ms Stryland's surgery. The Committee finds that Dr. Liberman's frequent absences from the operating room suggest a lack of concern for his patient.

The Committee also considered the case of *De Pass* (Re), [2010] O.C.P.S.D. No. 5, which was relied upon by Dr. Liberman. Dr. DePass had been found to have deficiencies in his judgement and skill by the College of Physicians and Surgeons of Nova Scotia. He

had restrictions placed on his certificate of registration in that province but he moved to Ontario. He subsequently ran into difficulty in Ontario. This Discipline Committee found that he had committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession in his care and treatment of three patients. They also found that he was incompetent. The College sought revocation of his license. Dr. DePass submitted that a program of remediation would be the most appropriate penalty.

The Committee in the *Depass* case did not accept that revocation was the appropriate penalty. The Committee notes at paragraph 18 that “Revocation is the most severe penalty imposed by the Committee and is usually reserved for the most egregious cases or repeat offenders.” The Committee found that Dr. DePass was aware of his deficiencies and had made some attempts at remediation in the past. The Committee, however, found that he lacked insight and understanding of his limitations. In the *DePass* case, the Committee was persuaded that it was not necessary for the protection of the public that the doctor not practise at all. Although his remediation plan was not accepted for various reasons, the Committee placed terms, conditions and limitations on his certificate of registration that severely restricted his practice to that of being a surgical assistant.

In the Committee’s view, the Dr. DePass case should be distinguished from that of Dr. Liberman. There does not seem to have been any issue with respect to Dr. DePass’ integrity or honesty. In addition, Dr. Liberman’s specialty of anaesthesiology is narrow and no plan was presented for having him work in an alternative or circumscribed capacity.

Dr. Liberman’s counsel argued that it would be inappropriate to revoke a member’s certificate of registration because the doctor believes the factual foundation of the decision is incorrect. He relied on the case of *CPSO v. Boodoosingh*, [1990] O.J. No. 921 (Div. Ct.). Dr. Boodoosingh had been found to have committed an act of professional misconduct by the Discipline Committee of the CPSO and his license to practice medicine revoked. The doctor appealed to the Divisional Court which affirmed the finding but reduced the penalty to a reprimand and a three month suspension. The

College appealed the reduction in penalty to the Court of Appeal, and the doctor cross-appealed the finding of professional misconduct. The Court of Appeal upheld the decision of the Divisional Court and dismissed both appeals [1993] O.J. No. 859].

According to the reasons of the Divisional Court, counsel for the College had argued that the doctor had not shown remorse and that “by failing to do admit his guilt it is unlikely that he can ever be rehabilitated.” The Court stated, “The argument, if followed to its logical conclusion, results in the message that a plea of not guilty will result in a higher penalty than that imposed where there is a plea of guilty” (para.7). The Court continued, “This discipline proceeding is quasi-criminal in nature. The maximum penalty of revocation is more serious than many penalties imposed for criminal offences. A reprimand alone is devastating to the recipient. A person charged with a serious offence under [the Act] is entitled to have the case against him proved by cogent evidence and he or she is entitled to make full answer and defence without fear of the threat of increased penalty” (para.8). The Court then stated, “The penalty of revocation should be reserved for repeat offenders and the most serious cases” (para.10).

The Divisional Court notes that the Discipline Committee’s decision in Dr. Boodoosingh’s case “...covered both the conviction and penalty. It is unfortunate that in serious cases, such as this, the hearing is not divided into two stages. The result is that the board and this court were deprived of the benefit of evidence and meaningful submissions on penalty” (para.6). This is not the case in the matter of Dr. Liberman. Dr. Liberman’s hearing was divided into two stages. Dr. Liberman had the opportunity to make full answer and defence during the first stage. He then had the opportunity to consider the Committee’s findings before making his submissions and tendering additional evidence during the penalty phase of this hearing. This is a significant distinguishing factor between the two cases.

The Committee is not revoking Dr. Liberman’s certificate of registration because he failed to admit the allegation during the first phase of this hearing, nor because he denies the factual findings made by the Committee during the first phase of the hearing. He is

not being “punished” because he chose to make full answer and defence. When in a case such as this, however, the doctor seeks an order focussed primarily on remediation, the Committee must take into consideration the doctor’s degree of insight into his deficiencies in determining whether this is an appropriate order. The Committee must also consider the risk to the public in the context of ongoing denial.

This Committee recognizes that revocation is a very serious penalty. The Committee, however, agrees with the Alberta Court of Appeal’s comments in *Adams and the Law Society of Alberta*, [2000] A.J. no. 1031 (Alta. CA), at paragraph 11:

It is therefore erroneous to suggest that in professional disciplinary matters, the range of sanctions may be compared to penal sentences and to suggest that only the most serious misconduct by the most serious offenders warrants disbarment. Indeed that proposition has been rejected in criminal cases for the same reasons it should be rejected here. It will always be possible to find someone whose circumstances and conduct are more egregious than the case under consideration. Disbarment is but one disciplinary option available from a range of sanctions and as such, it is not reserved for only the very worst conduct engaged in by the very worst of lawyers.

In considering the language from the *Boodoosingh* and *DePass* cases, the Committee finds that this is one of the “most serious” or “most egregious” cases that it has seen. Dr. Liberman’s care of Ms Stryland was simply reprehensible.

The primary function of the College is to protect the public. Dr. Liberman is unable to elaborate in any way on how his care of Ms Stryland may have been deficient (with the qualified exception that he admitted he maybe could have called 911 sooner, in hindsight, if Dr. Yazdanfar had not). This does not bode well for his ability to address the issues that led to the tragedy through remediation. Dr. Liberman refutes almost all of the findings of this Committee (even those that are very clear from video evidence and forensic examination of the records). Dr. Liberman had an opportunity to demonstrate to this



Committee that he has insight into his errors and that he is a good candidate for remediation, but he did not take that opportunity. Although he stated that things could have been handled better, the Committee was not clear if he was referring to himself or others.

It is the Committee's task to come to its conclusions based on all of the factors. It is the Committee's view that, if Dr. Liberman were permitted to continue to practise, he would pose a risk to the public due to his incompetence, ability to deceive, and inability to be self-reflective. We do not think he is a good candidate for remediation at this time.

The Committee agrees with the comments of the Court in *Adams and the Law Society of Alberta* with respect to the right of self-governance and the enormous responsibility it entails:

“Professional bodies are those to whom the government has seen fit to grant monopoly status. With this monopolistic right come certain responsibilities and obligations. Chief amongst them is self-regulation. Self-regulation is based on the legitimate expectation of both the government and the public that those members of a profession who are found guilty of conduct deserving of sanction will be regulated — and disciplined — on an administrative law basis by the profession's statutorily prescribed regulatory bodies. Thus, a professional disciplinary hearing is not a criminal hearing; it is an administrative hearing. Admission or proof of the alleged professional misconduct (or incompetence) is not the same as a plea or finding of guilt in a criminal matter.... This public dimension is of critical significance to the mandate of professional disciplinary bodies.” (para 6)

The public dimension was a very important factor to this Committee in determining that revocation is the appropriate penalty in this case. As the Committee heard, generally patients do not have a choice of anaesthetist when they go to a hospital or clinic for surgery or a procedure. They need to have confidence that the anaesthetist who is responsible for their lives while they are incapacitated is competent and diligent in his/her work. Dr. F testified that practising anaesthesia is stressful; ninety percent of the time it is

boring as nothing happens, and then it is sheer terror for the other five or ten percent of the time when complications arise. Dr. T's comments in the findings portion of the hearing also reverberate that anaesthetists can easily put someone to sleep, keep them asleep, and then drop them off at the recovery room. He went on to say, however, with respect to complications, "These events are rare, but they do happen, and that's why we're trained as specialists in anaesthesia to deal with these critical events in a timely fashion", so patients can survive. Dr. Liberman did not deal with Ms Stryland's complications in the most basic way, even though this was what he was trained for.

Besides having taken no responsibility for his actions and failing to demonstrate any insight, he has also been found to be dishonest. His integrity is questionable. These factors place the public at risk. The circumstances and findings are so outstandingly offensive to this Committee that in our view revocation is the most appropriate penalty.

#### *9. The Decision in the Dr. Yazdanfar case*

After the Committee had heard the evidence and submissions of the parties on penalty, another panel of this Committee released its decision on Penalty and Reasons for Penalty in the case of the *CPSO v. Dr. Behnaz Yazdanfar* (December 21, 2011). The Committee granted the parties leave to provide further written submissions in response to the decision in the Dr. Yazdanfar case. Dr. Yazdanfar is the doctor who conducted Ms Stryland's surgery. She worked with Dr. Liberman.

Dr. Yazdanfar was found to have failed to maintain the standard of practice of the profession and to have engaged in conduct or an act or omission relevant to the practice of medicine that would be regarded by members as disgraceful, dishonorable or unprofessional. She was also found to be incompetent.

The Committee ordered a two year suspension of Dr. Yazdanfar's certificate of registration and that she appear before the Committee to be reprimanded. The Committee also imposed very serious terms, conditions and limitations on her certificate of registration for an indefinite period of time. Following her suspension, she will only be

allowed to work as a surgical assistant in a hospital based setting with oversight of a qualified surgeon. The Committee rejected her request to be permitted to conduct pre- or post-operative assessments of patients. The Committee deemed that the restrictive terms were necessary to protect the public.

Dr. Liberman's counsel argued that the decision in Dr. Yazdanfar's case suggests that revocation is not an appropriate penalty in Dr. Liberman's case. (The College had also been seeking a penalty of revocation in Dr. Yazdanfar's case). He argues that Dr. Yazdanfar's care was deficient with respect to multiple patients while Dr. Liberman's care involved only Ms Stryland. He submits that there was no evidence Dr. Liberman fell below the standard with respect to any other patient or in any other respect. The Committee did find, however, that Dr. Liberman engaged in professional misconduct, in that he failed to maintain the standard of practice of the profession with regard to charting the patients' vital signs on admission to the recovery room in his care of 55 patients. In the case of Ms Stryland, Dr. Liberman's failure to determine what her vital signs were on admission to the recovery room set the stage for what followed.

Dr. Liberman's counsel argues that there are similar mitigating factors in both cases. He argues, for example, that neither doctor had previously appeared before the Discipline Committee. While this is true, the similarities end there. In the Dr. Yazdanfar case, the Committee notes that there was no evidence suggesting that Dr. Yazdanfar was not technically proficient in performing some surgical procedures and she had devoted time and resources to her education. In contrast, Dr. Liberman's competency is related to one circumscribed field of medicine. No evidence was presented that suggested he had other areas of competency in medicine. Although there was some evidence of his studying, this was quite informal, self-reported and seemed to be mostly related to the area of surgical liposuction, rather than anaesthesia. Although Dr. Liberman's counsel contends that Dr. Liberman is amenable to remediation, for the reasons set-out herein it is the Committee's view that this is not a viable option at this time.

With respect to revocation, the Committee in Dr. Yazdanfar's case stated that "serious sexual abuse, fraud, dishonesty and exploitation are undisputedly reasons for revocation of a member's certificate of registration..." (p.15). There was no finding that Dr. Yazdanfar had been dishonest. By contrast, the dishonesty and lack of integrity displayed by Dr. Liberman are serious aggravating factors.

This Committee agrees with the rationale in the case of *Law Society of Saskatchewan v. Nolin*, [2008] L.S.D.D. No. 158 at paras 102-103 and 105:

[...] Where a lawyer's behaviour is manifestly lacking in integrity, he or she does not meet the standard the public rightfully expects of all lawyers.

Where a lawyer's behaviour is incompatible with this standard he or she is unsuited for membership. It is not sufficient therefore to suspend his or her right to practise, while maintaining membership. [...]

[...] An individual lawyer may only sustain his or her identity as members of the profession if he or she maintains the highest standard of integrity. If his or her conduct in all the circumstances shows that he or she cannot be trusted, the lawyer does not meet the requisite standard of integrity and is therefore not suited for membership.

The Committee also considered the cases of *R. v Solowan*, [2008] 3 S.C.R. 309 and *R. v. L.M.*, [2008] 2 S.C.R. 163, in which the Supreme Court of Canada dismissed the "worst offender, worst offence" rule in the context of criminal sentencing. The Committee agrees that the penalty must be proportional to the gravity of the findings. Although like cases should be treated in a like manner, no two cases are identical. This Committee's view is that revocation is the appropriate remedy in this case.

The effect of Dr. Liberman's revocation will mean that he will be able to apply for a certificate of registration after one year. Dr. Yazdanfar has been suspended for two years and will have very serious terms, limitations and restrictions placed on her certificate of registration for an indefinite period of time. Although Ms Stryland was a patient of both

Dr. Liberman and Dr. Yazdanfar, the penalties in each of these cases reflect the specific findings made by each panel of the Discipline Committee. This Panel notes, however, that the penalty in Dr. Yazdanfar's case is not a lenient one.

### **Reprimand**

The Committee finds that a reprimand is appropriate in this case as it is an expression of the profession's abhorrence for the actions of Dr. Liberman. It is an appropriate mechanism to condemn his actions which were disgraceful, dishonourable and unprofessional.

### **Costs**

The Committee has decided to order costs against Dr. Liberman in the amount of \$62,050 to compensate the College for the expense of conducting the hearing. This figure is calculated at the rate of \$3,650 per day for seventeen days of hearing.

In coming to its decision regarding costs, the Committee reviewed the submissions of the defence and the College on costs. Defence counsel argued that it was unnecessary for the College to call two witnesses and the paramedics to testify on the same set of facts. He also argued that the evidence of the internist at the hospital, Dr. G, could have been admitted on consent as the defence did not wish to cross-examine him. The Committee concluded hearing the evidence from these witnesses assisted us a great deal. They put the condition of Ms Stryland into perspective in a way nothing else could have.

In addition, although there was an abbreviated day arising out of a response to a motion, the original objection arose from the defence. Defence counsel was concerned that in order to be able to speak to his client prior to the closing arguments, Dr. Liberman's testimony needed to be concluded in the penalty phase of the hearing. That necessity was accommodated. The defence had another witness who could have been called on that day but he was not.

Notwithstanding the arguments of defence counsel on Dr. Liberman's behalf, the

Committee's view is that the costs are appropriate. There are no compelling reasons to alter them.

### **Conclusion**

In summary, Dr. Liberman abdicated responsibility for Ms Stryland during the time she was under his care. He exhibited deficiencies in his judgement and/or knowledge. He did not convince the Committee that he has any insight or understanding of his deficiencies. Given the particular facts of this case, a reprimand and revocation of Dr. Liberman's certificate of registration is appropriate. The Committee hopes that this penalty will serve as a general deterrent to remind the members of the profession that patient safety must come first. Competence, adherence to professional standards and integrity are essential requirements for those who enjoy the privilege of membership in the College.

A reprimand will express the Committee's and the profession's abhorrence of Dr. Liberman's actions and will further function as a general and specific deterrent. Maintaining the integrity of the profession in the eyes of the public will be enhanced by the penalty decision. Patients need to know that high standards are expected of physicians. Honesty, integrity, willingness to self-evaluate and address areas of weakness in their care as part of their profession is the norm for physicians in this province. Public trust in the profession is paramount and the penalty ordered will serve that end.

### **ORDER**

The Discipline Committee therefore ordered and directed that:

1. The Registrar revoke Dr. Liberman's certificate of registration, effective as of the date of this Order.
2. Dr. Liberman appear before the Panel to be reprimanded, on a date to be fixed by the Panel, which shall be no later than three months from the date that this Order becomes final.
3. Dr. Liberman pay costs to the College in the amount of \$62,050, within 6 months of the date of this order.