NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Behnaz Yazdanfar, this is notice that the Discipline Committee ordered that there shall be a ban on the publication of the name or identity or any information that could disclose the identity of the patients whose names were disclosed at the hearing, or in the documents filed at the hearing, except for the names of Ms Krista Stryland or Ms Francine Mendelson, pursuant to 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.

College of Physicians and Surgeons of Ontario and Dr. Yazdanfar

Decision and Reasons for Decision

INDEX

Indexed as: Yazdanfar, B. (Re)

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

IN THE MATTER OF a Hearing directed by the Complaints Committee, the Executive Committee and the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Sections 26(2), 36(1), and 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***, S.O. 1991, c.18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. BEHNAZ YAZDANFAR

PANEL MEMBERS:

DR. M. DAVIE (Chair)
S. DAVIS
DR. P. CHART
S. BERI
DR. P. TADROS

Hearing Dates:	**2009:** July 13 to 17, 22 to 24, September 14 to 16, 18, 21, 22, 30, October 1, 2, November 2 to 6, 9 to 12, 18, 23, 24, 26, 27, 30 and December 1, 2, 9 to 11 **2010:** January 11, 12, 20 to 22, February 8, 17, 18, 22, 23, March 1 to 4, 22, 23, 25, 30, 31, April 12 to 16, 20, June 7 to 10 and July 21 and 22, 2010**.**
Decision Date:	**May 4, 2011**
Release of Written Reasons:	**May 4, 2011**

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario ("the CPSO") heard this matter over sixty-eight days at Toronto on: July 13 to 17, 22 to 24, September 14 to 16, 18, 21, 22, 30, October 1, 2, November 2 to 6, 9 to 12, 18, 23, 24, 26, 27, 30 and December 1, 2, 9 to 11, 2009; January 11, 12, 20 to 22, February 8, 17, 18, 22, 23, March 1 to 4, 22, 23, 25, 30, 31, April 12 to 16, 20, June 7 to 10 and July 21 and 22, 2010**.** At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATIONS

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

1. she failed to maintain the standard of practice of the profession, under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O.Reg. 856/93");
2. she has contravened the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts, under paragraph 1(1)27 of O.Reg. 856/93; and,
3. she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, under paragraph 1(1)33 of O.Reg. 856/93.

It is also alleged that Dr. Yazdanfar 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").

RESPONSE TO THE ALLEGATIONS

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

PREAMBLE

The *RHPA* requires that those providing medical and surgical treatment to patients hold a certificate of registration with the College. This is in the public interest as those holding such registration are held to accepted professional standards and are trusted by the public to act in the best interests of patients.

Elective cosmetic surgery is not part of the Ontario public health care system, nor is it regularly covered by OHIP. It has proven to be a popular business venture and has provided some physicians with incomes outside of traditional practice. The costs charged for cosmetic procedures are typically borne by the patient. Within the medical profession, there are differences of opinion as to the qualifications that are necessary to perform cosmetic surgical procedures. The demand for cosmetic surgery appears to be increasing and physicians, other than certified plastic surgeons, have moved into this field. Aspects of the regulation of cosmetic surgery are currently under review. These issues are not the subject matter before the Committee but they provide a context, which needs to be acknowledged.

In this case, strongly held opinions make it important to ensure that the issues to be decided are not clouded by a debate extraneous to the issue of appropriate medical care. The issues that were raised before the Committee regarding a turf war, or the profitable aspects of elective aesthetic surgery, played no role in our decision. This case is about one doctor and the medical care she provided to her patients.

OVERVIEW OF THE CASE

Dr. Yazdanfar is a Canadian trained physician, qualified in family practice. Since 2003, she has focused her practice on cosmetic surgery and has chosen to limit her practice to the operative procedures of liposuction and breast augmentation. She is the owner and operator of the Toronto Cosmetic Clinic (TCC).

The allegations against her arise from complaints to the College and the investigation carried out by the College as a consequence of a tragic death following liposuction surgery at the TCC.

The Executive Committee of the College issued an interim order under s.37 of the Code on May 26, 2009, which prohibited Dr. Yazdanfar from performing all surgery, except as a surgical assistant in a hospital based setting. She was also restricted from performing any pre or post-operative care. On March 4, 2010, the Discipline Committee varied the Order to allow Dr. Yazdanfar to do limited pre-operative and post-operative care and to act as a surgical assistant in a free standing cosmetic facility, as well as in a hospital based setting, as long as a member of the CPSO who is approved by the College is performing the surgery and in attendance.

The College alleged that Dr. Yazdanfar failed to maintain the standard of practice in her care of three liposuction patients treated in 2007 (Krista Stryland; Francine Mendelson; Ms MP); and, in her care and treatment of two breast augmentation patients in 2007 and 2008 (Ms WX; Ms QR). The College also asked for a finding of disgraceful, dishonourable or unprofessional conduct and a finding of incompetence related to these patients.

Also, the College alleged that Dr. Yazdanfar failed to maintain the standard of practice and is incompetent in her care of a number of liposuction and breast augmentation patients in her cosmetic surgery practice between 2005 to 2007, as identified by a s.75 investigation. The College also alleged disgraceful, dishonourable or unprofessional

conduct in regard to aspects of care of these patients and to her clinic's communication with another patient in 2008 (Ms GR).

Further, the College alleged that Dr. Yazdanfar's website advertising contravened the advertising regulation under the *Medicine Act*. This allegation specifically refers to the use of misleading information, including the use of testimonials and /or superlative statements on her website. Dr. Yazdanfar brought a constitutional challenge to the advertising regulation, which is dealt with by the Committee in a separate written decision. The College also alleged disgraceful, dishonourable and unprofessional conduct related to several aspects of Dr. Yazdanfar's website advertising.

Dr. Yazdanfar denied these allegations.

The Committee heard evidence from a number of experts involved in the field of cosmetic surgery, plastic surgery and other disciplines. The Committee received extensive documentary evidence and heard the evidence of 52 witnesses, including many patients and some family members.

The Committee was required to examine standards of practice in a number of complex areas and determine the allegations of a failure to maintain standards. In some instances, the standard to be applied was in dispute and the parties vigorously put forth evidence in support of their respective positions. Areas of dispute included aspects of informed consent, the standard applicable to liposuction in Ontario, breast augmentation techniques, and booking procedures and payment requirements.

The Committee carefully scrutinized the evidence with respect to individual patient care to ascertain if the allegations were made out. This is set out in detail in the decision and reasons which follow.

SUMMARY OF THE EVIDENCE

Documentary Evidence

The Committee accepted into evidence 211 numbered exhibits. These included: patient charts; guidelines, policies and regulations; various photographs, diagrams, videos, CD's, and e-mails; transcripts; website excerpts; *curriculum vitae*; various legal documents; and, referenced articles and texts.

Oral Evidence

The Committee heard many witnesses over the course of this proceeding. A summary of the testimony is organized in three parts: Part I – Fact Witnesses for the College; Part II – Fact Witnesses for the Defence; and, Part III – Expert Witnesses.

Part I – Fact Witnesses for the College

To provide meaningful continuity, the testimony of the witnesses is organized in relation to the subject patients as follows:

Krista Stryland

i) Dr. C
ii) Dr. G
iii) Dr. B
iv) Mr. AB
v) Ms CD
vi) Mr. H
vii) Mr. X
viii) Mr. Y

Francine Mendelson

i) Mr. NO

ii) Francine Mendelson

iii) Dr. AC

Ms MP

i) Ms MP

Ms QR

i) Ms QR

ii) Ms YZ

iii) Mr. UV

Ms WX

i) Ms WX

Patients in Cosmetic Surgery Practice from 2005 to 2007 and a Patient in 2008

i) Ms ST

ii) Mr. AZ

iii) Mr. BY

iv) Ms CX

v) Ms DW

vi) Ms EV

vii) Ms FT

viii) Ms GR

ix) Mrs. HP

Other Witnesses

i) Ms JD

ii) Ms AR

iii) Ms BW

iv) Mr. RV

v) Ms JZ

Part II – Fact Witnesses for the Defence

i) Dr. Behnaz Yazdanfar

ii) Mr. R

iii) Dr. E

iv) Ms GB

v) Dr. F

vi) Nurse Q

vii) Nurse J

Patients

i) Mr. DQ

ii) Ms KM

iii) Ms KY

iv) Ms SB

v) Ms LV

vi) Ms XO

vii) Ms EK

Part III - Expert Witnesses

i) Dr. A (College)

ii) Dr. GH (College)

iii) Mr. P (College)

iv) Dr. O (Defence)

v) Dr. K (Defence)

vi) Dr. L (Defence)

vii) Dr. N (Defence)

viii) Dr. GI (Defence)

ix) Dr. T (College reply)

In its reasons, the Committee sets out its view of the credibility of each witness following a summary of that witness's evidence. That credibility assessment takes into account all of the evidence at the hearing that the Committee has admitted and weighed.

Part I – Fact Witnesses for the College

Regarding Patient Krista Stryland (Liposuction)

Dr. C

Dr. C graduated from an Ontario university in medicine in 1981 and was certified by the Royal College of Physicians and Surgeons of Canada (RCPSC) in Anesthesia in 1985. He works at private clinics and is not hospital based, although he has worked in hospitals in the past. He started working at the TCC in 2005. He described his work as piecemeal, with no formal number of hours or set pay. He worked approximately three mornings a week, seeing one to three patients each morning, and Saturdays, when he could work more. He was paid on the basis of time for cases in the operating room down to the number of minutes, but this changed, he believes, after September 20, 2007, when he was paid more to cover time at the end of the day.

Dr. C had very limited recall of specific details regarding much of what happened on September 20, 2007.

Dr. C testified that, normally, he, Dr. Yazdanfar, Mr. H, and a nurse are present in the operating room (OR). Continuous monitoring in the OR includes ECG, blood pressure (BP) every five minutes, pulse oximeter, temperature, expired carbon dioxide and level of the anesthetic gas. No print-outs of the readings are done; he makes a little check to record the BP on the anesthetic record and he is always the one who does this. The last BP on the chart is done just before the dressing is applied.

Dr. C testified that Dr. Yazdanfar made it clear that she was to control the amount of intravenous fluids that liposuction patients receive in the OR (Vol. 6 p.174-175).

Patients are always awakened in the OR by giving oxygen and reversing paralytic agents. They are then extubated and a dressing is applied. They either move themselves, or they are assisted to the transfer stretcher, and are wheeled to the recovery room (RR).

Dr. C testified that he is at the patient's head 99% of the time. In the RR, the nurse puts on the monitor, a warming blanket and does mouth care. The RR monitor is set lower and may not be loud enough to be heard in the OR. Patients may remain in RR from one hour and twenty minutes to overnight. He usually stays in the clinic for one hour but often leaves the clinic before the patient and, then, is available by pager. He testified that he is responsible for any anesthetic problem, not a surgical problem. Dr. Yazdanfar and he share responsibility overall.

In respect to Ms Stryland, Dr. C testified that he had no recall of the patient prior to surgery. It was his usual practice to go through the chart and lab work. Dr. Yazdanfar usually decides the type of anesthesia, usually a general anesthetic. "Dr. Yazdanfar usually tells me before I meet the patient." (Vol.4, p.126, line 18) All values were normal. An antibiotic was given. He assessed her as RC 1 (completely healthy).

10:08-1:08 (surgery)

Dr. C did not mix the subcutaneous infiltrate. Ms Stryland's anesthesia was reversed with Zemuran at the end of the procedure. IV fluids (3400 ml of Ringers Lactate) were given during surgery. Dr. C testified that he eyeballed the total liposuction fluids extracted at 5900 cc. Ms Stryland was extubated between 1:00 and 1:12 p.m. Dr. C had no recollection of who was in the room then, or about the transfer to the RR, but believed that Ms Stryland helped in moving herself. The last BP recorded on the anesthetic record at 1:15 p.m. was 110/70.

1:08-1:38 p.m. (RR)

Dr. C indicated that he was in the vicinity of the RR from 1:15 to 1:35, or so. ECG, pulse oximeter and BP were monitored. He was aware of a BP taken in the RR of

approximately 60/28 and a normal heart rate (HR) at 1:15 p.m., or believes he was aware. Dr. C testified that he does not just look at BP but also the vitals, and he felt it was highly likely he was aware of the vitals. A bolus of 1000cc's of Ringers Lactate (RL) was given at 1:15, but he could not recollect whose decision this was or how quickly it was given. When asked about the patient's anticipated response, Dr. C eventually answered that he would have preferred a larger response. He did not think this situation alarming.

At 1:20, Ms Stryland's BP was still low but she was warm, pink and conscious. Dr. C had no further recollection about how long he remained in the RR and guestimated that she received between 500 and 1000cc's of RL before he left. By 1:30, her BP was 60/28 with a HR of 76 (Vol.6, p.72) and oxygen was given by face mask (usually applied by the nurse on her own). He strongly believed that he spoke with Ms Stryland, but has no independent recollection of what took place between 1:20 to 1:35. He agreed that there had been no improvement in her vital signs up to 1:35. He did not feel she was on the verge of shock, nor did he believe that her BP was extremely low.

Dr. C testified that he strongly believes Dr. Yazdanfar was in the RR, but cannot remember for how long; normally, she would be aware of the vitals. He agreed the records show he went to the OR at 1:38 p.m. to start the next case. He testified that either Nurse Q or Nurse J popped in and gave him an update on Ms Stryland at least a couple of times. He popped into the RR to check her, a couple of times, but couldn't recall the time (he was 99% sure that it was before 2:45). The general sense he got was that there was no change. Dr. C testified that he believed that Dr. Yazdanfar would be aware of everything the nurse said to him. When he checked Ms Stryland, she was awake and talking, not cold or clammy, pale or sweaty, and this puzzled him.

Dr. C testified that he probably ordered more RL solution but could not recall asking the nurses to put Ms Stryland in the Trendelenberg position or seeing her in that position. He believed he discussed with Dr. Yazdanfar that the patient looked better than her BP.

Around 2:45 p.m., the nurse came in and reported an acute change; BP was down, HR up and there was a decreased level of consciousness. Dr. C testified that Dr. Yazdanfar was aware of the change. He did not recall any discussion about who would go. He went to Ms Stryland. She was being ventilated by mask. He returned to the OR to get his laryngoscope and endotracheal tube and instructed Mr. H to look after the OR monitor. He intubated her, started more IV's, and ran in more fluid under pressure. The nurse inserted a Foley catheter and he assisted Ms Stryland's ventilation.

Ms Stryland's BP came up and her consciousness improved. Dr. C indicated that she fought against them and they needed to hold her down. She perked up for between one to thirty minutes. The systolic BP came up to 110. However, her pulse remained fast and she was not stable. Dr. C testified that he had changed his opinion in regard to her stability from the information that he had provided earlier to the College by letter (exhibit #44 - December 2007), in which he described her condition as very stable during this time. Dr. C had no explanation regarding the lack of chart entries after 14:45. He may have gone back to the OR but cannot recall.

Dr. C testified that Ms Stryland then had a second fall in BP associated with an outpouring of fluid from all of her wounds. A second abdominal binder was applied; there were three IV's, two with pressure pumps, and they poured in fluids (he could not say how much). Dr. C testified that he agreed that he told the College that Dr. Yazdanfar was there for a large part of the resuscitation but, during his testimony, he could not recall, other than that he had a distinct memory of her squeezing the Ambu-bag. He did not recall Dr. Yazdanfar asking if he needed anything from the crash cart. Under cross examination, he admitted that he could be wrong. During this time, he recalled no discussion with Dr. Yazdanfar about possible diagnoses. He was 99% sure it was Dr. Yazdanfar who called 911. No epinephrine was administered before emergency medical services (EMS) arrived, though a crash cart was available.

When the paramedics arrived, Dr. C testified that Ms Stryland was not conscious, and was not fully breathing on her own. Dr. C's recollection was that her BP was 100/55 and,

when moved to the ambulance stretcher, there was a change. He could not explain why 911 was called if her BP had improved. He had no explanation of why nothing was written after 2:45. He said CPR was started on the ambulance stretcher, but was not 100% sure.

Dr. C testified that he agreed to write a resuscitation note, which he did the next day and which he showed to others, including Dr. Yazdanfar, so there was no misunderstanding. They have subsequently discussed the case many times. When taken to the Guidelines to the Practice of Anesthesia, Dr. C disagreed with the aspect of the guidelines that said there is only one responsible physician in the post-anesthetic period, as some complications may be surgical. He did not recall calling Ms Stryland a whiner and did not believe his role was to diagnose surgical complications. He had no working diagnosis and still does not know why she died.

When taken to the record of the patient who followed Ms Stryland (Mr. AK), Dr. C admitted to writing his BP readings in at 16:20. He may have asked Mr. H about the trend line for Mr. AK and Mr. H was there all the time. He denied that the BP readings on the OR record for Ms Stryland could have been done the same way.

Dr. C was questioned regarding a note made by Nurse Q titled a “Personal Log”. He believed he first saw this note on Saturday, September 22, 2007, when it was given to him at the TCC by Dr. Yazdanfar’s husband in his office and he assumed it would be part of Ms Stryland’s chart. He did not recall any discussion about it or speaking to anyone about it. He specifically had no recall of discussing the note with Nurse Q.

Dr. C was asked to make a resuscitation note for the chart and did this on September 21, 2007. Dr. C testified that, in the afternoon or evening of September 20, 2007 after Ms Stryland left the TCC, he jotted notations that consisted of points to assist him in making a summary. He was unsure whether he took a copy of the anesthetic record or the RR record with him as well. He could not recall any details of the notations and shredded or tore them up. He discussed his resuscitation note with Dr. Yazdanfar and her husband,

showed it to Nurse J and discussed it with Nurse Q on the phone. When asked about these events again, his recall was unclear.

The Committee was dismayed by Dr. C's consistent lack of recall for significant and relevant events. His evidence was unreliable in a number of areas and his memory lapses too extensive to accept. There were admitted inconsistencies in his evidence. He described Ms Stryland as "very stable" during the period after intubation and bolusing of IV fluid up to 3:35 in his letter to the College. He then agreed in his oral evidence she was not stable. His testimony that her BP was 100/55 when EMS arrived was inconsistent with the evidence of both paramedics who responded to the EMS call and whose evidence is supported by their documentation (exhibit #30). His memory was poor for important events in the RR period. Many responses were evasive. He avoided answering some questions altogether on what the Committee believed was the pretext of failing to understand familiar terms and concepts. His evidence in regard to jotting down notes was consistent with the forensic document examiner's findings, though some of the values differed between what was jotted down and what was entered into the resuscitation note.

Dr. G

Dr. G testified that he currently is a general internist/hospitalist at the Toronto hosptial to which Ms Stryland was taken and was on call on September 20, 2007, when Ms Stryland was admitted (4:25 p.m.). He was paged to the emergency room (5:00 p.m.) where she was intubated, having chest compressions and receiving fluids or blood products. She was in shock on arrival. Dr. V was the emergency room physician in charge.

Dr. G observed oozing of serosanguinous fluid from multiple puncture sites from the pelvis to the knees, to the extent that drainage poured out when she was turned. She was cool to cold. Pupils were fixed and dilated. He spoke to a nurse who accompanied the patient from the clinic and learned that the patient had had elective liposuction. She became mildly hypotensive after surgery, had copious bleeding from more than one site and became unresponsive. She was intubated, and was reportedly given twelve litres of RL. Pre-operative Hgb was 120 [12 g/l]. Her blood tests in emergency indicated**:**

- Hgb was 6gm/l (critical)
- Hct 0.026 (critical, she had lost almost all her red blood cells)
- Platelets 26 (critical)
- INR > 9.00 (critical)
- PTT > 150.0 (critical)

The absence of Vitamin K and other clotting factors helped explain her ongoing bleeding. He suggested another central line be added and called Dr. HQ (5:30 p.m.) who was more skilled at this and who quickly came and stayed. He left after 6:07 p.m. to see other consults.

His diagnosis in order of importance was:

1. Hemhorragic shock
2. Cardiac arrest
3. Rapid atrial fibrillation
4. Disseminated intravascular coagulation (DIC)
5. Profound hypothermia and severe thrombocytopenia, post blood, platelet and fresh frozen plasma transfusion.

He considered that Ms Stryland developed a series of complications from the surgery that led to her demise.

The Committee accepted Dr. G's evidence as credible. His evidence was clear and concise and was consistent with the documentary evidence.

Dr. B

Dr. B is a plastic surgeon who works out of the Toronto hospital to which Ms Stryland was admitted and has a clinic in his office. He was certified in 2002 by the Royal College, and he does both plastic and cosmetic work. On September 20, 2007, he was

called at home during dinner by the general surgeon on call to give an opinion on a patient who had liposuction and was being resuscitated.

He was not on call but the plastic surgeon on call was operating and unavailable. The question was whether the patient needed to go back to the OR. He was there within five to seven minutes. He was told on the phone that the hemoglobin was 6, the vital signs absent and the patient was bleeding profusely from multiple puncture sites.

When he arrived, there were multiple people present in the resuscitation room and the patient was having chest compressions. A radiologist was doing ultrasound at the bedside (no blood was seen in the pleural or pericardial spaces and there was hardly any fluid in the abdomen or pelvis). He observed multiple puncture sites, including the axillary area, which made him worry about organ puncture. He spoke to the nurse who came in the ambulance with Ms Stryland and then he called Dr. Yazdanfar and asked if there was a potential for organ puncture.

The call lasted a few minutes. Dr. Yazdanfar inquired how the patient was doing and he told her that he did not think she would survive. He did not feel there was a reason to go to the OR and the patient was in no state to do so.

He received a call from the College on September 21, 2007, asking if he wished to file a complaint against the doctor who did the liposuction. He said no. Two months later, he was served papers that he was being sued by Dr. Yazdanfar for statements that he was alleged to have made that caused her business to decline.

During cross examination, he denied saying “Where is the family, this is going to be a lawsuit” or “Maybe this will shut her down for good”.

Dr. B gave his evidence in a clear manner which was consistent with others on the scene at the Toronto hospital and with documents filed. Under rigorous cross examination, he expressed offense when motives of bias and vindictiveness were attributed to him.

Mr. AB

Mr. AB gave evidence that he was married to Ms Stryland in 2001.They had a son in 2004, separated in 2005 and divorced in 2007. Subsequently, they had a good relationship as friends and co-parents.

She called in early September 2007 wanting help with ferrying to liposuction and caring after the surgery. He voiced concern but later agreed after looking up the TCC website. The impression he had was that liposuction was safe, with minor side effects, and she would be back at work in two days.

He dropped Ms Stryland off at the TCC. He was her emergency contact and was to be phoned one hour before she was to be picked up. He called at 1:20 p.m., was advised she was finished, groggy and needed time to recover. He called again at 2:45 p.m. and was told someone would call him back within five minutes. As there was no response, he left to go there and called again on the way with the same response.

Mr. AB arrived at the TCC at 3:30 p.m. He saw the ambulance pull up, went inside, was put in a room and was told Ms Stryland lost a little blood and was being transferred to a Toronto hospital for observation. He did not speak with Dr. Yazdanfar. They gave him Ms Stryland's personal effects.

Mr. AB testified that he went in the ambulance with the paramedics and was shocked by Ms Stryland's appearance. At the hospital, they closed down the ER and worked on her exclusively, but she passed away between 6 and 7 p.m. Her sister and husband were there and his father. He was not called by anyone from the TCC, including Dr. Yazdanfar.

The Committee found Mr. AB's evidence to be clear and corroborated by others. His recall of details was good and he gave testimony in an objective manner. Overall, he was judged to be a credible witness.

Ms CD

This 41 year old lady gave evidence that she was the best friend and colleague of Ms Stryland since 2005. She knew her friend was contemplating liposuction. They googled liposuction/Toronto and compared the site of Dr. VS and the TCC.

She said that Ms Stryland felt that the TCC were the experts, liked the before and after shots and the testimonials. They were going to use a new technique that was safer and would go right down to muscle, which made her excited.

The Committee found her evidence to be credible, straightforward and clear though she was emotional and was brought to tears upon discussion of her friend.

Mr. H

Mr. H testified that his role at the TCC is surgical assistant. He has a medical degree and had practised in Asia. He assists a number of doctors but mainly Dr. Yazdanfar. During surgery, he preps and cleans the skin, holds the suction tubing, passes instruments and positions and holds the patient. He mixes the tumescent solution with the nurses.

Before Ms Stryland's death, he would assist Dr. Yazdanfar on request with infiltration of the tumescent solution and aspiration of fat and fluids. He did this at the beginning of surgery and usually only for the large sized patients (big cases, big areas) as the procedure is longer and the fat harder to take out. He stopped doing this several weeks after Ms Stryland died (Dr. Yazdanfar just did not ask him to do it any more). He agreed there were two aspiration pumps and sometimes he would operate one and Dr. Yazdanfar the other. There was one infiltration pump used with a needle to inject the tumescent solution and he and Dr. Yazdanfar would take turns.

Mr. H testified that he was there on September 20, 2007, for Krista Stryland's surgery. He did not do either infiltration or aspiration on her. He remained in the OR the whole time. He generally remembers that she was fine. She was awakened by Dr. C giving her medication and he thinks they helped her to move or slide slowly to the stretcher.

At some point in the next surgery, the nurse came in to talk to Dr. Yazdanfar and Dr. C about Ms Stryland. He recalled the nurse coming in a couple or three times, talking very fast, something about blood pressure. He could not remember if Dr. Yazdanfar or Dr. C did or said anything. Dr. Yazdanfar asked Dr. C to go to check and he did. He could not remember when the nurse came in, but thought it was past the middle of the surgery. Dr. C went out first, and then after the nurse came in again both Dr. Yazdanfar and Dr. C went out and then came in and out.

He thought he was alone in the OR with the patient for about thirty minutes. Dr. Yazdanfar came back and finished the surgery. He could not remember if Dr. Yazdanfar and Dr. C came back together.

He acknowledged that the TCC is being sued over the Krista Stryland matter and that he is included.

The Committee was struck with his lack of recall of the events of this day and the remembering of some facts and not others. While there was some language difficulty, the Committee was not convinced that Mr. H's evidence was as fulsome as it could have been. He was recalled by the College prior to the closing of its case, at which time an interpreter was provided (notwithstanding his assertion that he understood the questions) mainly to assist the panel in hearing his evidence. The Committee granted leave to counsel for the College to cross examine having been satisfied that he was a hostile and unforthcoming witness. He remains employed at the TCC.

Mr. X

Mr. X gave evidence that he is a level three paramedic. He was on duty September 20, 2007, when notified of an emergency at 15:52 p.m. They arrived at the TCC at 15:57 p.m., where they initially went to the back. Finding poor access and no one there, they came to the front entrance and followed staff to the patient.

Mr. X testified that he found Ms Stryland to be chalky white, very ill, lying supine with legs elevated, with spontaneous but ineffectual breathing, and lying in bloody fluid with a compression type stocking over her legs and torso.

He spoke to a female physician who gave them a brief history, which included a 32 yr old woman who underwent liposuction and about one hour later became unresponsive. He spoke to no male physician and did not know an anesthesiologist was there. He asked if she was sedated prior to intubation and was advised no. This indicated to him that she was much more ill and had been unconscious when intubated. EMS was called forty minutes later. He was told she lost a lot of blood (two to three litres).

The nurse continued to ventilate using a mask, the cardiac monitor was put on and, at 16:05, vital signs were absent and CPR started. She was transferred to the ambulance stretcher (16:08) was given the epinephrine and then atropine (16:10). This was repeated several times and they left for the hospital at 16:18, arriving there at 16:23. At 16:20, the cardiac monitor showed PEA (pulseless electrical activity) at 30 to 40.

Mr. X testified that he asked the nurse to accompany them to the hospital to be able to answer questions, which she did along with the patient's former husband. Firefighters were doing the chest compressions. In the ambulance, the nurse [Nurse Q] appeared a little shocked at the patient's condition. She said twelve litres of fluid were given before EMS arrived and that the patient had been hypotensive for roughly one hour and forty minutes before 911. This is noted in his incident report [exhibit #31]. This was her second day on the job and would be her last. He understood her to be frustrated with the care and treatment. She said she mentioned the drop in blood pressure several times, and was just to continue to give fluid. She thought a lot of fluid was given and a long time was waited to call the ambulance. (Vol.4, p.48-49)

When asked if her BP was 100/55, HR 110, and oxygen saturation 100% on their arrival, he responded not when he saw her. He filled out an incident report the next day (exhibit #31).

The Committee was impressed with the evidence given by Mr. X, which was clear, unbiased and objective. His evidence was consistent with his written report and with his partner's evidence as well as others. He was considered to be a credible witness

Mr. Y

He is a level 2 paramedic who responded to an ambulance call on September 20, 2007, to the TCC just before 4:00 p.m. Along with his partner, Mr. X, they responded to a code Delta (meaning health or safety at risk). They arrived at 3:57 and went first to the back of the TCC as directed. When there was no one there, they unloaded and proceeded to the front entrance.

He went directly to the patient who looked very sick. She was intubated and the nurse was on the airway. The patient was not communicating, was ashen and was lying in a pool of pink fluid. She had on a body bandage or girdle. He could not feel a carotid pulse. Numerous IV's were running. He put on their cardiac monitor and transferred her to the ambulance stretcher. Vital signs were absent (VSA) and he proceeded with CPR. She had no blood pressure at that time. When they moved her, the staff put an apron on him to avoid soiling as the fluid came over in a wave.

There was some chaos there and his partner talked to one of the physicians. The nurse remained on the airway. They left TCC at 4:18 and drove to the hospital, arriving at 4:23 with Ms Stryland's husband in the front seat and Mr. X, the firefighter and the nurse in back. He filled out an incident report the next day (exhibit #21).

The Committee found this witness to give credible evidence consistent with the documentary evidence and the testimony of others. He delivered this in a professional and unbiased manner.

Regarding Patient Francine Mendelson (Liposuction)

Mr. NO

This 70 year old man, husband of the patient, testified that he brought his wife to the TCC on July 11 or 12, 2007, for liposuction. He had not attended any pre-operative visits, but understood the operation was a simple routine thing. He was supposed to pick her up at 3 p.m. but she was not ready, her garment was wet and they had to wait until it was washed and dried.

At 5 p.m., she was still groggy, incoherent and in pain. He thought she looked horrible and asked how he was going to look after her. When he asked if she could stay for the night, they told him no, there were no facilities to keep her overnight. In a wheelchair and with the assistance of a lady, they got her into the car. It was an ordeal getting her from the car to their apartment. He described that so much blood was coming out of her that he tore green garbage bags in half to cover the mattress.

He did not recall being given an instruction sheet, but admitted they must have given us something. He called his daughter, as he did not know what to do. He described his wife as bleeding all over the place and that her garment was saturated and she was in terrible pain.

When the daughter came around 7 p.m., she was very concerned. She stayed overnight. He looked after her for the next few days, except when his daughter came in after work.

They went back to the TCC two days later, when his wife saw a nurse and Dr. Yazdanfar while he was in the waiting room. They were told she needed an ultrasound. Two staff members went also in a different car. She walked very slowly and was in pain. No results were given.

He next recalls that sometime later they went out for the first time to dinner on Saturday evening and his wife received a call and was warned that if she had chest pain to go to the hospital. He was scared.

On Monday, they went to see her family doctor who did another ECG and told him to take her to the hospital immediately. He took her to a Toronto hospital where she remained for five days. At a later time, she went back to the TCC for some kind of treatment and she went on her own.

The Committee found Mr. NO to be a truthful witness whose evidence was consistent with others and with the relevant documents. Minor inconsistencies, such as whether a shower curtain or green garbage bags or both covered the bed, were noted. He was elderly and his memory for some details, such as receiving an instruction sheet(s), was poor, but his memory of the events in question, in particular his wife's condition, was good. He understood and responded appropriately to questions.

Francine Mendelson

This 68 year old lady gave evidence that she was interested in Smartlipo, which she understood was an easier form of liposuction. She passed the TCC many times, finally went in and got a card, noting all the people there looked beautiful. She looked up Dr. Yazdanfar on the computer noting her training and license and made an appointment.

She and her daughter met Ms D, the patient consultant, on her first visit on June 20, 2007, at which time they talked about liposuction. Ms D told her she was a good candidate. Prices were discussed. There was a $500.00 deposit and the balance was to be paid in full before meeting the doctor. She understood that 50% was nonrefundable and had initialed this.

With respect to risk, Ms Mendelson testified that Ms D may have discussed this but all that she recalled was that she was a good candidate. She was never told of a risk of death, heart problems or of an increased risk because of her age either then, or later, by Dr.

Yazdanfar. She paid the deposit, returned on June 28, 2007, and met with Ms D to review and sign a stack of papers. She initialed the forms acknowledging risks of swelling, pain, bleeding, bruising and rarely blood clots, but barely looked at them. She testified that they talked about it a little, but Ms D gave her the impression that these things were not going to happen. There were no serious risks to her health discussed and she felt confident.

After paying in full on July 9, 2007, she and her daughter met Dr. Yazdanfar for a detailed discussion. The meeting went well. Dr. Yazdanfar said, “I was a great candidate”. A physical examination may have been done and she was sent for pre-operative blood work and an ECG. Photos were taken and Dr. Yazdanfar drew lines where fat was to be removed. She did not think there was a discussion of volume to be removed or increased risk related to increased volume.

On July 11, 2007, her husband drove her to the TCC at 9 a.m. The next thing she recalls is being in the recovery room and hearing one of the nurses saying, “we can’t send her home like this”, and then they put a damp garment back on her. She did not recall being given paperwork to go home with. She had little recall of the details of her trip home, other than pain when the nurse and her husband shifted the car seat. Her daughter came over and, at that time, she was having a lot of pain and was very wet. Her daughter took off her garment, washed and dried it and put it back on and covered her with a blanket as she was cold.

She returned to the TCC on July 13, 2007 with her husband. She was very weak, very, very sore and walked bent over. They sent her for an ultrasound as there was swelling in her stomach. Two of the clinic staff went with her, but in a different car.

She recalls standing in the waiting room, because if she sat down more stuff came out of her. She found it very difficult to get on the table and recalls a doctor coming in and saying, “My God what has happened here, this is brutal”.

She and her daughter attended the TCC the next week, at which time she was weak and still in quite a lot of pain. Dr. Yazdanfar said her recovery was normal, everything looked good and, at one point, said something about her age and that maybe it was taking longer because of her age or words to that effect. This shocked her. She found Dr. Yazdanfar's demeanor to be defensive and her daughter was a little upset when they left. More blood work and another ECG were ordered and done the next day.

Ms Mendelson did not recall anyone from the TCC calling her to make an appointment for the next week or saying that her tests were abnormal. She did not hear about the test results until Dr. Yazdanfar called her Saturday evening on her cell phone while she was out for dinner. She was told that her ECG showed changes and her Hgb went from 145 to 92 and that it would take some time to come back. She was told, if she had chest pain, to go to the ER. She responded I have so much pain I don't know where it is coming from.

There was no mention of going to her family doctor. She saw him because her daughter insisted. She called the TCC to have her reports sent to her family doctor. He repeated her ECG and sent her to a Toronto hospital.

She attended the TCC later for lymph massage treatments, which it was agreed she would not be charged for. She slept in a separate room for four to six weeks and felt that her total recovery took about nine months. She did not complain to the College until after Ms Stryland died. She felt no one else should go through this.

The Committee viewed Ms Mendelson's evidence as truthful. She appeared to understand all questions and to answer them to the best of her ability. Her memory for some details immediately after surgery, and when and if certain phone calls were made, was not good. Her evidence was consistent with her daughter and husband on major points and, for the most part, with the health record. There may have been some exaggeration of her recovery time.

Dr. AC

This 40 year old veterinarian is the daughter of Francine Mendelson. Dr. AC testified that she attended the TCC with her mother on June 20, 2007, to learn more about the procedure of liposuction and whether her mother was a candidate. They met with the nurse, Ms D, who said she was a good, great or excellent candidate (she could not exactly recall which term was used). They would remove ten to twelve pounds of unwanted fat. Ms D was not concerned with her mother's age and assured them that a licensed anesthesiologist was there.

She could not remember discussing her mother's personal health risks. There was no mention of the risk of death or other medical risks. They were told there would be some leaking from the incisions, bruising, and that fat loss could be uneven. Payment was discussed and that she would meet the surgeon after the surgery was booked.

Two days before the surgery (July 9, 2007), Dr. AC and her mother met with Dr. Yazdanfar. She described this as a friendly meeting. The chart was reviewed, there was a discussion about what would happen and photos were taken. A physical examination was done and there was a discussion regarding the volume to be removed. Risks were discussed, but there was no discussion of risk of death, cardiac complications or risk increasing with age. The only reference that Dr. Yazdanfar made to age was limited to trouble losing weight and that diet and exercise would not help. Dr. Yazdanfar felt her mother had great skin and was an excellent candidate for liposuction. There was no mention of skin laxity. As a result, she felt calm and confident that it was not going to be a big deal.

Dr. AC testified that she was called the evening of her mother's surgery (July 11, 2007) by her father and went over around 7 p.m. to find her mother lying on a shower curtain surrounded by bloody fluid. Her mother was weak, in pain and could not move from the bed. Towels were underneath her for leakage and had to be changed every thirty to sixty minutes. The garment was soaked, so she removed it several times, washed and dried it

and put it back on. She used maxi pads to try to keep the incisions dry. She carried out re-bandaging hourly.

Dr. AC saw some documents given to her by her father, but could not be sure they were the standard instructions for patients with liposuction. She was aware that instructions were that the garment should not be taken off for 24 hours. She accepted that, because the nurses had taken off the garment and washed and dried it at the clinic, she could do that at home and she got it back on as soon as possible. She gave her mother Percocet for pain and alternated this with NSAIDS or Tylenol, probably the latter. She was shocked at the huge amount of fluid loss and stayed overnight. She did not take her mother to the hospital because she did not want to alarm her. She did not recall ever having a cell phone number to call Dr. Yazdanfar or she would have used it. She agreed that it was possible the number could have been on the instruction sheet(s) and she did not see it.

Dr. AC visited daily and returned one week later to the TCC with her mother and met Dr. Yazdanfar. Her mother was still weak and in pain but they were told that the incisions were closing, bruising was within normal limits and that recovery could take longer because of her age. As her mother had more symptoms than usual post-operatively, she sent her for blood work and an ECG.

Her mother told her that Dr. Yazdanfar had phoned Saturday night with the results. Based on what she heard, she told her mother to go to the family doctor on Monday and this led to the admission to a Toronto hospital.

She and her mother returned to the TCC three weeks post-surgery so they could see the surgical results and discuss what went wrong. She told Dr. Yazdanfar that it was abominable that her mother was discharged in such a condition. No average person could look after her and that they should screen women over 60 more carefully. She denied being confrontational, or that she was agitated or upset. She found Dr. Yazdanfar defensive in her responses saying, “but this wasn’t my fault” and “it’s normal to lose lots of fluid”. She had no further contact with the TCC.

Dr. AC testified that her mother was sick for three to six months. They wrote a letter of complaint to the College three months later (she wrote the letter but it came from all three of them). Her mother was well enough to go to Las Vegas in October and to Florida in the fall.

The Committee accepted Dr. AC's evidence on the major points as credible, noting that there were some inconsistencies with her mother's description regarding length of recovery. It was clear that she was unhappy with her mother's treatment at the TCC and holds them, to a degree, responsible for her mother's subsequent heart problem.

Regarding Patient Ms MP (Liposuction)

Ms MP

This 36 year old lady was first seen at the TCC on April 1, 2007, to discuss liposuction of her stomach, which was big after two babies. She met with Ms D who told her that other areas could be done at the same time, which excited her. She was reassured about scarring and loose skin as she was a perfect candidate being Asian; the skin would bounce back and not to worry. No medical risks were discussed with Ms D. She remembered initialing and signing forms in the waiting room but no one went through them with her.

Ms MP met Dr. Yazdanfar a week later, photos were taken and she left feeling like the perfect candidate, as though she had the right body for this magical procedure. She asked if everything could really be done in one shot and was told by Dr. Yazdanfar that she would do her best, but that there was a maximum she could remove at one time. Medical risks were not discussed. She agreed that she read and initialed forms including those describing risks of liposuction. She did not have any worries as Dr. Yazdanfar was enthusiastic and encouraging and it seemed she had the perfect body type.

Her surgery was performed on a Saturday evening (April 21, 2007). She had liposuction from the upper arms, upper back, stomach, mid-thighs and around the knees. The nurse told her she was amazed how much was able to be removed. She was discharged around 11:30, after waiting for a prescription for pain medication. She was not offered the option to stay overnight. They then had to drive around to find a pharmacy that was open.

Ms MP was seen on April 26th for her first post-operative visit and had a further series of photos taken. At her next visit on May 24th, she was worried about the scars and a gel was recommended. She had expected to recover in 24 hours, as this was the period of time that someone would have to stay with her. After hearing of Ms Stryland's death, she sent an e-mail to the College. When taken to this communication, she said that seven litres of fat was removed from six areas, though she did not know exactly how much had been removed. It was stated in the letter that she hoped Dr. Yazdanfar would be barred from operating her clinic. She described a lot of pain, being very swollen and bruised and in bed for a month. When questioned directly, she indicated that she was in bed for a month, with a nanny to look after her children, and had food brought to her in bed.

Ms MP agreed that she told the College she wished to remain anonymous or to withdraw her complaint. She then explained that she had a history of panic attacks and was worried about being put on the spot.

The Committee felt that, in view of the photos, Ms MP's complaints of scarring were exaggerated and that it was likely that her complaints of being bedridden post-operatively were overstated as they were not mentioned in the follow-up notes. She attended her follow-up visits. It was apparent that Ms MP was dissatisfied with the care and treatment she received at the TCC and still harbors residual resentment.

Regarding Patient Ms QR (Breast Augmentation)

Ms QR

This 29 year old woman learned about the TCC on line and contacted them regarding breast lifts and breast augmentation. Her breasts had become deflated and saggy after having children. She contacted the TCC by e-mail. It was her understanding at that time that Dr. Yazdanfar offered both breast lifts and augmentation. After sending a letter of complaint to the CPSO, she learned that Dr. Yazdanfar did not do breast lifts.

On July 14, 2008, she went to her first consultation at the TCC with her sister for the purpose of figuring out if she needed a lift, the pricing, and to look at some sizes. She met Ms D who told her she did not need a lift, as her nipples did not point to the floor, that she was a good candidate for augmentation and that she would be very happy. She was told that a 500cc implant would fill the skin and a breast lift would not be needed.

Before attending, she had made notes about questions she had and subsequently noted answers and crossed out areas that were no longer applicable. She understood that a deposit of $500.00 was required to meet with the doctor.

On July 19, 2008, she and her husband met with Dr. Yazdanfar for a pre-operative examination, and to confirm there was no need for a breast lift. Her goal was to return to a large D or small double D, as she was before having children. Dr. Yazdanfar told them a breast lift was not needed, as her nipples did not point down, and that a 500 or 550cc implant would fill in the skin. She knew that there were scars with a breast lift, so was not unhappy with the recommendation, and it would cost less as well. Risks were discussed including bleeding and capsular contracture; she could not recall other risks. There was no discussion of risk related to implant size. She indicated that, on July 19, 2008 at her pre-op, she signed the consent forms in the waiting room and had no discussion with TCC staff in that regard. She initialed the same forms again on September 27, 2008, prior to her capsulectomy.

Surgery was performed on July 22, 2008. She called the next day, as she was bleeding from the incision, and was advised to apply ice packs. On July 26 or 27, 2008, she attended with her mother. The steristrips were changed, photos taken and she was given a bra to wear. She felt “not too bad”.

Early in August, Ms QR testified that she called complaining of pain in her breasts when sitting up in the morning, and was advised to splint them when moving. On September 6 or 7, 2008, she saw Dr. Yazdanfar who said she had capsular contracture, but that it was not too serious, and that she should lie on her stomach a couple of times each day.

On September 27, 2008, she returned with her husband, as symptoms worsened, to discuss options for treatment. She said she was told the options were:

(i) capsulectomy with replacement of implants
(ii) removal of the implants
(iii) leaving capsules intact and putting in smaller implants

She could not recall others. When asked what she thought was best, Dr. Yazdanfar said that option (i) was the best in terms of the chance of the condition recurring and there might be a little more bleeding. She said she would only charge the anesthetic fee and they booked and re-initialed the initial consent forms that same day.

On October 11, 2008, she underwent capsulectomy at the TCC done by Dr. Yazdanfar. She came back one week later with her cousin and felt good with less pain.

In mid-November, she returned with her husband as symptoms of pain and hardness were worse and, when she lay on her back, she had pulling between her breasts. The same options for treatment were given. Dr. Yazdanfar wanted option (iii). Ms QR wanted to do more research and get a second opinion. She discovered that Dr. Yazdanfar was not a certified surgeon and no one knew about option (iii), leaving the capsule and using a smaller implant.

Ms QR testified that she consulted Dr. U and, subsequently, had her implants removed and has done nothing more to date.

In February 2009, she and her mother returned to Dr. Yazdanfar asking why she was told Dr. Yazdanfar was a surgeon, and why leaving the capsule and using a smaller implant was recommended. Dr. Yazdanfar responded that she does cosmetic surgery and that option (iii) was one of her options. Ms QR requested a refund, which was denied.

The Committee was impressed with the openness of this witness. Ms QR answered all questions directly and had a good memory for the events at the TCC. Her evidence was consistent with that given by her husband and sister.

Ms YZ

Ms YZ is Ms QR's sister. Ms YZ testified that she went with Ms QR in June 2008 to the TCC and met with Ms D. Ms QR was told she was a good candidate for augmentation and absolutely did not need any sort of breast lift as the nipples pointed up. They looked at different types of implants and went over them briefly.

Ms YZ's evidence was consistent with that given by her sister, was clear and accepted as credible by the Committee.

Mr. UV

This 35 year old man identified himself as Ms QR's husband. Mr. UV testified that he attended the TCC with his wife in July 2008, to discuss specifically whether she required a breast lift and sizing. Dr. Yazdanfar did not think she needed a breast lift but an augmentation. They looked at implant sizes. The only risk he can recall that was discussed was capsular contracture; no risk about sizing. It was his understanding from the TCC website that both lifts and augmentation were done.

He attended the TCC with his wife in August 2008, when hardening of the breasts was a problem. Dr. Yazdanfar described the options as follows:

(i) Removing the capsule and replacing the implants
(ii) Removing the capsule and putting the implant under the muscle
(iii) Remove the implants and capsules altogether.
(iv) Remove the implants, leaving the capsule and putting in smaller implants.

Dr. Yazdanfar said the best option was (i). He testified that she did inform them that there was a chance of further recurrence. They did not discuss the other options much, except that there was a longer recovery time when the implant was placed under the muscle. It was described as similar to augmentation, except removing the capsule and putting the implant back in.

He returned again with his wife after surgery, when she was better but started having firmness again. The same options were listed but were not gone into.

The Committee noted that the evidence given was consistent, with minor understandable exceptions with that of his wife. He was clear and direct and his evidence was reliable and helpful.

Regarding Patient Ms WX (Breast Augmentation)

Ms WX

This 36 year old testified that she came to the TCC on the advice of friends. She had seen Dr. QT in 2003 for breast implants. After a motor vehicle accident, she underwent weight training for three years and her implants had shifted to the sides. These were 360cc implants. She would have returned to Dr. QT, but he had retired.

Ms WX was seen at the TCC on August 22, 2007, by Ms D, at which time she had a quick examination and discussed the problem. She was told by Ms D that the situation

was correctable and she looked at a bunch of implants that were in a drawer. There was no discussion regarding size. She saw Dr. Yazdanfar the same day and was advised to have removal of the implants and replacement with a larger implant to give her a fuller look. There was no discussion of a breast lift.

Ms WX was taken to her medical chart and agreed that she had initialed and signed the consent forms, but did not remember reviewing them, or when she filled them out. She could recall no discussion of risks at that time, but agreed that she had time to ask questions. She was told a large implant would be needed to fill the pocket and bring the breasts together. She denied that she complained of small breasts as noted in the chart. Dr. Yazdanfar recommended 550cc. She agreed and signed that she had chosen these. When she raised concern regarding the size, heaviness and the possibility of damage in the future, she was told by Dr. Yazdanfar, “absolutely not”.

On August 29, 2007, Ms WX testified that she discussed implant size again with Dr. Yazdanfar and was assured that a larger implant was needed. No other sizes were mentioned. The implants were to be above the muscle to give a fuller look.

Surgery was performed on August 30, 2007, and she was discharged to stay with a friend. She believed she received post-operative instructions, but never had Dr. Yazdanfar’s cell phone number. She agreed she had initialed that she received post-operative instructions and a follow-up appointment.

The next day, Ms WX testified that she noted a rash (red, itchy and burning) on her chest. She called the clinic to find out whether she should continue medications. She was reassured that the antibiotic she was given to take home was different from what was given earlier. When the rash spread, she called again and arranged to see Dr. Yazdanfar the next day. As her symptoms worsened, she had to attend the emergency of her local hospital. An allergic reaction was diagnosed, all medications were stopped and she was started on Prednisone. She proceeded to see Dr. Yazdanfar later that day and nothing further was done.

Her next visit to TCC was one month post-op, at which time she was still noting burning in the breasts, her nipples were painful and asymmetric and she had to wear a sports bra all the time. Dr. Yazdanfar told her that nothing was wrong, not to worry, and that she looked great and was still healing. Ms WX was concerned that Dr. Yazdanfar did not acknowledge what she was saying.

At her next appointment (six months), Ms WX testified that she still had the same concerns about shifting, burning, and discomfort along with nipple asymmetry. She was told everything is fine.

Ms WX decided to get a second opinion from Dr. TZ who told her the implants were too large for her frame and removal was advised.

Ms WX returned to see Dr. Yazdanfar in June/July 2008 to address her concerns (burning discomfort and uneven nipples). Dr. Yazdanfar said, in her opinion, she looked good, she did what she could with what she had and to wear a bigger bra. Removal of implants was discussed but she cannot recall what Dr. Yazdanfar said about this. She described Dr. Yazdanfar's attitude as belligerent, and was told that she would have to pay to have the implants removed. She left in tears and was escorted to the door.

Ms WX admitted that she had a pending small claims court case against Dr. Yazdanfar to cover the cost of redoing the surgery.

She agreed that she had signed forms indicating she knew that other physicians may recommend a different procedure and that she had the opportunity to ask questions and get a second opinion.

The Committee found Ms WX to be forthright and clear in giving her evidence. Her memory was good. She disagreed with some of the medical record entries. She appeared familiar with breast augmentation issues. The Committee accepted that she has some

bitterness in regard to Dr. Yazdanfar and that her care is the subject of a small claims court action.

Patients in Cosmetic Surgery Practice 2005 to 2007 and a Patient in 2008

Ms ST (Liposuction and Tummy Tuck)

This 60 year old woman came to the TCC on May 18, 2007, with her daughter, who was having liposuction performed. While there, she discussed liposuction and a tummy tuck with Ms D, paid her deposit, spoke to Dr. Yazdanfar and signed the form agreeing to pay $9,540.00. This was a deal (a better price), because her daughter was a patient as well. This was paid in full two days before surgery. She asked Ms D about risks and was told regular risks, not many, it's nothing. No discussion occurred about risk of death or increased risk with two procedures. She was sent to have some blood tests and an ECG.

She met with Dr. Yazdanfar two days before surgery, at which time it was decided that surgery would be a tummy tuck with liposuction on the sides. Dr. IA was to do the tummy tuck. She understood that Dr. Yazdanfar felt it was not safe to do liposuction in the upper tummy, but claimed that other risks were not discussed. Someone helped her fill out the forms. As far as risks were concerned, she understood that there was nothing serious. They just had to have the forms signed. She was helped in filling out the forms by a nurse.

She did not have her personal medical risks discussed, or the risk of death, but she knew, with any surgery, there is that risk. She asked if Dr. Yazdanfar could get her medical records from her family doctor, but was told she did not need to. She did remember reading and initialing the forms, but did not understand them well.

Surgery was performed on May 26, 2007, a Saturday, by Dr. IA and Dr. Yazdanfar. She was discharged in the care of her husband, spent the night at a local hotel, which she described as a rough night because she experienced pain and some difficulty breathing. She did not recall any instructions and said nothing was given to her husband.

They saw Dr. Yazdanfar the next day, were reassured that she was okay, and drove back to London with painkillers. During the next ten days, her incision on the left was not healing well, was painful and was discharging green stuff. She was seen by Dr. Yazdanfar on June 9, 2007, at which time all but four or five staples were removed, and the wound was cleansed and redressed.

Within a couple of days, she got worse with fever and felt awful. Her friend took her to her family doctor who sent her right back to the TCC (June 15, 2007). At that time, the rest of the staples were removed and the wound was cleansed and packed with gauze. She spent that night at her daughter's house. She developed a fever and again returned to see Dr. Yazdanfar the next day, and had the dressing changed again. She saw Dr. IA at the hospital the following day; he reassured her and packed the wound. Arrangements were made for a nurse to come in daily.

The next weekend, she felt very bad. The nurse called an ambulance and she was admitted to a hospital in London for IV antibiotics. She went back later to see Dr. Yazdanfar, after hearing of the death of Ms Stryland and, on that occasion, Dr. Yazdanfar said, "Ms ST, its not my fault, it happens." She also said she could do more liposuction on her, but that it would cost her $11,000.00, after which Ms ST said no.

The Committee noted some language difficulty. Ms ST was soft spoken but appeared to understand the questions posed. Her recall for some events was not clear but, with respect to her pre-operative interviews and post-operative care, her evidence was considered reliable and consistent with the medical record.

Mr. AZ (Liposuction)

This 35 yr old man testified that he attended the TCC for liposuction. He learned of the TCC from an internet search.

His first appointment (late May 2007) was with Ms D, who explained the procedure, some risks, aftercare and recovery time. Documents were signed. They went over and he

initialed the liposuction risks. He asked no questions. There was no discussion of risk of death, pulmonary embolism, fat embolism or shock.

He met with Dr. Yazdanfar, but could not recall any discussion of medical risks. In general, risks were presented as being minimal, and any that would occur would be mild.

His evidence was clearly given and found credible.

Mr. BY (Liposuction)

This 37 yr old man gave evidence that he sought liposuction treatment for gynaecomastia from the TCC in June/July of 2007. He found the TCC by accessing information on the internet and was persuaded by before-and-after patient photos, testimonials, and the convenient site of the clinic, to make an appointment.

At the first visit with Ms D, no risks to health or risk of death were discussed, nor was the volume to be removed. Forms were given but signed later. Payment was to include a deposit of $500.00, which was paid August 1, 2007, and the balance of $9,888.00 was paid August 21, 2007.

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He met Dr. Yazdanfar on August 21, 2007, at which time he signed the papers regarding payment, and he initialed a document, which included agreeing that 50% of the fee was nonrefundable in the event of cancellation. Some potential risks were discussed, such as swelling, bruising, pain and the need to keep a garment on for some time, or needing a touch up. He initialed all the complications listed, but was not sure if someone discussed them.

Surgery was performed on August 31, 2007, and was terminated early because of bleeding.

Mr. BY’s evidence was clear, forthright and accepted as credible.

Ms CX (Liposuction)

This 51 year old lady and her friend, Ms DW, sought Smartlipo at the TCC having seen advertising in a cosmetic magazine. They drove to Toronto in June or July 2007 for their first appointment with Ms D. They discussed Smartlipo, but she did not recall any risks being discussed; in fact, Ms CX left believing she was a good candidate, not overweight and muscular. They discussed payment, which included a deposit with the balance due one week before surgery. She recalls reading, initialing and signing documents including a payment document noting a 50% nonrefundable cancellation fee. She just gave them to the receptionist and did not discuss them with anyone.

Ms CX could recall no discussion of the medical risks with Dr. Yazdanfar. Specifically, there was no discussion of risk of pulmonary embolism or fat embolism. There was no discussion of increased risk in smokers, but she was asked not to smoke for 48 or 72 hrs before surgery.

Ms CX and her friend had surgery the same day, September 7, 2007, and were discharged together. They left in a taxi, which had been called by the clinic staff. She described this as pretty gruesome. Hospital pads were placed on the seats so they would not make a mess. Her friend was in a lot of pain, in a wheel chair, and both were draining.

They walked with difficulty to the hotel room. Ms CX aided her friend, who was dizzy and in pain. Her friend, Ms DW, could not get off the bed, and needed assistance to go to the bathroom.

They returned to the TCC the next day and had their dressings and garments changed. Ms CX then drove home with her friend in the passenger seat reclined as far back as possible.

Under cross examination, when asked why she had not complained to the College, Ms CX said that family issues at that time, including the death of her dad, were all that she could deal with, and that time remains a blur for her.

The Committee found Ms CX's evidence to be straightforward. She had good recall for the details of the discharge experience, which were consistent with her friend's evidence. Her memory for other details was poor and was attributed to contemporaneous, significant family events.

Ms DW (Liposuction)

This 50 year old woman testified that she sought liposuction at the TCC with her friend, Ms CX. She read about the TCC, first in a magazine and then on the internet, and was impressed with the positive testimonials. She first visited the TCC in the summer of 2007 with her friend. They met with Ms D, discussed Smartlipo and were told they were good candidates - not too fat. No risks were discussed.

They spoke with Dr. Yazdanfar together on August 27, 2007, got forms, went through them with her and then signed more on the day of surgery. She does not remember a discussion of risks. Risks of death, pulmonary embolism or fat embolism were not mentioned. Risks related to her own personal history (BP, smoker) were not discussed and there was no mention of risk related to how much fluid was removed, just that there was a maximum.

Surgery was done in early September 2007. After surgery, Ms DW was in a lot of pain, especially when moving, and needed to use a wheel chair when leaving the TCC. They left by taxi and her friend helped her during the night.

They returned to the clinic the next day, changed garments and then, around noon, drove home, during which time she was still really sore. She was unprepared for the pain that she experienced. She felt Ms D was a sales person, who was reassuring, giving a false sense of security – the gist of what she remembers is that there could be risks, but it never happens, don't worry.

The Committee found Ms DW to be clear and consistent in her testimony. She was happy with the results of her liposuction and unbiased. Her testimony was consistent with that

given by her friend, particularly in respect of the discussion of medical risks and discharge details.

Ms EV (Liposuction)

This 45 year old patient testified that, some time in January 2007, she met with Ms D and discussed liposuction. When asked how much would be removed, she was told as much as could be done, down to the bone, or something like that. She could not remember discussing the medical risks. She was not told she could die.

She remembers signing the forms, but not reading them. Ms D may have been present, but did not explain the forms. When taken to the consent forms, she agreed that the question mark beside some questions may possibly have been hers to discuss with Dr. Yazdanfar.

She met with Dr. Yazdanfar before surgery, was marked up and told everything would be okay. She was not nervous. There was no discussion of the amount of fat to be removed, risk of death, and no discussion regarding serious risks. She signed the payment documents, including the 50% nonrefundable part, but no one explained it to her.

Surgery was done March 28, 2007. She walked out but, later that night, developed chest pain, which she initially ignored. Pain came and went and she could not breathe, precipitating a call to 911. She was then taken to hospital. Diagnosis was determined to be a panic attack.

The Committee noted that, while Ms EV's evidence was clear, there was some imprecision with respect to dates and details. However, her evidence was consistent with the TCC record. She had little recollection of signing and reading the consent forms, though she obviously did, and therefore the Committee gave little weight to this aspect of her evidence.

Ms FT (Liposuction)

This 29 year old woman from Barrie testified that she chose the TCC based on client testimonials and the use of Smartlipo. She first attended in early July 2007, met with Ms D, and discussed the areas she wanted treated. She was told by Ms D it was fine to go ahead and discussed with her dates and fees. Risks were not discussed. She was told about unevenness and lumps and other cosmetic effects. Recovery varied, but some were back in a day or two. Smartlipo was more expensive.

She remembered initialing and signing consent forms when Ms D was present. She had the opportunity to ask questions and did ask about pain and recovery time. She signed the agreement to pay $5,300.00 and initialed the nonrefundable part, though she said she did not understand 50% was nonrefundable.

She saw Dr. Yazdanfar on August 22, 2007, for her pre-op visit. They discussed the areas to be treated, photos were taken and Smartlipo versus regular lipo was explained (decreased bruising, speeds up recovery), as were recovery times, pain, lumps and asymmetry. She testified that she wanted, but could not afford, Smartlipo. Dr. Yazdanfar said it would be free (a gift for an upcoming event). There was no discussion of the serious risks of liposuction (pulmonary embolism, fat embolism, death, shock bleeding). Dr. Yazdanfar did not discuss volumes, but showed by pinching. There was no discussion of increased risk with increased volumes. She recalled being told that twelve to fifteen pounds would be removed.

Surgery was done on August 28, 2007. Recovery was painful, especially with movement, and she was unable to work for one week and, even then, it was hard. She still has numbness and mild pain/tingling today.

In mid-September at follow-up, she discussed more liposuction on the arms and neck. On October 19, 2007, she paid a $500.00 deposit for that procedure. Dr. Yazdanfar told her they had a death, it saddened them, and it happens. She did not, however, discuss the serious risks on this occasion either.

She decided not to proceed.

The Committee observed Ms FT to give clear testimony which was consistent with the health record, except for her assertion that serious risks were not discussed. The clinic note of November 8, 2007, documents that fat and pulmonary embolism and death were discussed. Otherwise, her memory for events appeared good. The Committee found her to be a reasonable and unbiased witness.

Ms GR (Breast Augmentation)

This 23 year old woman testified that she went to the TCC for a breast lift and implants after having read advertisements in newspapers and heard them on radio advertisements, but mainly from information online, including videos, lots of photos, testimonials and descriptions of the procedures. Her impression was that all was good, and she thought a female doctor would be more understanding.

Ms GR met with Ms D on May 13, 2008, at which time they discussed breast asymmetry and implants. She was told that Dr. Yazdanfar was an artist, sitting patients up during surgery to be sure the breasts look even, and that she should plan on a week for recovery, but that it would more likely be a couple of days. Costs were discussed and she needed to leave a deposit and fill out some forms before seeing Dr. Yazdanfar. She initialed and signed the payment agreement, including the nonrefundable cancellation fee, and left a $500.00 deposit. She filled in some of the forms on her own. She approached the receptionist and said that things were not discussed and then they put her back in a room and Ms D went over everything with her, including the pre-operative instructions. She was told complications were not common, and they have done this surgery many times and never really had any problems. It was implied that she could have a 375cc implant on the left and a larger one on the right and that they would be able to do a breast lift. She did not understand at that time what a hematoma [a localized collection of blood, usually clotted, in a tissue or organ] was. She agreed that she initialed and signed various forms describing risks, including the risk of hematoma.

She saw Dr. Yazdanfar with her mother on May 28, 2008, and was advised to have implants first and that a lift may not be needed. They viewed a lot of pictures online and, after trying on a number of implants, she decided on the 400cc size (she was under the impression that the larger the implant, the less likely she would need a lift). She signed a form indicating that she had tried on implant sizes larger and smaller than what she chose, but the smallest she tried was 400 cc. She was also advised that Dr. Yazdanfar could use her fingers to lower the breast crease so it would give the appearance of a lift. She said that another doctor would do a lift later if she still wanted it. Risks were discussed briefly (infection treated with antibiotics and, if a capsule needed surgery, she would only have to pay for the anesthetist and the implant).

Dr. Yazdanfar left her with the impression that they had done this a ton of times, they had not really run into many complications and that she was going to be fine and would be really happy with the results. She recalls having her breasts examined and a BP taken; she did not recall a full physical examination.

Someone told her about Ms Stryland prior to her pre-operative visit with Dr. Yazdanfar. She was scared and, if she had not signed the agreement, she would not have gone ahead. She did not want to lose money, but decided to go ahead after meeting Dr. Yazdanfar because they had made it seem that she would be so happy.

Surgery was performed on May 31, 2008 (a Saturday), and she was discharged home after the procedure to her parents. She was given some paper work on discharge, but could only identify the “Fainting Instructions”.

She testified that Ms D called on Sunday and she told Ms D that the right breast was really sore. She was reassured that this was normal and to put ice on it. By Monday, the right side was better, but the left breast was getting larger and larger and was hard and painful. She fainted while walking back from the bathroom with her mom. She continued to faint to the point that she had to lie in bed. Dr. Yazdanfar was called and returned her

call around 9 p.m. She was reassured that pain, swelling and fainting were normal and to call her in the morning and that she could see her at 1:00 p.m., after a procedure. She did recall Dr. Yazdanfar saying not to eat or drink as the left breast may need to be drained.

Things got worse overnight; she was fainting even when in bed. She called the TCC around 4 a.m. on Tuesday to let them know that she was going to go to the hospital, but they were closed. She also called the emergency room at the hospital and was told that there would be a wait and that their surgeons might just stabilize her as they had not done her surgery.

At 6:30 a.m., she left a message for Dr. Yazdanfar, who called back and told her not to go to the emergency room, that her breast would need to be drained, and that she would see her at 9:00 a.m. Dr. Yazdanfar said she would have another doctor do the surgery, and that it wasn't an emergency. She felt like she was dying and would be safer in the hospital and that Dr. Yazdanfar did not take her seriously.

An ambulance was called and she was taken to a hospital in Toronto (6:45-7 a.m.). She was seen by the ER doctor around 8:00 a.m. and was given pain medication and fluids as her BP had dropped. She indicated she did not want to go back to the TCC. She was seen later in the day by a plastic surgeon, Dr. KL, and had a hematoma evacuated that evening. He later removed both implants (December 2008).

The Committee accepted Ms GR's testimony to be a true interpretation of events. Much was confirmed by the health record. Her memory for discussions about risk was clear. Her testimony was consistent with that of her mother, aside from discrepancies in the number of fainting spells, which appeared exaggerated.

Mrs. HP – Ms GR's Mother

Mrs. HP gave evidence that her daughter, Ms GR, went to the TCC after looking on the internet, because she was unhappy with the appearance of her breasts. She attended with

her daughter a few days prior to the surgery, at her daughter's request, to meet the doctor and review the procedure.

They looked at implants and her daughter was given a bra and implants to try. Ms GR asked about using a small implant in the larger breast and a larger one in the small breast, as she was concerned about asymmetry, but Dr. Yazdanfar said it was better if the same size was used for both, and that it would be fine after surgery. Before leaving and after seeing Dr. Yazdanfar, her daughter paid the surgical fee of $7,000.00 in full.

She became aware of the Stryland death, other cases and ongoing suits and was concerned. Her daughter was afraid to lose her money and made the decision to go forward.

Surgery was carried out on Saturday, May 31, 2008. She went in with her daughter, met Dr. Yazdanfar again and met the anesthetist.

When her daughter came home after surgery, she was unprepared for the amount of pain or assistance she would require. By Monday night, the pain was much worse and the left breast was triple the size of the right. She remembered her daughter speaking with Dr. Yazdanfar that evening, who told her to continue the medication and that the pain and swelling was normal. Ms GR called the TCC again in the middle of the night and an appointment was made to come in the next day at 1:00 p.m. and, then, after another call, the time was changed to 9:00 a.m.

Later that night, her daughter became pale, cold and was shaking, and then proceeded to faint when coming back from the bathroom. Prior to this, Ms GR had called a Toronto hospital and was advised to call the TCC. After the faint, she took control, called an ambulance and went with her daughter to the hospital.

She was told by a doctor there that he wasn't sure a plastic surgeon would come as they don't like to treat someone treated elsewhere. However, as Ms GR's blood pressure was

low and she was not doing well, she was assessed, given IV fluids, analgesics and later seen by a plastic surgeon (Dr. KL). He operated on her in the late evening.

When she called her son at home (8:00-9:00 a.m.), she was told that the TCC had called numerous times asking for us to call back. She returned the call to Ms D, and testified that she was told her daughter was having a blood clot and needed to see Dr. Yazdanfar to have it drained. She was then told that hospitals didn't understand anything about this type of surgery and, if her daughter decided to stay in the hospital, she would lose the right to come to the clinic to be checked after; it was in the contract. She spoke with her daughter who said there was nothing like that in the contract.

During another call, she was told, "your daughter is not going to die", expressed in a manner that offended her. Ms D called a number of times and this ended with her being angry, as Ms D denied ever having said that Ms GR would lose the right to have check ups. She was upset. She read the contract again and it did not say that.

The Committee found Mrs. HP's evidence to be straightforward and consistent, but she still bears some animus against the TCC, insofar as the manner they handled her daughter. It was clear she did not want her daughter to have the surgery, and was fearful when her daughter fainted, given what she had found out.

Other Witnesses

Ms JD

Ms JD is an investigator at the College. She testified that the College had been made aware that Dr. Yazdanfar was doing liposuction in her office and, on October 21, 2002, she made an unannounced visit to her office. Dr. Yazdanfar informed her that she had been doing tumescent liposuction since April 2002, and that she had taken a course in the U.S.

The anesthesia used was Valium per os, Demerol intramuscularly, and she infused a local infiltrate containing lidocaine and epinephrine. There was no discussion of use of general anesthetic. She told the investigator she removed one to two litres of fat (it was not completely clear whether this was fat only or fat plus infused fluid). She said she did one area for a given procedure, that it was safe with no complications, and she did this only on healthy patients and not on teens or seniors.

The next visit was in December 2002 to the new office (5400 Yonge) for the purpose of collecting charts, and fifteen of thirty were selected. Ms JD explained that the charts would be reviewed by an opinion provider, who was a plastic surgeon. Then, she would be interviewed and her facility inspected. The next step was an interview at her office with Dr. PG, which occurred in March 2003 and for which she was present.

At that time, Dr. Yazdanfar said she usually removes 700-800cc of fat in one procedure and that the most she had done was 900cc of fat from each thigh. She said she would only do one site at a time. She was using local anesthetic, not general. She spoke to whoever picked the patient up. She had no hospital privileges, but indicated she could arrange admission to a Toronto hospital. She indicated that she was planning to have more training, and that she had applied for fellowship in the U.S. She had done Advanced Cardiopulmonary Life Support (ACLS) and produced her card. She received the report for comment and response and, subsequently, it went to the Executive Committee of the CPSO.

The Discipline Committee found Ms JD straightforward and clear in her evidence in describing the first contact of the College with Dr. Yazdanfar.

Ms AR

This witness brought the hospital chart of Krista Stryland and was ordered to produce it to the Committee.

Ms BW

This witness was called by the College and affirmed that she was the patient appearing in the TCC website video giving a testimonial. She was a patient of the TCC and had a tummy tuck by Dr. IA and liposuction by Dr. Yazdanfar. She had a good experience at the TCC.

Mr. RV

This witness was called in reply to clarify Independent Health Facility (IHF) information that the Committee had received. He has been the manager of the IHF program at the CPSO for eight years. The College works in partnership with the Director of IHF at the Ministry of Health (MOH) and has been involved in the development of standards and assessment tools for the MOH facilities.

IHF licenses can only be granted by the MOH and the College is contracted to run the program with respect to facility standards and quality of care.

There are two types of assessments, (i) pre-licensing assessment and (ii) rotational assessment, done every five years, or earlier, if there are concerns. Assessments deal only with OHIP billable procedures.

There are a number of IHF facilities doing different things; there are seven plastic surgery IHF's in Ontario.

The IHF Facility Guidelines for plastic surgery 2009 update (exhibit #208) resulted from an update process and were circulated and posted on the College website in April 2009. The target of these guidelines would be the seven licensed plastic surgery facilities, and the specialty of the members practising in those facilities would be plastic surgeons.

The guidelines are used to specify facility standards and have a clinical practice element, including quality assurance (QA) and infection control. Even though liposuction is not covered by OHIP, the task force deemed it important to make a statement in respect to

liposuction volumes. Other departments within the College may make reference to these facility standards.

He is not familiar with the TCC; it is not an IHF and the IHF guidelines do not apply to it. In April 2010, a regulation covering facilities not captured by the previous regulations, such as the TCC, was introduced.

Part II Witnesses for the Defence

Dr. Behnaz Yazdanfar

Background

Dr. Yazdanfar is an Iranian born Canadian trained physician. She graduated from medical school at the University of Ottawa in 1994 and then completed a family practice residency at the University of Toronto in 1996. She was a member of the College of Family Practice for several years thereafter. In 1996, she did various family practice locums and then opened a general and family practice (1997-2002). She speaks English, Persian and a little Spanish. She had a lot of Iranian patients with hirsutism in need of laser hair removal, and this caused her to become interested in cosmetic work.

In 1999, after a personal experience with liposuction, she started attending liposuction courses and introduced this into her practice. Her curriculum vitae outlined an extensive list of courses, mainly on breast augmentation (268.5 hrs), and liposuction (196 hrs), combined breast and liposuction (250 hrs), and others (142.5 hrs). In 2003, she had a personal training program on breast augmentation with Dr. L, one on one, for one week, where she observed and assisted him. She had further training with Dr. N, which involved one on one and workshops, where she observed, assisted and did some procedures. She has been recertified in Advanced Cardiopulmonary Life Support (ACLS) and Advanced Trauma Life Support (ATLS). She estimated the cost of this education at hundreds of thousands of dollars. She is no longer doing family practice. By 2004, she felt her

knowledge, training and expertise was equivalent to a six year residency program, and she felt competent. She has no hospital privileges.

Mastopexy, or breast lift, is always included in the breast surgery courses, but she does not do it. She has taken the written and oral examinations for the American Society of Breast Surgery and qualified in 2008. To qualify, she had to do 100 cases and be observed or videotape a surgery. She has seen breast augmentation done in many ways, but believes that the tumescent technique has truly almost become a standard of care.

Toronto Cosmetic Clinic (TCC)

Dr. Yazdanfar testified that she is the owner and operator of the TCC, which she described as a first class state of the art facility. She noted, in particular, a large number of cannulae, breast implants and a camera that has software which lists all possible kinds of implants and gives patients an idea of what they may look like. The TCC has been located at 5400 Yonge Street since 2002.

At the TCC, there is an RN who is ACLS certified, and the anesthetist must be ACLS certified. There are a number of other surgeons who operate at the TCC and they have privileges at hospitals in the area.

There are no committees. She is the quality advisor and meets with staff quarterly to deal with safety related incidents, as far as she can. She described herself as a perfectionist in terms of patient safety, OR function, cleanliness, forms, records and office function. There are no mock drills for fire or Code Blue. There have been no incident reports, as this has never come up. Her access to emergency care is through 911. The TCC is not a licensed IHF. Fresh frozen plasma is not available at the TCC and there are no back up surgeons.

When taken to the Emergency Plan Book kept in her OR, she agreed that she got this from another surgeon in California knowing that it would be required to be in place for an inspection. She showed it to the College inspector and took his report as approval of its

content. She has not read it recently but, when taken to the directives, she said she did not go by every line. The roles of her staff are confused and many of the forms are inappropriate and have not been changed from the California originals. She said that the wording of the document did not impact on patient safety, as staff knew what to do.

Within six months of the death of Krista Stryland, she hired a consultant (nurse) to assess "how we were doing things", looking in particular to procedures in the operating room (OR) and recovery room (RR).

Dr. Yazdanfar testified that all calls to the TCC have been monitored since sometime after September 20, 2007; this seemed like a good idea. Changes were made to consent forms as well, adding further information, including clotting problems, thromboembolism, fat embolism and unforeseen events which could lead to ICU admission. A request for advance notice for an overnight stay/nurse has also been added. The anesthesiologist must record the first vital signs in the RR. Since the Stryland death, anesthesiologists are paid for an hour at the end of the day.

Nurses must write a lot more information in the RR chart.

Patient Flow

On the first visit, prospective patients are seen by a patient consultant. They fill out a registration form and provide an overview of their medical history. The patient consultant notes the medical history, complaints and what they really want. There is a discussion of the risks of the procedure of interest and patients are asked to initial these. For patients seeking breast augmentation, they spend some time choosing implants. An estimate of the surgical fee is provided.

If they decide to proceed, they are given a package of forms, including a pre-surgery health questionnaire and consent forms to fill out. Patients must initial each line, are given time and are told not to initial if they have a question. One form is the main list that Dr. Yazdanfar uses when she is doing the pre-operative assessment. There are a number

of forms focusing on specific issues, such as smoking, hematoma, and infection. Death, stroke, heart attack and pulmonary embolism did not appear in the consent forms until after the Stryland death. Pre-operative and post-operative instruction sheets are given and a copy is filed in the chart.

A form, which indicates the costs of the proposed procedure and has a 50% non refundable clause, is filled out and then signed by the patient. There is no requirement to pay more than the $500.00 deposit if, after seeing Dr. Yazdanfar, they decide not to proceed. If Dr. Yazdanfar does not think they are a good candidate, they are refunded the $500.00.

A requisition for pre-operative blood work and, when appropriate, for an ECG, are given and the patient is then booked to see Dr. Yazdanfar for pre-operative assessment. There is a protocol for standard tests. Dr. Yazdanfar signs the requisition.

At the pre-operative assessment visit, Dr. Yazdanfar testified that she performs a full medical history and physical examination. Referring to forms on risks and complications of cosmetic surgery, each point is discussed in detail. In discussing the anesthetic risks, she said drug reactions and death, heart attack, pulmonary embolism and stroke, though rare, can occur. She believes the anesthetic risk is 1:10,000 to 1: 20,000.

For breast patients, bleeding/hematoma (3-4%), infection, pain, necrosis and capsular contracture (she overestimates those needing re-operation at 30-50%) are specifically discussed. She accompanies the patient and they see a range of implants of different sizes and shapes starting around 300cc’s. She tells all patients that the best size is what suits the body frame, and her preference is 300-400cc moderate profile. Once they are happy with their choice, she proceeds to do the physical examination.

The procedure is discussed in detail including use of tumescence, hydro-dissection, incision placement and creation of the pocket by blunt dissection, a lot of which is done with your hands. This is a long process (one to two hours). Before they leave, the implant

choice form is signed and the pre-operative sheet is given again and gone over thoroughly. They receive a post-operative instruction sheet and her cell phone number for questions.

For liposuction patients, Dr. Yazdanfar personally goes over the medical history to rule out material risks, reviews the pre-surgery evaluation form and then moves on to consent. She discusses the details of the procedure, leakage and the need for a compression garment. She said that she discusses complications and tells patients about heart attacks, stroke, emboli and death, which are rare but they can happen. Pain is discussed in detail. She informs patients that she uses five litres of fat as a guideline and will rarely exceed this, and only when the body surface area (BSA) is large. After this discussion, she does a physical examination.

After this visit, full payment is required if the patient decides to go ahead.

On the day of surgery, the patient has additional forms (anesthetic form and CMPA form) to fill out and sign. Dr. Yazdanfar does not take note of the ASA classification [American Society of Anaesthesiologists Classification of Physical Status] and has not discussed this with Dr. C; it is part of the anesthetic form he designed and he fills this out upon seeing the patient. An anatomic form is prepared by Dr. Yazdanfar, pictures are taken and skin markings made. Nurses fill out a summary of the OR events, including drugs given and times. Dr. Yazdanfar might make a comment on the OR record. Dr. Yazdanfar uses a template in making her operative report. The anesthesiologist's record includes RR orders.

Standard TCC discharge policy requires that patients must be accompanied home and have someone with them for 24 hours. Cell phone number and clinic phone numbers are given for calls 24/7. Standard post-operative instructions are given for the third time.

Patients may go to a hotel close by and often TCC staff make these arrangements. At times, a nurse may accompany the patient to the hotel and may be hired to stay overnight.

The TCC is fully equipped and staffed to keep patients overnight. Surgery is cancelled if no one is available to be with the patient post surgery.

The responsibility for discharge is the nurse's. Dr. Yazdanfar usually sees patients before discharge and examines them sometime during recovery. Patients may stay overnight if unwell, unstable, or if they want to. They would be monitored by a nurse.

Patients are seen again within three to seven days, at three weeks, six weeks and three months approximately. The SOAP (Subjective Objective Assessment Plan) charting pattern is used in recording follow-up visits. If capsular contracture occurs, Baker's classification is used.

In the case of hematomas, patients are seen within an hour or two hours of reporting symptoms. Sometimes, if notified in the middle of the night, patients can wait until the morning. Dr. Yazdanfar said that she reacts quickly as there is increased risk of infection, capsular contracture, pain, and the chance that it will worsen if there is delay.

History with the College

Dr. Yazdanfar testified that, in 2002, the College began an investigation of her practice after a complaint from a "disgruntled landlord". After meeting with Ms JD in October/December 2002, Dr. Yazdanfar became aware of the CPSO policy on change of scope of practice. However, as she had been doing liposuction before the policy date, she did not believe it applied to her.

Dr. PG was asked by the College to assess Dr. Yazdanfar's practice of liposuction. He carried out a review of her charts and interviewed her. In 2002, when Dr. PG evaluated her practice, she said no guidelines were brought to her attention. She told him she used the AACS guidelines. The largest volume she had removed was 4800cc total aspirate, or 1375cc fat, and she did not use general anesthesia. He said this was fine. He had the CPSO send her the Alberta guidelines and she said that she implemented them. The Alberta guidelines did not include volume limits. He made a number of

recommendations, including the need to have proof of discussions regarding informed consent, as well as preprinted forms, which she implemented. She was sent and reviewed the IHF document (2002) regarding plastic surgery and found it was relevant to her practice. She said that she meets all recommendations, except that she does not hold privileges at a local hospital.

It was only after Dr. PG review that Dr. Yazdanfar started to use general anesthesia in her liposuction practice. In respect of the need to transfer in an emergency, she relied on 911. She does not recall making any special arrangements; the need never arose. She relied on Dr. PG's report to conclude that she had sufficient knowledge and that she was following good guidelines.

Before the College's change in scope of practice policy became mandatory, she applied to the CPSO for a change of scope to introduce breast augmentation into her practice. As part of the process, she needed to undergo more training and she arranged a preceptorship with Dr. N in the USA, who would train her, supervise her and then write a report to the College. When asked about the cost component to her, she said, "Oh, yes. A large one." She asked, but she was unable to find anyone in Ontario who would train her.

In November 2007, after the Krista Stryland death, the College came to the TCC and copied documents, including her emergency protocols. She was asked to fill out a practice questionnaire as well, which was reviewed with her, and she agreed that the completed questionnaire contained some omissions and errors, which she said were minor and unintentional (Mr. H was omitted from the staff list; she indicated under CME that she had written articles for journals when what she actually did was respond briefly to questions in the aesthetic magazine "Elevate").

In 2004, Dr. S, a colleague, showed her a letter he wrote to the College, agreeing to remove no more than five litres of fat. In March 2007, Dr. S was the subject of a s.37 order, which stipulated five litres of fat as the least restrictive order in keeping with public safety. He gave a copy of the s.37 order to her. On this basis, she assumed that five

litres of fat removal was a safe guideline and continued to use it. She agreed in cross examination that individual agreements do not make up College Policy, that Dr. S's fluid management differed from hers, and that she had no specific details of how the order came about.

When she read Dr. A's report, she said that she realized that this was a hot issue for the College. In 2009, she reviewed the IHF Clinical Practice Parameters and Facility Standards for plastic surgery and made no changes, believing that #4 (exhibit #126) referred to 5000cc's of fat. She assumed she was doing the proper thing. No one said to do anything different between November 2007 and May 26, 2009, when she was stopped from performing procedures independently by the s.37 order. At that time, she said that she believed that the College approved what she was doing based on her interactions with the Quality Assurance Department of the College.

After the s.37 order, Dr. Yazdanfar testified that she felt the College was picking on everything she did and not just volumes. She indicated she would have signed an undertaking and that she did everything the College asked. When probed, she agreed that, in 2008, the College wanted to interview her and she told counsel she would not be interviewed or observed and she was not prepared to have her nurses interviewed. She did not recall that the College sought to have her compelled to be interviewed. Investigators from the College came to the TCC many times in January/February 2007. She did not remember if they were refused entry.

In her letter to the Executive Committee of the College (May 19, 2009), she said she felt relieved to be able to tell her side. However, she now agrees that the summary of what happened as written in her letter was not accurate. She was assisted in writing this by her counsel and, at that time, she was relying on her memory and records. In regard to Krista Stryland, she indicated that she was not informed of her deterioration when she should have been. She said that at 3:50, when she first knew, she called 911. Her recollection changed in August 2009 when she viewed the hallway DVR (digital video recording).

Dr. Yazdanfar agreed she brought an application to the Divisional Court to overturn the s.37 order, but said she never read the decision. She just knew it was not in her favour. She said she never saw for approval the documents about the relief sought or attachments, but relied on her counsel and had no worry.

In January 2009, she was interviewed by Dr. A at the College. She found the atmosphere hostile and answered only what was asked. She refused to answer some questions on her counsel's advice.

Liposuction

In regard to liposuction, Dr. Yazdanfar testified that she agreed that the more fat removed the greater the risk to the patient, the more body parts treated the greater the risk to the patient, and the more body surface area treated the greater the risk to the patient. Large volume liposuction means more risk of fluid shifts, shock and death. When asked about what she tells patients if more than five litres of fat is removed, she said she would tailor the discussion to the patient. Risk is increased with seniors, but this also depends on their health otherwise. When asked about the patients who gave evidence denying they were informed of the risks of serious complications and death, she indicated they were either wrong or did not remember. She testified to the Committee that the consent discussion is not a short process but at least an hour or two hours with her, and that patients have seen the forms beforehand.

Dr. Yazdanfar holds the view that total aspirate is an inaccurate predictor of trauma, a view which was held by Dr. LR, a dermatologist, who was identified as one of the pioneers of tumescent liposuction. Dr. LR was not called as a witness at the hearing but excerpts from Dr. LR's text were filed with the Committee. While she relied on his text, she did not read it cover to cover and believes that much has changed in the decade since its publication. Dr. LR is of the view that removal of more than 4000cc's of fat is dangerous and that general anesthesia allows surgeons to be too aggressive. He writes that removal of 3000cc's of supernatant fat is probably excessive in most patients and that removal of 6000cc's is dangerous in all patients. She disagrees. She follows the

AACS [American Academy of Cosmetic Surgery] guidelines of 5000cc's of fat and said that she believes that, currently, Dr. LR condones these guidelines.

These AACS guidelines have been criticized by the plastic surgical community, who measure total aspirate rather than fat removed. A number of references were filed as exhibits related to technique, definitions and history of liposuction, providing information upon which she relied.

Dr. Yazdanfar testified that, during the liposuction procedure, she watches the fluid coming out, which is like a mixture of oil and vinegar. She testified you need to let it settle for about thirty minutes before you can tell how much fat you have. As liners are used in the canisters to collect the aspirate, the measurement of volume is not exact, tending to an overestimate.

Dr. Yazdanfar explained the basic elements of fluid shift, supported by a diagram. Generally, she would infiltrate 7-8000cc's when removing 5000cc's of fat. On occasion, she may exceed the 5000cc's of fat, when this is in the best interest of the patient (given risks of repeated anesthesia and increased risk of bleeding if liposuction is done through scar tissue). She was familiar with both hypotension and pulmonary edema as related problems. She does not want a lot of IV fluid given during surgery and had disagreements with Dr. C on the subject.

The first guidelines that Dr. Yazdanfar was familiar with were the American Society of Dermatological Surgeons (ASDS) guidelines. She testified that she interpreted their training requirements as residency in a board certified specialty or training in liposuction [emphasis added]. She agreed that physicians can only practise in areas where they are experienced, commensurate with training, and that it is important to deal with the complications. She was aware that the maximum volume of fat that should be removed in accordance with the ASDS guidelines is 4000cc's.

Dr. Yazdanfar testified that she did not become aware of the ASPS guidelines until Dr. A's investigation. She agreed that 5000cc's of total aspirate is more conservative than 5000cc's of fat. Under cross examination, she said that she did not think that the AACS guidelines were more liberal, but agreed that plastic surgeons would see it that way.

Dr. Yazdanfar indicated that her training was mostly through the AACS and it is their guidelines she followed in 2007. In her interview with Dr. A, she told him she removes up to five to six litres of fat when she performs liposuction.

Dr. Yazdanfar believes that plastic surgeons use less infiltrate and, the way they do it, they do not get the full effect of tumescence to stop bleeding. She has done more than 1000 cases of large volume liposuction under general anesthesia since the beginning and cannot recall complications, other than the two central to this matter.

In regard to Smartlipo, she uses this technique to soften fat and tighten skin, not to liquefy fat. She disagrees with Dr. GH's evidence of how it should be used.

In discussing what she had learned from the Francine Mendelson and Krista Stryland cases, she indicated that it may be preferable to take smaller volumes and repeat procedures, not because it would be better for patients, but because when you are not a certified plastic surgeon you are particularly vulnerable if there are complications. She felt unfairly attacked in the Stryland matter because she was not a plastic surgeon. She still believes removing 5000cc's of fat is safe. She would improve her paperwork and follow her instincts.

Breast Augmentation

Dr. Yazdanfar described the technique she uses for augmentation as the tumescent technique. Infiltration of the pocket has the following benefits: increased pain control; decreased requirement of general anesthesia; less blood loss; less hematomas; potentially less capsular contracture; less bruising; and, swelling and pain control lasting many hours, decreasing the need for narcotics. She said it has become almost the standard of

care to do it this way, which the Committee understood to be in the USA. They all infiltrate to some degree (250-300cc typical). This is what she learned in her preceptorship and she said the College approved it. Early on, she used less volume (50-70cc); now she uses 250-500cc with much less medication and more saline.

Dr. Yazdanfar testified that she has seen a letter from a Dr. Z describing his technique and also has seen an article in the CPSJ (Canadian Journal of Plastic Surgery) [exhibit #84], which describes an approach to augmentation using blunt dissection, tumescence and a minimal inframammary incision. She agreed that her technique and Dr. Z's differed, as he does not use general anesthesia. The differences in her technique from what is usually done are the use of tumescence and resultant hydrodissection, blunt dissection, and the minimal use of cautery. She agreed that breast augmentation can be done in a number of ways, including that described by Dr. A, and she has observed one case done with very little infiltrate.

Dr. A's and Dr. GH's techniques vary as to the amount of cautery. She agreed that she may have said that she rarely uses cautery, but it is always out and she always uses some on bleeders. She disagreed with Dr. GH on the need for cautery and on his view that the use of general anesthesia and tumescent anesthesia makes no sense. She stopped using Marcaine several months ago, but never had a problem.

Krista Stryland

Dr. Yazdanfar testified that the same consent and payment process occurred as is standard at the TCC.

The pre-operative assessment by Dr. Yazdanfar was done on September 12, 2007. Serious risks including death were discussed. Dr. Yazdanfar testified that she always raises heart attacks and stroke with everyone under anesthetic risks.

Surgery was performed on September 20, 2007, starting around 10:00 a.m. and continuing until around 1:08 p.m. At the beginning, 6000cc's of fluid was infiltrated and

2715cc's of fat was removed. She does not believe this was a large case. It was small volume liposuction compared to others.

After surgery and removal of Ms Stryland to the RR, Dr. Yazdanfar testified that she passed through the RR on the way to her office. Nurse J may have been alone with Ms Stryland for a short time until Nurse Q returned having removed the first patient of the day to the parking lot. Ms Stryland was definitely hooked up. This was before the next patient was started. Around 1:25-1:28 p.m., Dr. Yazdanfar returned to the RR and did go to the patient. She did not note an abnormally low blood pressure, and no alarm was sounding as would be expected (she believes the monitor alarm was set to go off if BP was below 80). She had no recall of what the reading was, but knows it was not 60 or 65. She had a conversation with her patient. Her eyes were open, she was drowsy, and did not speak. Before she saw the video, she had a different view. When she testified, she said she has a specific memory of BP numbers in the mid 80's.

Photographs illustrate the collected fluid on Krista Stryland. These were taken by Nurse Q approximately one half hour after the surgery ended.

Dr. Yazdanfar testified that, about an hour into the next case (2:35 p.m.), she heard moaning. Nurse J came in and spoke to Dr. C. She does not recall any discussion and she said she asked Dr. C to go and check why the patient was moaning. Nurse J did not look upset and may have said the BP was a little low. When Dr. C returned, he indicated by hand gesture that she was fine, and said she was a "whiner".

Around 3:10 p.m., Nurse J came in again and got Dr. C; she does not recall what was said. He came back and forth several times and he spoke of intubation, but he was calm. She testified that this was when she knew something was wrong. Shortly after intubation, a couple of minutes later (3:17), she went to the RR and saw three IV's running with pressure bags. She thought the BP was around 100 systolic and never saw numbers of 60/20. She observed that the fluid oozing out was bloodier than usual, and she ordered another binder be put on. During this time, she went back and forth, as did Dr. C, to finish

the case in the OR. She asked Dr. C if he needed anything from the crash cart many times, if they should send her to hospital, and whether blood transfusion was needed. He was very dismissive. He did not act as if he was worried. She said she believes he was wrong when he testified that she knew about the very low blood pressure. She did do an independent examination, checking for perforation, bulges, and bleeding. She checked the patient's legs and turned her over to the side. This took about thirty seconds. She had no diagnosis. She did not consider fluid shift, iatrogenic injury, or hypovolemic shock from too much surgery.

Dr. Yazdanfar testified that she returned to the patient in the OR (for seven minutes), as she relied on Dr. C and thought things were getting better. She came back and put on the second garment. When Dr. C said the patient would have to go to hospital eventually for observation, and she observed oozing through the second binder, she called 911 (3:51 p.m.). She described Ms Stryland at the time the paramedics arrived as pale, gray, very sick, and in crisis. She had the history, operative note, and blood work copied for them.

The various comings and goings between the OR and the RR were seen on the hallway security video done that day, which was played for the Committee.

Dr. Yazdanfar testified that Mr. AB was told by someone at the clinic about blood loss, and that Krista was going to hospital for observation, which Dr. Yazdanfar agreed was inaccurate. No one checked with her and she did not speak to him. Ms D told her that Mr. AB was going to follow Ms Stryland to the hospital. She said she felt too traumatized and had too much on her mind to speak with him, and she did not get the chance. While she had his phone number in the records, she felt that contacting him would be too invasive and legal advice received the next day dissuaded her from calling.

Dr. Yazdanfar testified that none of the RR notes were made by her. She believes the RR record notes made by Nurse Q are inaccurate, as Nurse Q was not in the RR at 1:15 p.m., but taking a patient to the parking lot and, further, she herself would not have walked by a

monitor and missed a very low BP. Nurse Q also told her she made the RR notes much later when the paramedics arrived, and during the time she was bagging the patient.

Dr. Yazdanfar testified that Nurse Q made a personal log later in the evening of September 20, 2007. Nurse Q was not due to return until Tuesday/Wednesday of the next week and that was the first time she was aware of the personal log. Dr. C showed it to her and was upset. Dr. Yazdanfar claimed not to have read the note in detail. It recounted events occurring in the RR and contained information she used for a claim against Dr. B. She said she read and approved the claim, but did not read it carefully. She discussed this with her lawyer, but gave no written instructions.

Dr. Yazdanfar testified that she also believes Dr. C's note is inaccurate, as he was misled by the records that Nurse Q made after the fact. Dr. C left after Ms Stryland was taken to the hospital, as he had another case to do, but then returned as it was cancelled. They both waited in her office for calls from Nurse Q, who had gone in the ambulance with the patient. Nurse J and Ms D stayed in her office as well. Nurse Q returned at 8:00 p.m. Dr. Yazdanfar had a brief conversation with Dr. B. She denied telling him that she did Smartlipo for five minutes. She would not have said that and he was completely wrong. She used Smartlipo for about forty minutes in total, divided up and sufficient to soften up the fat.

Dr. Yazdanfar testified that the coroner arrived early the next morning and took the original chart. The next day, she was asked for the resuscitation note and informed them that Dr. C was doing it. It was faxed to the coroner on Monday.

Dr. Yazdanfar maintains the responsibility for Krista Stryland's death is Dr. C's, that there was no surgical cause, and that Nurse Q is responsible for the inaccuracies of her record. While agreeing there was dual responsibility for the care of the patient, she could not be responsible for his part, and he was the lead. She was never told of the very low blood pressure and agreed that, if it happened, it was grossly negligent.

Dr. Yazdanfar was questioned about a statement which was filed on her behalf in a civil suit on the Stryland matter. She had no memory of this and believed that it was filed without her review.

Francine Mendelson

In keeping with the TCC process, Dr. Yazdanfar testified that Ms Mendelson was first seen for an aesthetic assessment by Ms D on June 20, 2007. At that time, Ms D filled out forms and discussed risks. Screening blood work and ECG were ordered.

On June 28, 2007, Ms Mendelson was rescheduled for her pre-operative assessment and the consent forms were discussed again, read and initialed.

Ms Mendelson, accompanied by her daughter Dr. AC, was seen by Dr. Yazdanfar on July 9, 2007, when a medical history and physical were carried out. Dr. Yazdanfar believed that her family history of heart disease did increase risk, but was not a contraindication to surgery (mother died at 75, an older sister is well at 78). Blood pressure had not been an issue for four to five years. No other factors were considered material and blood work and ECG were normal. She thought Ms Mendelson was suitable for liposuction, and age alone was no reason not to proceed.

Other risks were discussed in detail and forms were gone over with Ms Mendelson and her daughter. Dr. Yazdanfar testified that she did not over promise or minimize the risks. She said that the risk of death was discussed at the same time as other serious complications, including a blood clot. She described Dr. AC as picky and wanting detail, and she went through risks in detail, including that Ms Mendelson could die (1:5000), that she may have a blood clot which could be fatal, that she could have a fat embolus in the blood stream, and that she could have a heart attack or stroke. She said her limit on the volume of fat to be removed was 5000cc's. Age did not come up. She did not discuss increased risk with more body parts. She never told Francine Mendelson that she was a great candidate, or had great skin. She may have used the words good or great just in terms of her skin being good for the aesthetic result, but she did not recall saying this.

Dr. Yazdanfar testified that she advised Ms Mendelson that only Tylenol was permitted as pain medication, unless it was something she specifically ordered.

Surgery was performed on July 7, 2007. She described the procedure as uneventful, with minimal bleeding. While this volume was a little over her limit, she felt the volume was less than 5000cc's because of the liner she used.

After surgery, all her vitals were stable. There was no reason to keep Ms Mendelson at the clinic. She knew of no request to stay overnight and was content to discharge her.

On July 13, 2007, the first follow-up visit, Ms Mendelson was weak but okay, with good results. The abdomen was prominent in the right lower quadrant and an ultrasound was ordered as she was concerned about perforation. Two staff members went along to the ultrasound facility as well to make it easy for her and bring back the results. She was told it was just gas. Dr. Yazdanfar discussed this with Dr. IA the next day.

On July 17, 2007, the second follow-up visit, Ms Mendelson was weak and had palpitations at night. She was more mobile, had better colour, and no pain. Blood work and ECG were ordered. Blood work results were received on July 19, 2007 and the low hemoglobin puzzled her. She now attributes this to removal of the garment and to medication administered by the daughter. She believes that one NSAID could cause the drop in hemoglobin. Blood work was to be repeated in one month.

The ECG results came later and were of concern. Her staff were asked to call Ms Mendelson to come in. Ms Mendelson informed them that she was too busy and would come next week. Dr. Yazdanfar tried calling her all day Saturday (five or six times at home and on cell) and could not reach her until Saturday night (July 21, 2007). The patient was told about the ECG changes and asked to go to emergency if she had chest pain and to see her next week. She told her to go to her family doctor to follow-up.

Ms Mendelson saw her family doctor on Monday morning and was referred to hospital. Dr. Yazdanfar does not believe that this patient had a cardiac event from her liposuction, but from her low hemoglobin. This was attributable to using medication, which was not advised, and not keeping the garment in place as directed.

When seen on August 8, 2007, Ms Mendelson was complaining of a lot of pain. However, she looked good apart from some unevenness in the abdomen.

Dr. Yazdanfar testified that if she faced this now, she would have sent her right away to the emergency room.

Ms MP

Dr. Yazdanfar testified that the manner in which consent was obtained did not differ from her standard. Booking and payment arrangements were the same, except that she paid by medicard.

The surgery was done on April 21, 2007; the procedure was uneventful. She was discharged the same day. She was stable and there was no reason to keep her overnight; the plan was for her to go home. Dr. Yazdanfar testified that she does not recall using the word “silly” in response to the letter of complaint Ms MP wrote to the College, but testified it was silly given the circumstances of her care.

Ms MP was seen next on April 26, 2007, and then on May 24, 2007, at which time she complained of scars. She reassured the patient and never saw her again, though she heard about her complaint to the College after the Stryland death.

Ms QR

Dr. Yazdanfar testified that Ms QR was first seen at the TCC on June 14, 2008, by Ms D. The consent procedure was the standard one that she used in her practice.

On July 19, 2008, at the pre-operative assessment, her breasts were droopy and she was a B cup and wanted to return to a double D cup size. A breast lift does not give volume. She spent a lot of time trying on implants and initialed her choice. She asked if she needed a breast lift and Dr. Yazdanfar gave her opinion. Dr. Yazdanfar testified that she never saw the emails asking for advice and guidance.

Dr. Yazdanfar was of the view that grade I or mild ptosis, where the nipple-areolar complex is at the level of the inframammary fold, can be managed by augmentation alone, along with some internal adjustment to lower the inframammary fold and result in a lifted look. This saves scars and a mastopexy can always be done later.

Ms QR wanted large implants. Her skin envelope could accommodate large implants. She never wanted a lift. She just inquired about it. It is not uncommon for patients to come for augmentation and ask about lifts. She discusses lifts if droopiness is severe.

In direct examination, Dr. Yazdanfar testified, “that for sure means you need an augment. In terms of if you feel you need a lift or not, this is my recommendation. For the grade one or mild to moderate ptosis, a lot of women are happy with just the augment alone. The look they get from the fullness, and the little bit of lift they get from it… makes them happy without the extra scars of the lift” (Vol. Nov 23/09, p.104). Ms QR was shown pictures of augmentations and decided she liked the look and that is where the discussion of lift ended.

In cross examination, Dr. Yazdanfar testified that she gave several options including: breast lift; augmentation; and, breast augmentation and lift done in combination. The Ms QR amd Mr. UV were not told Dr. Yazdanfar did not do lifts (Vol. Dec. 10/09, p.45-46).

Dr. Yazdanfar considered herself well informed regarding mastopexy and related scars, citing the numerous breast augmentation courses she has attended, and these have mastopexy components.

Regarding large implants, Dr. Yazdanfar told Ms QR that the best size is what suits her frame. She tells patients gravity can cause them to drop and that there is anecdotal evidence that there is increased risk of capsular contracture. She preferred 300-400cc moderate profile as they have a more natural look, but the patient has the right to choose. She showed Ms QR pictures (standard pictures that she shows to patients with ptosis) demonstrating the change when patients with droopy breasts have augmentation. Ms QR chose 550cc high profile implants, which Dr. Yazdanfar agreed were large and heavy.

When Ms QR developed capsular contracture in September (Baker 4) [see p.102 for Baker's classification], she was advised that her options were: (i) capsulectomy; (ii) change the pocket site (shape may not be as nice); and, (iii) capsulectomy and a bit smaller implants (25-50cc).

Capsulotomy was referred to in the pre-operative consent for breast augmentation surgery, where capsular contracture is said to require removal of the capsule completely, or release the tension by the fibres of the capsule. In her view, the recurrence rate is much higher when the capsule is left in place and released. She tells patients that capsular contracture can occur in 30-50% of cases (although actually 10-15% according to Dr. Yazdanfar) to emphasize that the complication is real.

In November, with recurrence of capsular contracture, Ms QR was advised to wait for complete healing and the options were discussed, including staying with the same pocket and going with a smaller implant (in essence she says this is a capsulotomy because she is reducing tension).

Ms WX

This patient came with the complaint of small breasts. Under cross examination, Dr. Yazdanfar agreed that this patient came because her implants had shifted and she wanted to fix it. She had implants done four years previously and the implants were below the inframammary fold. She saw both Ms D and Dr. Yazdanfar the first day. She had no volume on top, the nipples were laterally placed and spaced too far apart. Her breasts sat

low. There were a number of reasons for her problem, including weight training and her anatomy.

Options included: (i) a lift; (ii) raising the fold by plication (results not that good, complications occur); and, (iii) replacing the implant. The patient wanted larger implants. Ms WX was informed of all the options.

Dr. Yazdanfar testified that she disagreed with Dr. A that removal and waiting three to six months was needed. She said she preferred a moderate profile of 300-400cc's, but offered to have patients see her receptionist, who had augmentation with 550cc implants.

Ms WX chose 550cc high profile implants; there was no contraindication. Dr. Yazdanfar recommended a change in pocket site. A discussion regarding size occurred while she was trying on different sized implants, and this included that large implants can aggravate the lack of tissue support and descend or shift laterally again. She told the patient that a lift could be done later if needed, as noted in the chart. The patient liked the high profile look.

At her surgery on August 30, 2007, the old implants were taken out, and a new pocket was created and the new implants inserted.

Aside from an allergic reaction presumably to Ancef, which she had been given, the patient did well for a year. Dr. Yazdanfar had no recollection of her complaining of pain and none was noted in the chart.

In July of 2008, Ms WX returned complaining of bottoming out and pain at night. This was the first time pain was mentioned. The patient was angry and indicated that she thought the implants should have been removed for six months. Dr. Yazdanfar felt there was more to it and that she was repeating what another doctor had told her. She told her she would be happy to take them out. Dr. Yazdanfar denied acting in a belligerent manner

and blamed the patient's hostile manner on the advice she had been given by another surgeon.

Ms WX never returned but had her implants removed and later replaced by a plastic surgeon, following which she developed a significant hematoma.

Patients from Cosmetic Surgery Practice from 2005 to 2007 and a Patient in 2008

Dr. Yazdanfar believes that the charts which were reviewed by the College in November 2007 were not a random selection, but were chosen to illustrate problems with volumes and discharge. Five patients were discharged to a taxi, which she claims is very rare.

Combined Procedure Patients (Ms TJ, Ms UK, Ms ST)

Dr. Yazdanfar accepted that the combination of procedures increased risk. She testified that she always tells the patient about the risks of combining procedures, but also that it is often done and can be safe. There is no contraindication. When there are two procedures, she tells them each has its own risk, there is anesthetic risk, and there is increased risk with combining two procedures. She disagreed with Dr. A that the amount of liposuction should be limited in combined procedures, and stated, rather, that the volume should be on the lower end and patients should be chosen carefully.

In respect of Ms TJ (breast augmentation and liposuction), Dr. Yazdanfar testified that Ms TJ was just exchanging implants, requiring less extensive surgery. At liposuction, 2500cc's of fat was removed. Breast surgery was performed using the tumescent technique.

Ms TJ did well and is a happy client. Dr. Yazdanfar was the sole surgeon.

In respect of Ms UK, Dr. Yazdanfar testified that the total fat removed was 2425cc's, and total aspirate 4550cc's. She was of the view that this was not a large number. She had breast augmentation using tumescent technique and 400cc implants. Dr. Yazdanfar was the sole surgeon.

In respect of Ms ST, the surgery was a tummy tuck and liposuction, with Dr. IA doing the former. Dr. Yazdanfar went through the pre-operative assessment with the patient and she had another with Dr. IA. There was a history of depression and hypothyroidism, but high blood pressure was not mentioned. Risks were reviewed and the patient was told of the higher risk with combining the procedures, and that she would not do liposuction in the same area as the tummy tuck as this was not safe. Dr. Yazdanfar indicated that tummy tuck and liposuction were combined routinely when the liposuction was done in different areas. In such situations, she tells patients there are risks related to longer procedures, increased anesthetic risks, risks of both procedures, and potentially increased risk from the combination.

When confronted with the testimony of this patient, that no personal health risks were discussed, Dr. Yazdanfar testified that the patient was either mistaken or untruthful and noted that she barely spoke English. She said that these patients are followed carefully until completely healed. She agreed that a Body Mass Index (BMI) of 40 would increase risk anecdotally, but that liposuction is routinely and safely done and this is not a contraindication.

When asked about Dr. A's opinion that liposuction should be limited in combined procedures, Dr. Yazdanfar testified that it was a judgment call of the surgeon in each case. She said you would just do less liposuction and not from the same area. An ASA 3 classification would indicate a decrease in volume, but Dr. C did not discuss this classification with her.

Dr. Yazdanfar testified that Ms ST was seen a number of times in follow-up, as she had delay in healing and a wound infection. She returned in September 2007 for a pre-op for more liposuction, but did not follow through. At that time, Dr. Yazdanfar said she talked her out of more liposuction and referred her to Dr. IA for weight loss surgery.

Liposuction Patients (Mr. RZ, Ms KO, Ms JR, Mr. TC, Mr. PK, Mr. PC, Ms CX, Ms DW)

Dr. Yazdanfar testified that all liposuction patients went through the same consent process as was standard. All had tumescent liposuction under general anesthesia and the guidelines used were those of the AACS.

Post-operatively patients were followed carefully and all had Dr. Yazdanfar's telephone number.

There have been no complaints related to these patients.

Mr. RZ

In respect of the discharge of this patient, Dr. Yazdanfar testified that his friend did not show up. He was kept four to five hours and she did not want him to leave alone. He insisted and assured them that someone would be there at home. He was discharged by taxi. He had 6175cc's fat removed and a total aspirate of 9525cc's**.** The procedure was then stopped and he came back at a later date to finish. Once she had started, she thought it better to finish the area. She discussed with him beforehand that there was a chance she may only do one love handle.

Ms KO

At surgery, 5100cc's of fat was extracted, which exceeds her guidelines. Dr. Yazdanfar indicated that sometimes, depending on the circumstances, it is best and safer to complete the case instead of bringing the patient back. She acknowledged that removing more on a big patient was not as risky as with a small person. It also depends how much bleeding there is. She considers co-morbidity, as well as recognizing there is some leeway because of the liner of the container.

Ms JR

She removed 5875cc's fat, which exceeded guidelines. This patient was large 83 kg (170 lbs) and it was in this patient's best interest to finish the surgery

Mr. TC

This patient was 119 kg (260 lbs). She removed 5875cc's of fat. Dr. Yazdanfar testified these cases were all larger patients with fewer areas treated. This is different as there is less trauma on a large patient, if one to two areas are treated, than a small patient.

Mr. PK

The patient weighed 117 kg (250-260 lbs) and 5300cc's of fat was removed. Liposuction was done from one area (abdomen), which was not as traumatic. He then came back for more at a later date. He remained at the clinic for just over five hours. He was discharged by taxi both times. Dr. Yazdanfar indicated they wanted him to stay overnight but he argued with the nurses. There was no indication in the chart that he left against medical advice.

Mr. PC

This was a 99kg (210-220 lbs) patient and 5450cc's fat was removed. This was a large patient and a number of sites were not completed as Dr. Yazdanfar's limit was reached.

Ms CX and Ms DW

These patients were discharged to a taxi to look after one another. Staying overnight at the TCC was offered, but they wanted to go to the hotel. They felt well, wanted to go out for a smoke, were making jokes, stayed a long time and wanted to leave. This was a special case and she was a phone call away.

Breast Augmentation Patients (Ms MG, Ms GR)

Dr. Yazdanfar testified that, in all cases, the breast augmentation technique used was the same. In all cases, the consent process, pre-operative assessment, booking and payment and the care and treatment was the same.

Ms MG

In regard to this patient, Dr. Yazdanfar testified that she insisted on taking a taxi home and had given staff the name of her sister, but asked they not contact her. Dr. Yazdanfar indicated she could not keep patients against their will and it is a matter of judgment.

Ms GR

This patient came with volume loss and mild ptosis (sagging) and asymmetry. A detailed discussion, which included breast lift and augmentation, took place and the patient was told that, if she needed a lift, it could be done later.

This patient had a breast augmentation done on May 31, 2008. By June 3rd, she was exhibiting swelling on one side and symptoms of hematoma. She was asked to come in to the TCC at 9:00 a.m., but was taken to the hospital by her mother.

There were many conversations between Ms D and Ms GR's mother, and Ms GB (the clinic staff manager and patient coordinator) and Ms GR's mother. The tone was friendly at first, but something happened in the ER and the tone changed.

Dr. Yazdanfar indicated that she was not responsible for other doctor's complications and that, if removal or damage to the implant occurred, she would not be responsible for the charge. The patient "chose to wait when I was ready for her".

A complaint was lodged by Dr. KL, the plastic surgeon who took over the patient's care.

Advertising

Website

Dr. Yazdanfar agreed in her testimony that the patient testimonials were from her patients (the first two patient testimonials). She has a significant role in the pre-operative assessment, consent, and risk discussions, and assists in surgery when she is not the operating surgeon. Her profile is on the last page. She is the face of the clinic.

Dr. Yazdanfar does not do mastopexy. It is done by other surgeons at TCC. The reason clicking on mastopexy on her website takes you to Dr. Yazdanfar is that she is very much involved with patient care and a big part of their experience, even if she does not do the surgery. If patients ask, they are told the name of the surgeon. There have been different surgeons at different times.

The website is always being updated.

Over the years, Dr. Yazdanfar testified that her advertising has been the subject of complaints. First in 2005, a complaint was dismissed by the CPSO; next in 2006, again dismissed and the dismissal was upheld by HPARB; another in 2007, which was again dismissed; and, again, a new complaint in 2009, which is not yet resolved.

Only minor changes were recommended. She relied on these decisions, and believed that she was doing things right. She was aware that testimonials should not be used, but she had used them on her website for many years.

She is aware of the College bulletin of July 2009 regarding advice to the public about cosmetic surgery (exhibit #140).

Dr. Yazdanfar - Credibility

Dr. Yazdanfar answered questions and did not avoid addressing issues. There were a number of inconsistencies in her testimony of a minor nature, which she tried to clarify when confronted. Other inconsistencies stretched credulity, such as her evidence that she did not read the decision of the Appeal Court and other documents central to other legal claims she was pursuing.

There were major differences in her descriptions of discussions related to risks and options with those of patients. She was prone to positive exaggeration and there are many examples of this throughout her evidence. This spans her description of the hours spent at

educational sessions, her description of patients, her role as quality advisor and her assertion that her liposuction patients were all followed carefully, while a number were discharged to taxis. The resentment she holds for the College and plastic surgeons is apparent.

There is a lack of correlation between her description of events of the Stryland matter given to Dr. A and that given under oath. While she believed her recall changed with viewing the video, the Committee does not accept that, as a result of viewing the video, she has a precise recollection of BP readings.

Mr. R - Voir Dire

The witness testified as to the manner in which the hallway DVR (exhibit #151) was made.

Dr. E

Dr. E is a physician certified by the Royal College in Obstetrics and Gynaecology. He has privileges at two Toronto area hospitals. He has an interest in cosmetic surgery and performs labioplasty, hymenoplasty and vaginoplasty at the TCC (less than one percent of his practice).

Dr. E testified that he has worked with Dr. Yazdanfar as a co-surgeon, and she has assisted him. He has personally observed her doing breast augmentations utilizing electrocautery and a lighted retractor. He has observed her doing liposuction and conversing with anaesthesia regarding fluid replacement. He described her pre-operative assessments as exhaustive and detailed. In addition to Dr. Yazdanfar, on the day of surgery, he explains the risks and benefits with patients he operates on. He has observed no untoward or dangerous practices at the TCC and would never work there if he did.

He is responsible for seeing some of Dr. Yazdanfar's patients in follow-up and has not noted untoward effects or noted patient complaints.

The Committee accepted Dr. E as a credible witness.

Ms GB

This 23 year old woman is currently the staff manager/patient coordinator at the TCC. She started as a receptionist in 2006 and had been a patient of Dr. Yazdanfar in 2004. She has extensive duties involving the front desk, booking appointments, charts, stamping test results, billing and staff responsibilities. Staff meetings are held when needed; Dr. Yazdanfar sometimes attends.

Ms GB testified that appointments for liposuction are booked for one half hour. Breast augmentation is longer, and follow-up is twenty minutes. She indicated elsewhere in her evidence that one hour is booked for liposuction pre-op assessments and longer for breast augmentation patients. When shown the computer generated schedule, she said this was just a guide. Dr. Yazdanfar runs behind and patients often cancel.

When reports are received by fax or mail, she stamps and date stamps them and then leaves them with the file for Dr. Yazdanfar on her desk.

Ms GB prints off the consent forms she needs and answers simple questions for patients. These consents changed in November 2007, after the Stryland death. The emergency procedures book was also changed.

Ms GB sometimes sees patients with Dr. Yazdanfar for translation and also to show what 550cc implants look like. The most common size implants used are 350cc. She does not relay medical advice to patients unless directed to by Dr. Yazdanfar; usually, the nurses or Dr. Yazdanfar speak to them.

Payment of $500.00 is required to see Dr. Yazdanfar. This is returned if the person is not a good candidate. Patients would rarely pay in full before seeing Dr. Yazdanfar, but do so when they decide to proceed with surgery.

Ms GB agreed she made notes in the chart of Ms GR, indicating she said Ms GR probably had a hematoma and to come to the TCC. She did not believe this was medical advice and just wanted to be helpful. On a second call, she told them to come to the clinic from the ER and admitted that she was not aware of Ms GR having fainted, being pale and cold or whether she was in a safe condition to move. Dr. Yazdanfar did not tell her what to say. Usually, medical calls are taken by the nurses or Dr. Yazdanfar.

The Committee accepted the evidence given by this witness in regard to the running of the clinic as credible. Hesitation in responding to some questions seemed related to a lack of understanding.

Dr. F

Dr. F is certified by the Royal College of Physicians and Surgeons of Canada (otolaryngology, head and neck surgery and facial cosmetic surgery). He has privileges at a number of Toronto area hospitals and is an assistant professor at an Ontario university. The bulk of his practice is with medically necessary service.

Since February 2008, Dr. F testified that he has done cosmetic procedures above the clavicle at the TCC. He has not observed any problems with safety or standards, and said that the equipment is better than at the hospital. Dr. Yazdanfar has assisted him at surgery and he has observed her to be keen and concerned about patient care. He has not observed her doing breast augmentation or liposuction.

Dr. F has found the consent forms to be elaborate and very thorough for his patients. He personally discusses risks and complications with all the patients he operates on.

He was satisfied that safety issues were met at the TCC.

He is aware of two of his patients who have had full refunds. He was not aware of the details of the nonrefundable policy, but it is commonplace for a fee to be charged for cancellation or rebooking.

Dr. F was clear in giving his evidence and the Committee accepted his evidence as credible.

Nurse Q

Ms Nurse Q is a Registered Nurse (RN) licensed to practise in Ontario. She started working at the TCC on September 19, 2007, a clinical orientation day, and currently works there two days a week. She is certified in emergency nursing and ACLS. Her primary role at the TCC is recovery room nurse (RR nurse). Nurse J is the principal circulating nurse (CN). Their roles are interchangeable.

Her primary role is RR nurse which includes: documenting vital signs; raising the head of the bed when the patient is rousable; mouth care; and, oral fluids when they have an appropriate gag reflex. Vital signs are taken every five minutes for the first half hour, then every fifteen minutes for the second half hour and, then, every thirty minutes for the duration.

She arrived at 6:30 a.m. on September 20, 2007. She carried out a range of duties related to the first patient of the day including intra-operative and RR care. When Krista Stryland first came to the clinic that day, Nurse Q left the OR, took Ms Stryland to the change room and did the pre-operative history and vitals and recorded this on the top of the RR record. She then returned to the OR before the anesthetic was reversed on the first patient.

She followed the first patient to the RR with Dr. C and hooked her up. Dr. C watched for her first BP and then left. She spent most of the time in the RR with the first patient and

did no intra-operative care on Krista Stryland; the OR report is mistaken in listing her as the OR nurse.

When Krista Stryland arrived in the RR, Nurse Q was in the process of discharging the first patient, who was in a wheelchair. Nurse J and the anesthetist did the transfer of Ms Stryland. She does not have a clear recollection when the hook up to the monitor occurred. In respect of the monitor, it has the capacity to scroll back until turned off, when it resets. The machines have an upper and lower limit, which can be adjusted. The alarm cannot be turned off, but the volume can be turned down. She did not adjust the alarm setting on Ms Stryland. The monitor displays the heart rate and oxygen saturation continuously, as well as a blood pressure reading, which is updated every five minutes.

The RR record typically accompanies the patient from the OR to RR either as part of the chart in a folder or separately on a clipboard, and remains on a table at the bedside. She estimated that it may take around five minutes to get the stretcher in and out of the OR. In the RR, the physician reported to is the anesthesiologist.

After she returned from the parking lot to the RR with the wheelchair, Krista Stryland was there and was hooked up. Nurse Q asked Nurse J how Ms Stryland was doing, noting the BP was in the low 80's (she said below 88 systolic later on re-examination) and was reassured by Nurse J that this was not unusual (she had seen this many times before) and that Dr. C accepted anything over 80. There was only one reading on the monitor, indicating hook up was for less than five minutes. Ms Stryland was rousable, groggy and complained of being tired.

Nurse Q testified that she completed the discharge paperwork on the first patient (less than one minute).

Nurse Q testified that Dr. Yazdanfar, she believes, passed through the RR and went to see post op follow-up patients in her office. She passed through again on the way to the OR

and checked with the nurses and the patient. Elsewhere in Nurse Q's evidence, she could not recall clearly Dr. Yazdanfar coming in.

Nurse Q then did the measurement of fluids for Krista Stryland. Upon review of the video, both she and Nurse J were observed in the prep room carrying out this measurement around 1:39 p.m. She filled out the information on the fat extraction sheet and either gave it to Nurse J or then placed it herself with the chart. The specimens were taken to the freezer.

She testified that she went to the OR and did the OR set up for the third patient. She assisted in the induction (ten minutes) around 1:40 to 1:50 p.m. When completed, she briefly went to the RR door and spoke to Nurse J to tell her they were going to start the next case. She did not ask about the BP as Nurse J was assigned to/responsible for Krista Stryland in the RR. On direct examination, she testified that she approached Ms Stryland and noted the BP was close to 80 and she had a discussion with Nurse J about this.

Nurse Q testified that she returned to the OR to assist in the infiltration (thirty to forty-five minutes) of the third patient. She did not tell Dr. Yazdanfar about the low BP; she did speak to Dr. C, who reassured her it would rebound shortly. On cross examination, when shown the video which shows her in the RR rather than the OR, she still maintained a recollection of hanging the bags of fluid for infiltration and that she was in the OR for the most part between 13:20 to 14:05 p.m.

Nurse Q testified in chief that Nurse J was there all the time with Ms Stryland. On cross examination, she was less certain that Nurse J was there all the time, as Nurse Q's back was turned when completing the discharge forms. However, she testified that Nurse J was the RR nurse for Ms Stryland at that time; no handover had been done and, if others believed there was a handover, they are mistaken.

Sometime after 2:00 p.m., closer to 2:30, after infiltration of the third patient was done, she returned to the RR to assume Ms Stryland's care. She noted the patient's BP was still

in the low 80's and had not responded as expected. Nurse J was chatting with her. Ms Stryland complained of being tired, asked for water and appeared drowsier than earlier. Nurse Q got a second monitor and sent Nurse J to get Dr. C. She took a manual reading, which was below 70 systolic (monitors were higher). No treatment had been given to her knowledge as rebound was expected. She had not discussed this with Dr. C or Dr. Yazdanfar at this point. She never saw Nurse J giving a bolus. Nurse J had the chart. She described Krista Stryland as "in extremis", with an extremely low BP. She had received most of 1000cc's of RL, which was hung when she came from the OR. Nurse J was asked to bring a second bag.

Dr. C came and asked her to give a bolus of fluid and put the patient in the Trendelenberg position. On cross examination, Nurse Q said he told her to continue to give fluids, there was no direct order for a bolus and she saw him adjust the IV clamp, but did not see him open it up. He said just give her some fluids and she will perk up. Dr. C left, she assumed, to go back to the OR. A bolus of 500cc was given over fifteen to twenty minutes through the single IV line. The patient awakened more and discussed post-operative care. A range of BP's approached 100 systolic. The patient asked for fluid and Nurse Q indicated that she assured Ms Stryland that she would raise the bed and Ms Stryland could drink when her BP was stable. Nurse Q raised the bed to 45 degrees. Nurse J went back and forth between the OR and RR. Nurse Q testified that she wanted her back so she could be a runner in case she was needed. Improvement seemed to occur for ten to fifteen minutes with rising BP.

Ms Stryland wanted to go to the bathroom and Nurse Q offered her a bed pan. She insisted that she wanted to go to the bathroom, became quite upset, reached up and grabbed the rail of the stretcher, then slumped back and lost consciousness. Nurse Q testified that she called for Nurse J and told her to get Dr. C right away. She lowered the head of the bed, started giving her oxygen by Ambu bag and noted on the cardiac monitor that she was hypotensive and tachycardic.

Nurse Q testified that Dr. C asked for a second IV and catheterization and then went to the OR to get an endotracheal tube. He intubated her and then Nurse Q put in a catheter yielding very little urine. Dr. Yazdanfar was still in the OR. Nurse Q prepared the second IV, then the third. Nurse J got the IV and RL bag from the OR. On cross examination, Nurse Q's description was that intubation followed the setting up of IV's and catheterization. She admitted she may be mistaken, but remembers the events, not the exact times or order. The monitors were showing BP's in the high 70's systolic and more tachycardia. She released the clamps on the IV's.

Dr. Yazdanfar came to the RR after the third IV was set up, about ten to fifteen minutes from intubation. Nurse Q testified she was supporting respirations at the head of the bed. Dr. Yazdanfar asked Dr. C if he needed anything. He was curt and abrasive. He dismissed her and told her to go back to the OR. Dr. Yazdanfar asked Nurse Q if there was anything she needed and Nurse Q asked for a pressure infuser for the IV bag. Dr. Yazdanfar came to the left side of the patient, noted Ms Stryland was oozing significantly from the left flank side, and asked Nurse J to get a secondary binder. There were no pressure bags on at that time and only one was used.

Dr. Yazdanfar asked about 911, but Dr. C said the patient was going to be fine and needed to be stabilized, and then go to the hospital for observation overnight. Dr. Yazdanfar was dismayed and upset. Nurse Q said she did not share Dr. C's opinion that she would be fine, and said she should be moved to hospital precipitously [sic]. Dr. Yazdanfar did not respond and left to get the pressure bag and returned shortly. At some point, she left to go back to the OR. After five minutes or possibly longer, she returned and applied the garment.

About fifteen to twenty minutes after applying the second binder, EMS showed up. During this time, pressures were improving, heart rate was still high, but not over 100, and Ms Stryland was initiating breathing on her own. She described Ms Stryland as not needing assistance breathing, eyes open, making purposeful movements, obeying simple commands, and generally responsive. When EMS showed up, Dr. Yazdanfar was in the

RR. She spoke with the head driver. When challenged with the description of the patient by the paramedics, Nurse Q said they were wrong in saying that Ms Stryland was chalky white and unresponsive. She said they discussed extubation and that vital signs absent (VSA) occurred after transfer to the EMS stretcher.

In respect of the RR record, Nurse Q testified that the notation regarding IV fluids was hers and refers to those given in the RR. One bag was hanging when she left the OR; the other two were given during resuscitation. Nurse J made the entry regarding the Foley catheter. She said it was Nurse J's responsibility to fill in the RR record. She said that Nurse J handed her a blank document. She filled out the last vitals and entered the ticks on the record from scrolling through the monitor over the last twenty to twenty-five minutes although she did not document times, and handed it back to Nurse J to complete (she believes the times at the top were not there). The values and ticks were entered from the most recent to the least recent and, therefore, are backwards. At that time, there was only the one sheet on the clipboard. The oxygen values were from her memory. This was done while she was bagging the patient and when the patient was transferred to the EMS stretcher by the paramedics when she moved away to make room. Some entries were done with her left hand, the rest with the right.

Nurse Q describes this as follows: right hand on the airway; left hand depressing bag periodically; reaching to the monitor to scroll with the left hand; writing with the left hand on the chart while balancing the chart between her knees and under the bed mat. Nurse Q testified that she took over and put down as many vital signs from the machine as possible, then asked Nurse J to finish. Ms Stryland arrested and CPR was started.

The report of the forensic document examination, describing indentations from the RR record on the fat extraction sheet, suggests that the first two readings noted at 1:15 and 1:20 p.m. were made before the fat extraction sheet was placed in the chart, and the last three after, as these three notations are indented upon the fat extraction sheet. Nurse Q had no explanation and maintained all were put in later, notwithstanding the fact that fat measurement took place between 1:30 to 1:40 p.m.

Nurse Q disagreed with the times on the RR record and the forensic analysis, maintaining she was not in the RR. She agreed that when she was interviewed by the College in August of 2008, she believed that the times on the RR record were correct and only changed her mind after seeing the video. She also agreed that her personal log, made the night of September 20, 2007, supports the times and values as written on the RR record. Her response, again, was that she was not in the room.

Nurse Q testified it was not until later in 2009 that she realized the timeline was not in keeping with the events. The RR record is the responsibility of the nurse taking over care. She did not make any other chart notes, although she acknowledged that it is the duty of the nurse, and a legal requirement, to make notes.

At the time the paramedics arrived, Nurse Q maintained that Ms Stryland was improving and was not VSA on arrival, and that their evidence and records are wrong. She also maintained that she did not tell them twelve litres of fluid had been given, or that this was her second day and going to be her last day. She told Mr. X that it was only her second day. She went in the ambulance with Ms Stryland. She did not speak to Mr. AB and did not believe he went in the ambulance.

Nurse Q testified that she came back to the clinic from the hospital after the patient died, met with the staff and they went out to dinner for further discussion around 8 p.m. They discussed Ms Stryland's condition when EMS came and her care. She agreed that this may have affected recall of details later. She told them that she had made the entries on the RR record late, just before transfer. While at the hospital, she said she overheard Dr. B say, "Maybe this will shut her down". She believed she needed to make a nursing note for the chart, but Dr. C said he would prefer she did not, and that he would. She went home after this. She said she excused herself and then later admitted that Dr. C had driven her part way home.

Nurse Q testified that the personal log made that evening was a reflective note made to aid in reflective practice. She later said that the main purpose was to jot down what she could recall, because she knew there would be questions and she viewed it important to write. As it was a long and complicated day, she felt that there may be some inaccuracies in this personal log. When she wrote "MD aware", it was an assumption on her part. There was nothing in the log about not being responsible for the RR care of Ms Stryland, that she was in the OR with the next patient, that Nurse J was in the RR, that there were no vitals on the RR sheet when EMS arrived, and that vitals were written in reverse order hours later. She wrote in the vitals she recalled from memory and agrees they may be wrong. Later in her evidence, she said she was sure of the 14:45 time as she was not wearing a watch and went to put it on, noting the time.

Nurse Q testified that she gave Dr. C a copy of the log on Tuesday of the next week, when she returned to the TCC. She said Dr. C asked her to destroy it, but she did not. She was told by Mr. R, Dr. Yazdanfar's husband and the TCC manager**,** to keep the copy intended for Dr. Yazdanfar and, several weeks later, gave it to counsel representing the TCC at that time.

Nurse Q testified that she was interviewed under subpoena by the CPSO in August 2008. At that time, she never told the investigator that she was not in RR during the first hour for Krista Stryland, or that she was in the OR with the next patient. She now agrees that the times on the RR record were wrong, but believed them to be accurate at that time. Though she was asked by Ms OB for any other contemporaneous notes and had her personal log with her, she did not produce it as she interpreted the request to mean chart notes and, as she was not asked for her log, she did not volunteer it. She understood the College wanted to know what happened, the log contained detailed information, and the chart notes were sparse.

Nurse Q said she watched the video taken from the hallway on one occasion in October 2009, in defence counsels' offices. She testified that she recovered her memory at that time, including how the RR record was written.

On cross examination, the video was replayed slowly and Nurse Q agreed there were times when no one was with Krista Stryland. She spent three minutes in the OR and was back in the RR from 1:46 until 2:05 p.m., when she is seen coming out of the washroom and going back to the RR. Nurse J was back and forth a number of times and was fulfilling the role of CN as noted in the third patient's chart. She nonetheless said her recollection was that she was there in the OR for the infiltration of patient #3. She did not, however, indicate that she was involved with this surgery when interviewed in 2008.

On cross examination, when it was clear that Nurse Q was in the RR and that she was in error with regards to estimating times, she maintained her recollection and offered no other explanation.

On November 14, 2009, Nurse Q signed a statement given under oath and provided it to defence counsel. In this, she stated that she was involved throughout with the care of Ms Stryland. She offered that she did not mean to imply that she was involved the entire time. She was questioned on the entries on the RR record and indicated that she could recall taking the pre-op vitals but not transcribing them, though she had given evidence earlier that she had done so. She said she was just not certain. She described her conversation with Nurse J and indicated that Dr. C was comfortable with BP's as long as they were not below 70 systolic after liposuction, though a different figure was given earlier. When questioned, she said she really could not remember what the number was. She indicated that the entries of vitals were made from her memory and then explained it was the monitor's memory, not hers. While she had viewed the video on October 21, 2009, she did not include the description of how the RR entries were made when the EMS were there in her statement under oath.

Nurse Q testified that she was not aware that Dr. Yazdanfar was of the view that Ms Stryland was mismanaged by Dr. C and the RR nurse and blamed them for taking too long to recognize the need for transfer, or that her experts agreed. She disagrees. She believes the RR record was Nurse J's responsibility all the way, as she was secondary nurse on the scene.

This witness appeared controlled and purposeful in giving evidence. There were significant internal inconsistencies in the interview information she admitted to giving to the College in 2008 and her testimony, which she attributed to better recollection after the video. There were inconsistencies in her personal log and her oral evidence as well. There were aspects of her story of the events which were contradicted by the video. There are a number of troubling inconsistencies with the testimony given by others, including the paramedics and Dr. Yazdanfar. Her explanation of the RR record values was not convincing and was inconsistent with the forensic report. While she is an important figure in the events of September 20, 2007, the Committee had serious reservations regarding the accuracy of her testimony and found her recollections, though firmly held, to be unreliable.

Nurse J

This witness testified that she is a Registered Practical Nurse (RPN) licensed by the College of Nurses. In February 2009, she was upgraded to a peri-operative nurse (scrub nurse). She is a single mother of two children. She started full time at the TCC in May or June of 2007; she continues to be employed by the TCC but her hours are now reduced as Dr. Yazdanfar is not operating. She described her duties as circulating nurse (CN). She is under investigation at the College of Nurses and has been named in a civil suit. Her legal bills are covered by the TCC.

On September 20, 2007, Nurse J testified that she took Ms Stryland from the waiting room to the change room, talked to her and took her weight. She is quite certain. She recorded this on a post it note, which she told to Dr. C. After she was changed, Nurse Q came and did the balance of the pre-op. The pre-op vitals are done in the OR by Dr. C and the nurse transfers them to the RR record. Nurse J indicated she made no entries on the pre-operative part of the form. She was the CN for Ms Stryland and Nurse Q was in the RR with the first patient.

At the end of surgery, she said that Ms Stryland was groggy, but responded to commands. Ms Stryland assisted the staff in putting on the binder and needed minimal assistance transferring to the stretcher. Nurse J and Dr. C moved her to the RR.

Upon reaching the RR, Ms Stryland was groggy but upbeat, wanting to know if she had a curvy waist. She was hooked up to the monitor. The monitor was set to take a BP every five minutes, with continuous monitoring of the heart rate and spO2 (oxygen saturation). Nurse J put the chart on the counter, turned on the warming blanket, and raised the head of the bed. Dr. C saw the first vitals and then left, and did not return while she was there.

Nurse J testified that she was responsible for Ms Stryland for the first ten minutes as Nurse Q was involved with the first patient. Nurse J was there most of the time, but was in and out once. She entered the times on the RR record, but no vitals, even though she acknowledged it was important to do so. The BP was in the mid 80's and nothing seemed unusual or urgent. On cross examination, she estimated the BP to be in the mid to high eighties based on her reaction to it and Dr. C's, as well as her recollection. It was her understanding that Dr. C expected the BP to drop 20-30 points after surgery and then to fluctuate and come up. The patient was hungry and asking about food (first five to ten minutes).

At some point, Nurse J and Nurse Q discussed the vitals and that Dr. C was okay with them. There was no verbal handover of care, but Nurse J needed to leave to set up the OR for the next case. She assumed that Nurse Q would take over on her return from the parking lot.

Nurse J was the CN for the third case. She would go back and forth between the OR and the RR every two to five minutes. After hanging the last bag of infiltrate for the third patient, she returned to check with Nurse Q (about fifteen to twenty minutes after the case started). Nurse Q was flustered with the low BP. She sent Nurse J for Dr. C as the BP had dropped to the high 60's/low 70's. They did a bilateral simultaneous reading, which

confirmed this. She estimated the time to be 2:20 to 2:30. Dr. C came and ordered the reverse Trendelenberg position, to increase fluids and monitor.

He went back to the OR, Nurse J stayed with Nurse Q until the BP started to go up (78-low 80's). Nurse J then returned to the OR. She told Dr. C the BP was going up.

Ten to fifteen minutes later, Nurse J returned to the RR. Ms Stryland was talking and trying to sit up, then she collapsed. The BP dropped. Nurse J was asked to get Dr. C "right away". He came and assessed her, opened the IV all the way and lowered the head of the bed. He went to get an intubation tube from the OR.

Dr. Yazdanfar asked is everything okay? No response was recalled. Nurse J testified that she got an Ambu bag, more IV fluid and a pressure bag, which Dr. C attached and gave the patient a bolus. Dr. C intubated Ms Stryland and Nurse J assisted when he asked for a Foley to be put in, yielding only 100cc of urine, which she wrote down right away. The BP started to come up. At some point, Ms Stryland was gagging on the endotracheal tube. Nurse J and Dr. C went back and forth during this time.

Nurse J testified that Dr. Yazdanfar came to the door of the RR. Dr. C waved her off. Dr. Yazdanfar came back later, saw the drainage, and helped Nurse J put on a second binder. After moving Ms Stryland to put on the second binder, her vitals dropped a lot. During the time she was at the bedside, Dr. Yazdanfar asked if there was anything she could do or if he needed anything from the crash cart. Dr. C acted as if Dr. Yazdanfar was bothering him.

Nurse J testified that Nurse Q was bagging the patient and asked for the RR record. The only documentation was for the Foley and 1000cc of IV fluid, no vitals. Nurse Q said it was blank and started to write down the vitals as she was bagging and as Nurse J exited the room. Nurse J did not know how many vitals were written down, but did recall that Nurse Q changed hands during the writing. When challenged in cross examination that

there were vitals on the chart before giving it to Nurse Q, Nurse J adamantly denied there were.

The next thing Nurse J recalled is being asked to meet EMS. Thereafter, she returned to the OR to attend to the third patient. Later in the evening, Nurse Q returned. The staff there went out to dinner. It was emotional and her head was whirling.

In August 2008, Nurse J had an interview under oath at the College. She initially refused on legal advice, but then responded to a summons. When questioned as to whether Dr. Yazdanfar would have known about the low BP around 2:30, she said no. She went directly to speak to Dr. C and would not want to distract the surgeon. She answered differently in her interview at the College. At that time, she said she assumed that Dr. C would have told Dr. Yazdanfar.

In October 2009, Nurse J saw the security video, she thinks just after Nurse Q, at counsels' offices. She needed to identify herself and what was being carried.
She was questioned regarding the video, which shows Nurse J and Dr. Yazdanfar examining the electrical panel in the hall. Nurse J attributed this to a power outage in the prep room, which prevented her from using a sealer; power in the other rooms was okay.

In November 2009, when giving sworn statements to Dr. Yazdanfar's counsel, she and Nurse Q were left together in a room to resolve discrepancies.

Back in 2007, Nurse J was uncertain as to who wrote the pre-operative vitals on the RR record, but thought she had, as Nurse Q was so definite that she had not. In November 2009, she is now sure it was not her. She disagreed that Nurse Q asked her to complete the RR record, or prepare documents for the hospital.

The Committee had reservations about Nurse J's testimony. Her assertion of writing the times in is in contradiction with Mr. P's evidence. Her description of the BP normally going down 20 to 30 mm after liposuction is not in keeping with the liposuction charts

examined. Her evidence that she handed Nurse Q a blank RR form and that she saw Nurse Q scroll back and write in the vitals using both right and left hands was, in the Committee's view, unlikely. Her evidence that this happened before EMS arrived contradicts that of Nurse Q, who described this as occurring when EMS were present.

Patient Mr. DQ

Mr. DQ testified that he was interested in laser acne treatment and liposuction. He saw Ms D on his first visit to the TCC and possibly another visit (September/October 2008) and she provided details of the procedures, costs, risks and complications.

Mr. DQ met Dr. Yazdanfar the day before surgery and she went over the same things as Ms D. His concerns related to time off work and the effect on his fitness program. He was concerned with bleeding, pain and infection. He recalled initialing serious risks, but believed "blood clots" did not refer to him. Ms D mentioned stroke, heart attack and death. Dr. Yazdanfar did not. Later in his evidence, he said he joked with Dr. Yazdanfar about death being the most serious thing that could happen.

Mr. DQ testified that there was a big stack to read, he had only one or two concerns and the rest was mumbo jumbo. Items on the list were not explained if he did not ask. He does not understand blood clots or embolic phenomena and did not want to know; he just wanted the procedure done.

Mr. DQ understood the post-operative instructions and the need for the garment to help in getting a good result and to help control pain.

The Committee accepted him as a credible witness.

Patient Ms KM

Ms KM testified that she was seen at the TCC in January 2005 for breast augmentation and laser hair removal. She knew of Dr. Yazdanfar as she had attended her daughter at home. She was impressed with the TCC website, but was most influenced by a friend who had a nice result.

Ms KM returned in May 2006, at which time she saw Ms D, went over the procedure, and discussed implant sizes and payment arrangements. She booked that day and made a payment.

A week later, she saw Dr. Yazdanfar when she filled out the forms, gave her health history, and discussed the procedure and risks. She recalled a discussion of the risks of anesthesia, heart attack and blood clots, capsular contracture, bleeding and infection. She did not care about the risks. She had wanted breast augmentation since she was sixteen.

The Committee accepted her evidence as credible.

Patient Ms KY

Ms KY first knew of the TCC from Iranian newspapers, the TCC website and friends, but, mostly, she was impressed with the clinic itself. She was seen at the TCC in November 2006 wanting bigger breasts.

Ms KY testified that she saw Ms D on her first visit and then wanted to think about it. Later, she saw Dr. Yazdanfar and discussed measurements, sizes, prices and “risks and everything”. The main risk she recalled being discussed was death.

She had breast augmentation and then later, in 2008, had two liposuction surgeries. She was aware of the 50% nonrefundable policy and it made no difference. She understood the discharge arrangements.

The Committee accepted her evidence as credible.

Private Investigator Ms SB

This licensed private investigator indicated she was engaged by defence counsel's office to attend and pose as a patient at the office of Dr. A and, later, other plastic surgeons.

She first attended Dr. A's office on January 26, 2009, and discussed liposuction surgery. This included her history and risks, which she described as briefly gone through. His examination was limited to pinching fat in the regions to be treated. No tape recording was made of this visit. She understood she would have to return for a further visit before her surgery.

She attended a second time, February 6, 2009, at which time a tape was made (exhibit #198) and a transcript was provided. She was not examined on her second visit, but Dr. A reviewed the serious risks again. This included the risk of dying (1:5000), fluid shifts and increased risk with larger volumes. She said cardiac events and stroke from anesthesia were not mentioned.

She was booked (February 26, 2009) and paid for the surgery. She cancelled three days before surgery and was given a full refund. She was asked to cancel within a week of surgery, if not, she would probably be charged if the doctor could not fill the spot. She called his office on April 28, 2009, to ask about the nonrefundable policy and was told two weeks notice of cancellation was needed.

The Committee accepted her evidence as credible.

Patient Ms LV

Ms LV testified that she was seen in June 2007 at the TCC as she wanted liposuction. She found information on the internet, and read and was impressed by patient testimonials.

She met first with Ms D and discussed some risks and costs, and knew about the 50% nonrefundable policy.

She later met with Dr. Yazdanfar, reviewed the procedure and discussed the risks (blood clots, shock, and anesthetic risks). She found this somewhat "scary." She also discussed risks with the anesthesiologist. She paid $1,000.00 more for Smartlipo, which she understood to be less invasive, to speed up healing and a better technique. She received post-operative instructions, including having to wear a garment which she understood was to reduce swelling and improve drainage.

Ms LV's evidence was accepted as credible by the Committee.

Patient Ms XO

Ms XO testified that she was seen at the TCC in 2006 having accessed it through the internet. She read the testimonials and was sufficiently impressed by the website to make an appointment. She was aware of Dr. Yazdanfar's background. She described a cosmetic surgeon as any kind of doctor who can perform cosmetic surgery.

Ms XO had liposuction in October 2006 and breast augmentation in May 2007. She understood that, once she had paid, there was a 50% cancellation fee and did not feel pressured by this. She recalled being told about risks, the most serious being death. She had a list of risks and understood all of it; she had time to ask questions but did not recall asking any.

She did not recall being told she could die, or about serious medical risks relating to removing her garment. She gave information, which she agreed was contradicted by the record, regarding the dates she made payments.

This patient's evidence was of little assistance to the panel given her poor memory for conversations occurring years before and statements that contradicted the medical record.

Patient Ms EK

Ms EK testified that she was seen at the TCC for liposuction in May 2006. She described serious risks as: anesthetic; swelling; rippling of the skin; pieces of fat traveling; and, clots. She was told the garment was to keep the skin tight and reduce swelling.

The Committee noted her simplified discussion of fat embolism, which indicates that the risk of fat embolism was discussed. The Committee found Ms EK to be a credible witness.

Part III Expert Evidence

Dr. A

Background

Dr. A is a certified plastic surgeon with a Fellowship in Plastic Surgery from the Royal College of Physicians and Surgeons of Canada (1986). He was appointed as Lecturer in Plastic Surgery at an Ontario university in 1988 and has teaching responsibilities. Dr. A holds the position of Coordinator of Ethics Teaching for the Division of Plastic Surgery. He is a member of the Postgraduate Medical Education Internal Review Committee, which reviews all programs.

Since 1988, Dr. A has been a member of the attending staff at a Toronto heath centre and has a hospital based practice and a private practice. About 50% of his practice is private. All surgery is done either in the OR or day surgery at the hospital (patients pay for the time). He has been doing a full range of aesthetic procedures, except rhinoplasty, since 1987; this includes breast augmentations, breast reductions, breast lifts, abdominoplasty and liposuction. He performs liposuction four to six times weekly (approximately 200 yearly). He does not have Smartlipo equipment and has no training or exposure to this technique.

The Committee determined that Dr. A was qualified to give expert evidence on plastic surgery including cosmetic surgery.

Liposuction

Dr. A gave a detailed description of the techniques of liposuction and the tumescent technique in particular. A tumescent solution is infiltrated in the area to be treated, a cannula is inserted and a mixture of fluid and fat is removed with a vacuum pump. The tumescent solution contains lidocaine and epinephrine. Epinephrine acts as a vasoconstrictor, which produces blanching within ten minutes leading to decreased blood loss. Use of tumescent solution in liposuction has been shown to be safer, and improves cosmetic results with less bruising.

The tumescent technique means a certain amount of infusion has been applied. This makes it easier to remove the fat. A cannula is used to extract the fat and is moved about blindly. Typically, the fluid extracted includes fat, body fluids, tumescent solution and blood. In the suction bottle, fluids separate with fat rising. He testified that the ratio in the fluid extracted was usually 1:1 fat to aqueous fluid, or more aqueous fluid than fat. At the most, four litres of fat corresponds to five litres of total aspirate. Approximately, 30% of the tumescent fluid comes out with aspiration, the rest remains in the body. Some of the fluid remains at the site in the form of swelling and oozes out over two to three days and the rest is absorbed into the body's circulatory system.

Fluid shift implies a large volume of fluid shifting from one compartment to another. In liposuction, massive fluid shifts can occur. A large amount of tumescent fluid is infiltrated followed by aspiration of a large amount of fat and fluid. In the post-operative phase, further fluid shift occurs when tumescent fluid from the wound enters the circulation and/or perhaps new fluid from the circulation enters the wound itself. This compares to the type of fluid shift which occurs with extensive burns or major trauma. During liposuction, the amount of fluid shift is proportional to the total amount of material that is removed from the body and the number of body parts treated. If the

amount of tumescence and IV fluid given during liposuction is correctly balanced against the amount removed, the healthy person will tolerate this well. Patients who are large are better at dealing with fluid shifts than those who are small. Loss of intravascular volume occurs with bleeding, if vessels are injured, and as an inflammatory response to injury. This can lead to hypotension and the clinical signs of shock. On the other hand, increased intravascular volume from fluid overload (oral intake, IV fluids, tumescent solution) may produce congestive heart failure. The renal system acts to decrease the intravascular volume in the case of fluid overload by very much increasing urine production.

Adverse consequences of liposuction include: pain; bruising; swelling; and poor aesthetic outcome. Complications include: infection; bleeding; fluid shifts; injury to nerves and muscles; perforation of an organ; pulmonary embolism; fat embolism; and death. The consequences of these complications can cause kidney damage, heart damage, brain damage and death.

All patients will bleed during liposuction and the amount of bleeding is related to the degree of trauma (caused by the number of passes of the cannula), the amount of the body which was treated, and individual variables such as the ability of the individual to clot blood.

Factors that increase risk of complications include: volume extracted (increased risk exists with increasing the volume); number of body parts treated (increasing the number of parts treated increases risk of complications); thromboembolism risk, though present in all patients, is increased with the amount of surgery performed and post-operative immobilization for a number of days; and fat embolism, which is increased by the amount of fat removed and the number of areas treated.

Breast Augmentation

Breast Augmentation or augmentation mammoplasty as normally performed in Ontario is done under general anesthesia. A periareolar incision is made (options include an inframammary incision or axillary incision). A pocket is created usually by electrocautery

dissection. Hemostasis is checked, following which the implant is inserted and the wound closed.

Hemostasis is checked by looking for bleeding vessels and cauterizing them. There is always some bleeding.

Local anesthetic is used in the skin incision, typically, by infiltrating one percent xylocaine plus epinephrine along the incision line using about 5cc's per side. This is a small amount, but is adequate to anesthetize the incision and helps with skin hemostasis. Anesthesia, other than general anesthesia, can be done by regional block infiltrating the pocket or by nerve blocks.

Breast augmentation as practised by Dr. Yazdanfar differs in the following way: The breast is tumesced using a large volume of dilute solution containing xylocaine, epinephrine and Marcaine. An incision is then made around the areola and carried down to the chest wall and a pocket is created in the subglandular plane. The pocket is examined to make sure that it is dry and then a sizer is placed and inflated with air to the anticipated size. After irrigation with an antiseptic solution, the implants are placed and the incision is closed in layers.

Hemostasis is normally achieved by direct visualization and cautery to obliterate the lumen. If epinephrine and not cautery is used to achieve hemostasis, this may give a false sense of security. When it wears off, bleeding can occur, leading to hematoma or increased capsular contracture. The standard approach is to use general anesthesia without blocking the pockets.

Dr. A was asked about an article by Dr. Z where he uses injection of local anesthetic. Dr. A did not believe this technique was the same, in that Dr. Yazdanfar uses general anesthesia and she blocks the entire breast. To use both general and local anesthesia is not a rational approach. He agreed that the tumescent technique was used in breast reduction procedures.

Dr. A testified regarding a number of factors considered in breast augmentation as follows:

Where incisions are made

Incisions are usually made in the periareolar area, in the inframammary fold or in the anterior axilla.

Blunt/sharp dissection

Blunt dissection means that the tissue is separated by the finger or blunt instrument and this is used where a tissue plane exists and the tissue is likely to open up. Sharp dissection means an actual cutting through the tissue or using a cutting cautery. This opens up the tissue and hopefully leaves a dry plane.

Placement of implants

Implants are generally placed either in the subglandular position (under the breast gland but on top of the muscle) or the subpectoral position (beneath the pectoral muscle except inferiorly as the muscle only goes down so far and above the rib cage). Occasionally, they will be placed in a submuscular position, but this reflects a complete covering with muscle, is more complex and not often done.

The placement needs to be discussed with the patient, taking into consideration their expectations and their anatomy. The advantages of a subglandular implant are that it gives more definition to the breast, tightens the skin and possibly moves the breast more to the centre than a subpectoral position. For some, it is not the first choice, especially if there is limited soft tissue in the skin of the upper breast. There is also increased risk of capsular contracture. A subpectoral location is preferred when there is not enough soft tissue. The contracture rates are lower and the appearance is more natural. Subpectoral placement depends on the anatomy. It is not used when skin tightening is desirable, or in weight lifters.

Risks of breast augmentation

The risks of breast augmentation are exhaustive and include: scar quality (none to keloid) which may require removal; infection which may lead to removal of the implant; hematoma which is a surgical emergency; healing problems including delay, wound dehiscence and implant exposure which requires implant removal; anesthetic risks; patient dissatisfaction with the aesthetic results; implant deflation (saline leak); capsular contracture which may cause pain and distortion; ripples in the skin (more with subglandular); malposition with time, including bottoming out, which refers to too much in the bottom half and not enough in the top; changes in nipple sensation; and, interference with lactation. Silicone is not currently considered a cause of connective tissue disorders. There is no evidence that implants cause cancer or interfere with its detection.

Capsular contracture

A capsule forms around the implant in 100% of cases. Contracture occurs when the capsule tightens making the implant more spherical. Baker's classification relates to the severity of the contracture as follows:

- Baker 1 - essentially nondetectable;
- Baker 2 - hardening of the implant apparent to the doctor but not the patient;
- Baker 3 - Hardness evident to doctor and patient and may or may not be tender; and,
- Baker 4 - Contracture is evident to both and associated with hardness, pain and visible distortion.

Capsular contracture is observed more with subglandular positioned implants than subpectoral. The reason is unknown. There is no known way to prevent it occurring, but constant massage may help. He thought that the incidence of a Baker 4 developing was between 1 to 10%. There is a huge range.

Hematoma

Hematoma, a localized blood clot, occurs because of inadequate hemostasis. It may occur very quickly after surgery or late (up to ten days). Dr. A thought that 1-2% of patients had to go back to the OR to have the hematoma treated. The development of a hematoma does not necessarily mean substandard surgery.

Types of Implants

Size of implants used in Ontario may vary; 200 ml or less would be small, around 350 ml average, and 450 and up would be large. There are many adverse effects with large implants: a larger pocket means more surgery; there are more wound complications; there is more capsular contracture; and, weight of the implant will cause it to hang lower and gradually stretch with loss of definition of the inframammary fold.

Implants have a shell made out of polymers, which may be smooth or textured. Textured implants appear to have less capsular contracture, will bind to the body and are less mobile, thus remaining in one position.

Implants may be filled with silicone gel (preassembled) or with saline which is filled after the implant is in place. Subglandular implants are more noticeable. Saline implants have a watery feel, and, therefore, gel is often preferred. Implants may be round or have stable shapes; they vary in width or diameter and vertical projections. The decision regarding the type of implants is shared between the doctor and the patient and includes considering patient's preference, size, where the incision is placed, placement of the implant, and follows a process of informing the patient and getting feedback.

Mastopexy or Breast Lift

Mastopexy is a tightening procedure/enhancing support and is used to raise the nipple(s) or tighten the skin in the lower part of the breast.

Bottoming out

Bottoming out occurs when the implant is too heavy. It is often painful. Treatment may include: doing nothing; removing implants and then possibly replacing them three to six months later; mastopexy; and, possible use of an internal support such as a capsular sling.

Capsulotomy

This is one procedure used for capsular contracture. Using the previous incision, the implant is removed and a circular incision of the capsule is made at the base and in several areas on the anterior side, allowing the implant to relax.

Capsulectomy

This is a procedure for treatment of capsular contracture which involves incision and removal of the implant, usually by sharp dissection around the entire pocket, removing the capsule in one piece. Implants may or may not be replaced.

There is no consensus regarding the choice of capsulotomy versus capsulectomy. The choice depends on personal preferences. Dr. A's impression is that, in the U.S., capsulectomy is done more often; in Ontario, capsulotomy is done more often as it is considered less invasive. Usually, there is a plan at the time of surgery which allows a capsulotomy to change to a capsulectomy if something such as a calcified capsule is found.

OHIP Coverage

Cosmetic or aesthetic surgery is not covered by OHIP. However, OHIP coverage extends to cover many breast procedures including breast reductions, capsulotomy, capsulectomy and the management of hematomas. These are health issues and patients have a right to have health issues dealt with under the public health care system.

Standard of Practice in Ontario

Liposuction

In Ontario, those doing liposuction generally follow the guidelines of the American Society of Plastic Surgeons (ASPS). In the outpatient setting, the maximum of total aspirate (fat and fluid) to be extracted in a single procedure is 5000cc's. Dr. A referred to a Practice Advisory on Liposuction, which is a consensus opinion from the American Society of Plastic Surgeons (ASPS) published in Plastic and Reconstructive Surgery Journal (April 2004) and widely circulated (exhibit #54). There is no trend away from using total aspirate as demonstrated in the latest practice advisory from the ASPS in October 2009. Other factors, such as small size, may influence the volume removed, but the total aspirate would be revised only downward. Large volume liposuction (5000cc's) means liposuction with increased risk. It is safest and best to stay within these guidelines, or be more conservative. He said that 5000 cc's of total aspirate corresponds to 4000cc's of fat at most. If patients want more, the surgeon needs to discuss the increased risk, try to persuade them to change or have it done in two procedures, or refuse to operate. If more than 5000 cc's are to be removed, the risk of complications is increased and patients must be admitted for overnight observation and appropriate monitoring (vital signs, hemoglobin, fluid input, potential lidocaine toxicity).

Dr. A indicated he was aware of guidelines produced by the American Academy of Cosmetic Surgeons (AACS) as these guidelines permit extraction of volumes that exceed acceptable limits. In his opinion, they are not good guidelines and he is not aware of surgeons in Ontario using them.

He testified that the standard of practice in Ontario is to remain within the guidelines of the ASPS.

Breast Augmentation

The standard surgical technique for breast augmentation as currently taught in residency programs is as described previously, and used by plastic surgeons in Ontario. The tumescent technique used by Dr. Yazdanfar is not standard in Ontario or taught in residency. The safety profile is unknown. Dr. A said patients should be informed that a non standard technique is being used.

Payment/Billing practices

Dr. A agreed that it is usual for the full fee for cosmetic surgery to be paid upfront. He did not argue about the need for a cancellation fee. His opinion was that the amount of 50% was excessive. His experience relates to perhaps 20 plastic surgeons. They all have cancellation policies.

Informed Consent

In general, there are three components of consent: (a) voluntariness (b) capacity of the patient to understand (c) disclosure.

(a) Voluntariness

For consent to be valid, the patient needs to make a decision without any outside influence. It was Dr. A's view that having made such a substantial financial commitment, patients would be influenced not to change their mind.

(b) Capacity

Not applicable

(c) Disclosure

Dr. A agreed that the serious complications related to large volume liposuction are real risks. Fluid shifts, possibility of death, shock, pulmonary embolism, and fat embolism are material risks of large volume liposuction.

In respect of breast augmentation, specific consent issues include the nature and risks of the procedure, selection of implants, hematoma, infection, implant contracture and others. Additionally, patients need to have a discussion of alternatives and their expected outcomes, risks and complications.

Pre-operative assessment

A complete history and physical examination needs to be done before surgery. This includes any diagnostic or other testing that might be required. One of the purposes of the pre-operative assessment is to make a final determination as to whether the procedure is appropriate. The surgeon decides whether to proceed and the patient learns what can be done and whether they want to have it done.

Dr. A was asked by the College to provide an opinion on a number of patients as to whether the standard of practice was maintained and whether Dr. Yazdanfar exhibited a lack of knowledge, skill and judgment in her care of the patients.

Krista Stryland

Dr. A came to the opinion that Dr. Yazdanfar failed to meet the standard of practice and that she demonstrated a lack of knowledge, skill or judgment in her treatment of Ms Stryland.

Standard of Practice

In regard to the standard of practice, she failed to meet the standard in four areas:

(i) Informed Consent Process

Ms Stryland initialed and signed an overwhelming volume of papers. There was nothing in the written record to indicate that the more serious issues or issues of personal relevance were discussed, except for the note made by Dr. Yazdanfar that informed consent was discussed “in detail”.

(ii) Operation performed

The surgery involved large volume tumescent liposuction of more than 6000cc's. This was done at many sites (abdomen, love handles, lower back, inner thighs) and covered 34% of body surface area, according to the autopsy report. The volume extracted exceeded the standard of practice and was frankly dangerous.

In Ms Stryland's surgery, she received 6000cc's of tumescent fluid and 3400cc's IV fluid (Ringers Lactate) for a total of 9400cc's. To say that the volume of fluid had no adverse effect is not a responsible statement. What happened was a result of her liposuction surgery and not anesthesia.

(iii) Post-operative care

Dr. Yazdanfar failed to recognize that her patient was profoundly hypotensive upon reaching the RR. Aside from major trauma, significant arterial bleeding or a heart attack, it is difficult to explain the profound drop in BP. Usually shock does not come on suddenly, absent acute bleeding, and it may have been present earlier.

By 13:35, based on what he reviewed, Dr. Yazdanfar knew or should have known that her patient was in shock. She left an unstable patient and started another case. Dr. A disagreed that Dr. Yazdanfar was entitled to rely on her anesthetist; the surgeon is responsible until discharge.

Dr. Yazdanfar needed to be aware of what was happening in the RR and, if the anesthetist had to leave twice, she needed to leave the OR and go and check. The procedure she was performing in the OR was not critical; she could have left the room virtually at any time.

Dr. Yazdanfar failed to manage her extremely unstable patient and to treat the shock. She should have been considering a differential diagnosis such as hypovolemic shock, cardiogenic shock, unrecognized fluid loss or bleeding, etc. Both the anesthetist and the surgeon should be involved at this point. The low heart rate indicates the patient is decompensated and unable to keep her own BP up.

When a bolus of Ringers Lactate failed to produce a response within fifteen to twenty minutes, she should have arranged transfer of her patient to hospital. She failed to understand or act when the significance of lack of urine output demonstrated hypovolemic shock. No cause for the hypotension was sought. Both the surgeon and the anesthetist have responsibility. The surgeon in particular needs to attend to the fluid shifts, which have resulted from the surgery. Once the patient was reintubated with high speed intravenous infusion and a Foley catheter, it was clearly not a situation which would resolve easily and she needed to be transferred to a hospital.

Dr. A indicated that the surgeon remains responsible at all times and the last thing he/she should say is “not my problem”. With an unstable patient in the RR, surgeons have the obligation to identify causes directly related to surgery, such as organ puncture by the cannula, arterial injury, and extensive bleeding, and send the patient to a place where there is appropriate treatment. In her post-operative care, Dr. Yazdanfar failed to meet the standard of practice.

Dr. A agreed under cross-examination that events in the RR that were central to the case were unclear. He also agreed that if the records he reviewed were unreliable, it would influence his opinion. He had no evidence as to when Dr. Yazdanfar actually became aware that her patient was unstable.

In respect of documentation of the post-operative status, it would be normal to expect: documentation of a patient’s vital signs; decisions made; and a narrative of the level of consciousness, appearance, bleeding and treatment. If a note regarding the events was made at or within a reasonable time frame, it would properly be included in the chart. The charting in this case fell below standard in the absence of contemporaneous nursing notes and no note from Dr. Yazdanfar.

This patient was unstable because of fluid shift or blood loss as a consequence of her surgery, not the anesthesia, and the result was hypovolemic shock. Dr. A agreed that Ms

Stryland's outcome may not necessarily have been different if Dr. Yazdanfar had not exceeded ASPS guidelines, but the risk would have been less.

(iv) Professionalism

Dr. A believed Dr. Yazdanfar should have gone in the ambulance with the patient though it is acknowledged that she could do nothing in terms of actual care. It is a demonstration of caring in the situation where the patient may die. It was not a breach of standard of the profession and he agreed that, in his report, he indicated in his view that it was. This was a very unusual situation.

Dr. Yazdanfar had the obligation to communicate with the family and this she did not do.

v) Incompetence

Dr. Yazdanfar lacked knowledge, skill and judgment as follows:

- Dr. Yazdanfar exceeded ASPS guidelines, arrived at by a consensus of experts and accepted in Ontario, regarding volume of total aspirate that may be removed, and placed her patient at risk of increased complications;
- Ms Stryland's surgery involved frankly dangerous fluid management;
- Dr. Yazdanfar lacked knowledge when she failed to diagnose or did not recognize the serious nature of Ms Stryland's post-operative condition;
- She demonstrated no knowledge of the management of hypovolemic shock;
- She lacked skill in appropriate management of shock;
- She lacked judgment when she failed to recognize the inability of her facility to deal with the problem;
- Dr. Yazdanfar lacked judgment in commencing another case and not leaving the OR when the problems regarding Ms Stryland in the RR persisted;
- Dr. Yazdanfar lacked judgment when she did not abandon the surgery on the patient in the OR and shift her focus to Ms Stryland; and,
- She further lacked judgment in not dealing with Ms Stryland's family.

Francine Mendelson

In Dr. A's opinion, Dr. Yazdanfar failed to meet the standard of practice in her care and treatment of Ms Mendelson and she demonstrated a lack of knowledge, skill or judgment in her care of this patient.

Standard of Practice

Dr. Yazdanfar failed to maintain the standard of practice in the following ways:

i) Pre-operative evaluation

Francine Mendelson underwent large volume liposuction of the abdomen, lower back and upper back. Dr. Yazdanfar did not adequately address her personal risks, principally, her age (66), and that she had a past history of high blood pressure and smoking. These positive findings needed to be assessed and there is no evidence of a proper assessment.

There were enough red flags to refer Ms Mendelson for an internal medicine, anesthesiology or cardiology consult which would evaluate her underlying cardiac health and give feedback regarding risks of the procedure. Dr. A was of the opinion that such a consultation was required to meet the standard of practice.

While he accepted that Dr. Yazdanfar's background qualified her to make a judgment as to whether Ms Mendelson required a referral to an internist, Ms Mendelson was not "an ideal candidate". Her age alone would warrant a medical consult given the extent of surgery proposed.

ii) Informed consent

Issues related to consent include voluntariness, as described earlier, and disclosure. Regarding disclosure, some of the important issues are not mentioned, others are just wrong (surgical bleeding is a real, not a theoretical possibility, and should not be described as rare or very rare). Dr. A agreed that Ms Mendelson had the opportunity to

ask questions and that, after two years, patients do not always remember exactly what they were told.

iii) Performance of liposuction surgery

Dr. Yazdanfar performed large volume liposuction from a number of areas and exceeded accepted guidelines by removing 8800cc's of total aspirate (5050cc's of fat). This goes far beyond any published guidelines for total aspirate. She grossly violated the safety of the patient and increased the risk of complications. This would include the risk of bleeding, infection, possible damage to vital structures, excessive fluid shifts, pulmonary and fat embolism and death.

iv) Post-operative care

She was observed in the RR for four hours and forty minutes. Discharge arrangements were inappropriate; she needed to be monitored overnight.

Dr. Yazdanfar did not maintain the standard of practice in failing to respond to the dangerous observation on a cardiogram, where the appropriate response was to tell the patient to go immediately to the emergency room and to then phone the ER and tell them she was coming.

Ms Mendelson had attended for her post-operative visit on July 13, 2007, at which time she complained of pain, weakness and palpitations. Appropriate investigations were ordered (ECG, Hgb). The Hgb would be expected to drop after liposuction, however, Ms Mendelson had an Hgb of 9.2 (pre-operative 14.5), which indicates massive blood loss. Her ECG showed a pattern of anterolateral ischemia or a non-Q wave myocardial infarct, and a change from the pre-operative pattern. In the face of an acute coronary event, the drop in Hgb makes this is a serious situation; Dr. Yazdanfar advised her to go to the ER if she had chest pain and to see her family doctor two days later. This does not meet the expected standard of practice.

v) Incompetence

Dr. Yazdanfar demonstrated a lack of knowledge, skill and judgment as follows:

- If Dr. Yazdanfar did not feel Ms Mendelson was at increased risk and the procedure was safe, she demonstrated a lack of knowledge. If she was aware that her patient was at increased risk and did not deal with this issue she lacked judgment.
- In performing large volume liposuction she exposed her patient to excessive risk and demonstrated a lack of knowledge, skill or judgment.
- Dr. Yazdanfar exhibited a lack of knowledge and judgment by not referring Ms Mendelson to the ER immediately when she became aware of her abnormal ECG demonstrating an acute coronary event and a Hgb <10. Referral to the family doctor was inappropriate; the patient needed admission to a Cardiac Care Unit until her problem was sorted out.

Ms MP

Dr. Yazdanfar failed to meet the standard of practice in the care and treatment of Ms MP in the following manner:

i) Informed consent

As with the other patients, there were problems with the voluntariness of the consent.

Problems with the disclosure process are similar to other cases. The consent process should seek to build a knowledge base, but Dr. Yazdanfar's process plays down bleeding and important areas are omitted. While Dr. Yazdanfar indicates on her charts that they were discussed "in detail", there is no documentation to support this.

ii) Performance of surgery

Large volume liposuction was performed on the abdomen, love handles, upper back, inner thighs and arms. The amount (7150cc's total aspirate) exceeds safe guidelines for Ontario.

iii) Incompetence

Dr. Yazdanfar ignored patient safety by increasing the risks to this patient by performing a large volume extraction which exceeds accepted guidelines.

Dr. Yazdanfar either did not know or ignored her obligation to inform patients of shock, emboli, or death as a consequence of large volume liposuction. She underplayed bleeding and did not indicate that, as volume increases, so does risk.

Ms QR

Dr. A formed the opinion that Dr. Yazdanfar had failed to maintain the standard of practice in her care and treatment of Ms QR and that she demonstrated a lack of knowledge, skill or judgment.

Ms QR had a subglandular augmentation mammoplasty carried out on July 22, 2008, and a bilateral capsulectomy performed on October 11, 2008, at the TCC by Dr. Yazdanfar.

Standard of Practice

Dr. A gave evidence that Dr. Yazdanfar fell below the standard in three areas: i) consent; ii) technical performance of both procedures; and, iii) follow-up provided.

i) Consent

Ms QR came with ptotic changes in her breasts, there was laxity of the skin and the breasts were droopy. She had gone from a size D (during pregnancy) to a size B cup.

Standard disclosure requires a discussion of options if they are present. They cannot just be omitted. There was no documentation of a discussion of the options.

Ms QR should have been informed of three options: a) breast augmentation; b) mastopexy; and, c) breast augmentation and mastopexy in one or two stages.

Dr. Yazdanfar does not do mastopexy and should have discussed this option with the patient in a truly informative manner so that the patient may seek care elsewhere if she feels that is appropriate. She should discuss the risks, complications and consequences of each of the options.

A large implant (550cc) was chosen by the patient. With involutional changes in Ms QR's breasts, she has skin weakening and, if a large implant is used, the skin will be too weak to hold it. There is an obligation to discuss the pros and cons, which include increased risk of hematoma, capsular contracture, inferior descent, pain and the need for further surgery.

By September 2008, she was noting firmness (Baker's 2 to 3). Three weeks later, she was having pain (Baker's 4). He agreed that, according to the chart, there were three options discussed: a) capsulectomy; b) changing the pocket presumably to a subpectoral location; and, c) capsulectomy with replacement of smaller sized implants.

Option c) is not realistic, as a large pocket is left and a small implant will be mobile and will move up, down or most likely laterally.

There was no mention of capsulotomy, which has the advantage that the tissue supports are left in place. She could also have the implants removed and wait three to six months to decide if she wishes them replaced. OHIP would cover this, as she has a new pathological diagnosis. She is no longer a breast augmentation patient, rather, she has a pathological contracture and will require a reconstructive procedure.

ii) Technical performance of Breast Augmentation

Dr. Yazdanfar performed this surgery under general anesthetic using the tumescent technique. The tumescent solution contained xylocaine, epinephrine and marcaine. Marcaine is longlasting with side effects that are hard to treat, including seizures and arrhythmias, and should not be used. This is not standard procedure in Ontario and is not

taught by the universities or presented at medical meetings. As far as he knows, Dr. Yazdanfar is the only one doing this procedure in Ontario.

iii) Follow-up Provided

When capsulectomy is performed, it is standard to replace the implants with the same devices. In this case, it was inappropriate. Ms QR's implants were large and heavy. With this surgery, more support will be lost and capsules will likely recur. Removal of the implants was a reasonable option at this point.

iv) Incompetence

- Dr. Yazdanfar omitted the discussion of options with this patient. She was told that a breast lift was possible, but the procedure was not discussed. If Dr. Yazdanfar was unaware of the options for care of this patient, she lacked knowledge and, if she felt they were not relevant she lacked judgment;
- In her responses, Dr. Yazdanfar demonstrated a lack of knowledge in the possible position of scars in mastopexy, when she indicated that an inverted T was the result. In Ontario, there is a trend towards staying away from that scar;
- Dr. Yazdanfar has a lack of knowledge of standard procedures and uses a technique with unknown safety;
- In discussing the options for capsular contracture she did not discuss capsulotomy and the third option was not realistic;
- Size of implant should not be the patient's choice alone. The surgeon needs to give professional advice. It is poor judgment to have the patient take full responsibility. Dr. Yazdanfar used a larger implant than appropriate, which exhibits poor judgment;
- Dr. Yazdanfar should have truly informed her patient of all options, and if she did not perform an appropriate option, she should have presented this in such a way that the patient could follow-up elsewhere, and she did not.

Ms WX

Dr. A was of the opinion that Dr. Yazdanfar failed to meet the standard of practice in the care and treatment of Ms WX and that she demonstrated a lack of knowledge, skill or judgment.

Ms WX sought help for problems related to implants put in a number of years before by a plastic surgeon who had subsequently retired. She sought an improved appearance. Over the years, she had noticed loss of volume and descent of her implants and there had been changes in her body from weight loss and body building. The right nipple was higher on the breast mound than the left, and the bulk of the breast tissue was lateral. The upper breast lacked fullness. He agreed the chart indicated she wanted larger breasts. She had many options; to do nothing, mastopexy, mastopexy with a change in nipple location (some scarring), and replacement of implants in a different pocket. From the chart, it appears there was no discussion of options. A subglandular augmentation mammoplasty was performed, changing the pocket and increasing the implant size. At eleven months post surgery, there was bottoming out, significant distortion, implants had shifted laterally and the nipple was sitting high.

Standard of Practice

Dr. Yazdanfar failed to meet the standard of practice in: i) disclosure for consent; ii) she did not perform the correct operation; and, iii) her post-operative care.

i) Disclosure

The TCC record shows no evidence of a discussion of the options available and there were many options available to this patient. If surgeons do not perform one of the available surgical options, it is expected they would tell the patient the risks and benefits of that option and, if necessary, recommend the patient look into this elsewhere.

There was no discussion of increased risk with increased size of implant. The larger the implant, the larger the pocket and an increased risk of complications, including hematoma, capsular contracture, further descent from weight, further distortion, loss of

the inframammary definition, pain, implant exposure and the need for tertiary surgery. A large 550cc implant was not in this patient's interest and she should have been told. Choice of implant is a shared responsibility.

ii) Wrong operation

Augmentation was not the preferred option. The operation done was not correct for ptosis, and using a large heavy implant will cause the breasts to become droopier. She used a technique that was not, in his view, in accordance with the standards of Ontario.

It was reasonable to switch to a subglandular plane but the implant should have been smaller and possibly a form stable type of implant.

This patient was put at risk of capsular contracture and progressive deformity after surgery.

iii) Post-operative care

At the one year post-treatment appointment, she was unhappy with the shape of her breasts, claimed they fell to the side, and that the nipples were not even. She was having pain and had to wear a sports bra. This was a combination of capsular contracture, or bottoming out, or loss of inferior support. The reasonable course was to remove the implants for a minimum of three months up to a year. A failure to offer this to the patient is a failure to meet the standard of practice. Other options would include surgical plication of the pocket. In order to correct the nipple position, some sort of skin tightening would be needed.

iv) Incompetence

Dr. Yazdanfar exhibited lack of knowledge, skill or judgment as follows:

- The procedure done initially increased risk of progressive deformity and was not the ideal procedure for this patient.

- The implant size chosen was too large, and a formed type should have been considered.
- Options were not discussed.
- The course decided upon opened the patient to increased complications.
- She chose to use a technique that is not in accordance with Ontario standards.
- When complications arose later she failed to advise removal, which is the accepted approach.

Patients from Cosmetic Surgery Practice from 2005 to 2007

As a result of a s.75 investigation, Dr. A reviewed 40 of Dr. Yazdanfar's charts, which he believed were picked at random. Dr. A opined that Dr. Yazdanfar fell below the standard of the profession in her care and treatment of these patients in different ways on the basis of his review of the charts, including: consent; pre-operative assessment; procedures; and post-operative care.

In regard to consent, a lack of voluntariness was seen in all charts as all contained a 50% non refundable clause.

In terms of consent, there were many forms, there was no record of a discussion of the serious complications, and surgical bleeding was described as very rare. Where there was no record, Dr. A concluded that no discussion had taken place. There may have been several charts where death was mentioned, after the case of Krista Stryland, but not in the vast majority.

The following 28 cases are reviewed in detail.

Liposuction Patients

Ms ZX

This patient had large volume tumescent liposuction (7900cc's) from the abdomen, love handles, lower back and inner thighs. Smartlipo was used. The volume exceeded guidelines and the patient was not told of the increased risk.

The recovery was three hours and she was discharged home the same day. As complications can occur later, she should have been admitted overnight.

This is a failure to meet the standard of practice and exhibits a lack of knowledge, skill and judgment.

Mr. AZ

This patient had large volume tumescent liposuction of the abdomen, love handles and lower back; 5,250cc's of fluid was extracted, which exceeds accepted guidelines. Smartlipo was used.

He was discharged home same day. This placed him at increased risk of complications. There was no discussion of increased risk with increased volumes or serious risks such as pulmonary embolism, fat embolism and death.

In her treatment, Dr. Yazdanfar failed to meet the standard of practice and exhibited a lack of knowledge, skill or judgment.

Ms SJ

This patient had large volume tumescent liposuction to the abdomen, love handles, and lower back using Erchronia laser. The volume extracted exceeded accepted guidelines (5150cc's). She was discharged home the same day. She was not told of the increased risk of complications.

This did not meet the standard of practice and displayed a lack of knowledge, skill or judgment.

Ms EV

Ms EV had large volume liposuction of the abdomen, love handles, outer thighs inner thighs and lower back (6900cc's total aspirate of which 5000cc's was fat) performed by Dr. Yazdanfar on March 28, 2007. Dr. Yazdanfar failed to comply with guidelines for volume removal, and put her patient at increased risk.

This constitutes a failure to maintain the standard of practice and reflects a lack of knowledge, skill or judgment.

Ms AJ

This patient had tumescent liposuction with a total aspirate of 5400cc's, which exceeds the accepted guidelines in Ontario.

Dr. Yazdanfar demonstrated a lack of knowledge, skill or judgment in exceeding safe guidelines.

Ms EF

This patient had large volume tumescent liposuction of the abdomen, love handles, and lower back with Smartlipo, performed by Dr. Yazdanfar. A total aspirate of 7400cc's was removed, which exceeds accepted guidelines in Ontario and which has increased risks.

Ms KO

This patient had liposuction from the abdomen, love handles, bra line and back performed by Dr. Yazdanfar on September 22, 2007. A total aspirate of 8850cc's was removed, of which 5100cc's was fat.

This grossly exceeds accepted guidelines and does not maintain the standard of practice in Ontario.

To remove such a large amount of aspirate reflects a lack of knowledge, skill or judgment.

Ms JR

This patient had large volume liposuction done on September 28, 2007, from the abdomen, love handles and lower back using Smartlipo. A total of 8800cc's was aspirated, of which 5700cc's was fat. This grossly exceeded accepted guidelines.

This fails to maintain the standard of practice and demonstrates a lack of knowledge, skill or judgment.

Ms PR

This patient had liposuction from the abdomen, love handles, lower back and upper back done on August 8, 2007, by Dr. Yazdanfar. A total aspirate of 8300cc's was removed which grossly exceeds accepted guidelines.

This fails to maintain the standard of practice and demonstrates a lack of knowledge, skill or judgment.

Mr. TC

This patient had large volume liposuction of the breast, abdomen, love handles and lower back using Smartlipo, removing a total aspirate of 9400cc's, of which 5900cc's were fat. He was morbidly obese with a BMI>40, making him a poor candidate for surgery and at increased risk of many complications as well as an anesthetic risk. He was definitely a surgical risk from pulmonary and cardiac complications, massive fluid shifts, shock, DVT and death.

Patients must know if you are operating outside of the accepted range of volumes in the guidelines. The physician has a duty to inform if this is the case. There is no evidence of such a discussion.

Dr. Yazdanfar grossly exceeded accepted guidelines in this case, almost doubling the recommended total aspirate, which does not meet the standard of practice and demonstrated a lack of knowledge, skill and judgment.

Ms EK

This patient underwent large volume liposuction of the abdomen and love handles with a total aspirate of 5700cc's.

This exceeds accepted guidelines limiting removal to 5000cc's of total aspirate. Patients undergoing large volume liposuction should be kept in hospital overnight for observation with monitoring of their vital signs and urine output.

Ms LV

This patient had large volume liposuction of the abdomen, flanks, love handles and lower back with Smartlipo. A total aspirate of 6700cc's was removed which increased her risk of complications, which she was not informed of. She was not observed overnight.

This does not maintain the standard of practice and demonstrates a lack of knowledge, skill or judgment.

Mr. PK

This patient had liposuction performed on September 10, 2007, (7900cc's total aspirate, 5300cc's of fat) and, one month later, again, had liposuction done (6600cc's). Both were large volume procedures. Further, his BMI was 35, and obesity is an independent risk factor. He was a high risk patient who had a high risk procedure done and was discharged the same day, going home alone by taxi.

Dr. Yazdanfar failed to maintain the standard of practice and exhibited a lack of knowledge, skill or judgment.

Ms CX

This patient had large volume liposuction of the abdomen, love handles and lower back using Smartlipo. The volume removed was 5800cc's of total aspirate. She had an ASA 3 classification by the anesthetist on the day of surgery and was discharged the same day by taxi, unaccompanied by a responsible adult. Another patient would not be acceptable as she herself may be incapable of acting, and both would be under the influence of narcotics and analgesics. Many guidelines say only ASA 1 and ASA 2 patients should be operated on in ambulatory facilities.

This exceeded accepted guidelines, is a failure to maintain the standard of practice and demonstrates a lack of knowledge, skill or judgment.

Mr. PC

This patient had large volume liposuction on September 22, 2007, removing 8100cc's of total aspirate and 5500cc's of fat. He was discharged the same day when he required overnight monitoring. He was categorized as an ASA 3, which means, by most guidelines, that his medical status was not appropriate for an ambulatory facility. He had asthma, had been on steroids in the past and had labile hypertension. These factors affect surgical as well as anesthetic risks. Volume guidelines were designed for the average individual and volumes should be decreased for those who have increased ASA ratings.

Dr. Yazdanfar exceeded accepted guidelines and failed to maintain the standard of practice. She demonstrated a lack of knowledge, skill or judgment in performing liposuction surgery on this man.

Ms FT

This patient had large volume liposuction of the abdomen, love handles and lower back, removing 7200cc's of total aspirate, exceeding accepted guidelines. She was ASA 3 based on a history of smoking, being overweight and hypertensive. There is no evidence that this was discussed with the patient and the increased risk should have been made known to the patient.

This fails to maintain the standard of practice and demonstrates a lack of knowledge, skill or judgment.

Mr. RZ

This patient had liposuction of the abdomen, right upper and lower back, right love handle and chin with removal of a very large amount of total aspirate and fat (9.5 and 6.2 litres respectively), virtually doubling the accepted standard.

He was then discharged to a taxi unaccompanied. Even if arrangements had been made and no one came, he should have been kept at the TCC overnight for observation and monitoring, or admitted to a local hospital. This treatment does not meet the standard of practice in Ontario.

Dr. Yazdanfar placed her patient at an unacceptable risk and demonstrated a lack of knowledge, skill and judgment.

Mr. BY

This patient had large volume liposuction yielding 6900cc's of total aspirate. This exceeded accepted guidelines and failed to meet the standard of practice, as in other cases where more than 5000cc's of total aspirate was removed.

This demonstrates a lack of knowledge, skill and judgment, as with the previous cases.

Breast Augmentation Patients

Ms DS

Dr. Yazdanfar carried out breast augmentation using a non standard technique.

The same issues exist as with other patients in using what is considered a non standard technique in Ontario. There must be good published peer reviewed evidence for it or it remains non standard treatment in Ontario.

In respect of the above, Dr. A opined that Dr. Yazdanfar has failed to meet the standard of practice and demonstrates a lack of knowledge, skill or judgment.

Ms XB

This patient had a subglandular breast augmentation performed by Dr. Yazdanfar. She used a non standard technique and the patient was not informed of its non standard nature.

Dr. Yazdanfar lacked knowledge, skill or judgment when she did not inform her patient she would use a non standard technique.

Ms ZA

This patient had a subglandular breast augmentation using the tumescent technique. The issues are the same as with other breast augmentation patients.

This fails to maintain the standard of practice and it demonstrates a lack of knowledge, skill or judgment.

Ms YM

This patient had a subglandular breast augmentation using 350cc's of tumescent solution in each breast with Marcaine. Many consider the use of Marcaine to be contraindicated. All other previous comments regarding the technique apply.

Dr. Yazdanfar did not maintain the standard of practice and demonstrated a lack of knowledge, skill or judgment.

Ms WR

This patient had a subglandular breast augmentation using 400cc's of tumescent solution in each breast, including Marcaine. All other previous comments regarding the technique apply.

Dr. Yazdanfar failed to maintain the standard of practice and demonstrated a lack of knowledge, skill and judgment as with other augmentation cases.

Ms MG

This patient had a breast augmentation using tumescence and Marcaine. For the same reasons as in other breast augmentation cases described above, the standard of care was not met. In addition, she was discharged unaccompanied by taxi, which is unacceptable after a general anesthetic. The standard in the province of Ontario is not to discharge a patient unaccompanied following general anesthesia.

Dr. Yazdanfar demonstrated a lack of knowledge, skill and judgment in performing this procedure and in the discharge arrangements.

Liposuction and Breast Augmentation Patient (Different Dates)

Ms XO

This patient had liposuction done on October 25, 2006, by Dr. Yazdanfar, which resulted in a total aspirate of 5600cc's, exceeding accepted guidelines.

She also had a subglandular breast augmentation on May 18, 2007, performed by Dr. Yazdanfar. The same tumescent technique was used, including the use of Marcaine. This is not standard and many consider Marcaine to be contraindicated.

In the treatment of this patient, Dr. Yazdanfar failed to maintain the standard of practice and she demonstrated a lack of knowledge, skill or judgment.

Combined Procedure Patients

Ms TJ (Liposuction and Breast Augmentation)

Ms TJ had simultaneous procedures carried out on July 2, 2007 (augmentation mammoplasty and liposuction). There are documented increased risks with combining

these procedures. A full liposuction was done with 3150cc's of aspirate and this increases the general complications of liposuction such as fluid shift and deep vein thrombosis.

Dr. Yazdanfar failed to meet the standard of practice by carrying out these procedures simultaneously and by not discussing the added risks with her patient.

In removing 3150cc's of aspirate, she exceeded the limited liposuction referred to in the ASPS guidelines. Dr. A interpreted limited liposuction to be 500 to 1000cc's from a single site [Vol. 10, pgs.146-149].

Breast augmentation surgery was performed in the same manner as with other patients, and not in accordance with the accepted standard as taught in Ontario.

Physicians must let patients know if the treatment proposed is not standard. This is an ethical issue. In this respect, she also failed to meet the standard of practice of the profession.

Dr. Yazdanfar demonstrated a lack of knowledge, skill or judgment as follows: increasing the risks of complications by carrying out two procedures simultaneously; by not informing the patient of the increased risks; by exceeding acceptable volumes at liposuction; by using a technique in breast augmentation, which is not the standard in this Province and where the safety profile is not published; and, by failing to inform the patient she was going to use this questionably proven technique.

Ms ST (Liposuction and Tummy Tuck)

This patient had a combined procedure, tummy tuck and liposuction, under the same general anesthetic. Tummy tuck alone is a relatively high risk procedure. It is standard to use small amounts (500cc's) of liposuction as a direct adjunct to the procedure to reduce the bulge at the end of the incision. This patient had 3950cc's of total aspirate removed from the love handles and lower back. The combination of tummy tuck and liposuction from multiple sites is one of the more risky combinations. The risks of the combined

procedure were significantly greater than either procedure alone. In addition, this patient was morbidly obese with a BMI>40 as well as a smoker, which further increases her risk of cardiac and respiratory complications. She had an ASA 3, which is above that normally performed in an ambulatory facility. In this patient, the risk of liposuction was increased many fold.

Dr. Yazdanfar had the obligation to explain the additional risks. Dr. Yazdanfar did not meet the standard of care when she failed to inform her patient that there was added risk with the combination surgery. Dr. Yazdanfar displayed either a lack of knowledge or judgment when she did not inform the patient of the increased risk.

Ms UK (Liposuction and Breast Augmentation)

This patient had a breast augmentation and liposuction done at the same procedure. A non standard breast technique was used and the infiltrate (300cc's per breast) contained Marcaine.

Liposuction was done of the abdomen, love handles, lower back and anterior axillary fat using Smartlipo. A total aspirate of 4600cc's, though not large volume, is associated with increased risk when combined procedures are done.

The patient should have been informed of the added risk and this should have been documented.

Dr. Yazdanfar failed to maintain the standard of practice and demonstrated a lack of knowledge, skill or judgment.

Dr. A – Credibility Assessment

The Committee accepted Dr. A's evidence as reflecting careful thought. He provided the Committee with essential information about liposuction and breast augmentation and the complications of these procedures. While in the areas of informed consent, and booking

and payment issues the Committee believed that he was holding Dr. Yazdanfar to an exacting standard, in the areas of clinical care his evidence was consistent, clear and fair. The Committee considered him to be a credible witness.

Dr. GH

Background

Dr. GH is a plastic surgeon certified as a Fellow by the Royal College of Physicians and Surgeons in Plastic Surgery in 1994. Dr. GH is a practising plastic surgeon in Toronto. Since 1998, his practice has been 100% aesthetic plastic surgery. He sees 300 to 400 cases yearly, of which 75 to 80% stay overnight. He operates in a surgical facility that is certified by the Canadian Association for Ambulatory Surgical Facilities (CAASF). He oversees two businesses (aesthetic) and has a non-invasive practice in California.

Dr. GH is a member of the American Society of Plastic Surgeons (ASPS). Membership is limited to those who have completed a recognized plastic surgery residency program and successfully passed an oral and written examination. He is a member of the Canadian Society of Plastic Surgeons (CSPS), which is the Canadian equivalent of the ASPS. He is also a member of a number of other organizations reflecting the interests of like minded individuals such as lobbying, sharing information, public relations, etc. These are not regulated and include the American Academy of Cosmetic Surgeons (AACS), which is not recognized by the American Board of Medical Specialties (ABMS). The AACS brings together physicians with varied backgrounds. Some are ABMS recognized surgical sub-specialists and many members are not surgically trained.

The ABMS oversees programs and is comparable to the Canadian Fellowship. The ABMS regulates and monitors the adequacy of training programs, standards and accreditation.

Dr. GH testified that physicians may do selected cosmetic surgery procedures within their limits where safe. Large volume liposuction is potentially dangerous, fraught with

complications and the number one cause of cosmetic surgery deaths. He will train non-ABMS surgeons, including family doctors, in liposuction, if they restrict aspirate to 500cc's fat, less than 1000cc's of combined aspirate, and use just oral sedation and tumescent infiltration with no IV sedation and no general anesthesia.

The Committee accepted Dr. GH as qualified to give expert evidence in plastic surgery, including aesthetic or cosmetic surgery.

Liposuction

Dr. GH described the technique of tumescent liposuction. In practice, sufficient fluid is infiltrated to make the tissue feel firm to the touch. Up to five litres of total aspirate can be removed safely; this is never black and white but, with more volume, there is increased risk and more chance of fluid overload. There is a need to be careful, erring on the conservative side.

Suction assisted liposuction is the standard in Ontario. There is a large variety of cannulas, which can be used for this procedure. The Candycane cannula is one with a spiral series of holes; it is traumatic, but fast and efficient.

Smartlipo is the trade name coined by one manufacturer for laser assisted liposuction. Dr. GH uses and teaches Smartlipo. It acts to disrupt the fat cells and coagulate blood vessels. It takes ten to forty minutes. The advantages to patients are that the liposuction is less forceful, the extraction less traumatic, there is less blood in the aspirate, less bruising and better skin tightening for the patient.

This is known as a gentle technique and implies gentle extraction to achieve less bruising and more skin tightening. Use of a Candycane cannula defeats that purpose. To properly do a 5 x 5 sq.cm. zone, you have to spend time. You cannot stick the device in for two minutes and perform Smartlipo. It is intended for a single zone, aspirating a small amount of fat (600ml's) under local anesthesia insufficient to produce any fluid shifts. Smartlipo is not intended for multizonal use or to treat the whole body; to use it in this fashion is to

use it as a marketing statement and not for the physiological benefit of the patient. Use of the laser does not increase risk.

Fluid shift is caused by trauma and liposuction causes massive trauma; as the number of zones treated with liposuction increases, the trauma increases. If three to five zones are treated, it is the equivalent of a major burn to >30% of the body. If many sites are treated, there is much more fluid shift effect increasing the risk of shock, myocardial infarction and single/multiple organ failure. In the out-patient setting, you need to work and respond to conditions and constantly be aware of the colour of blood in the aspirate.

IV crystalloid needs to be given in a reasonable amount, depending on the amount you are taking out. Other than liposuction, there are no other aesthetic procedures that will produce massive fluid shifts. Blunt trauma and burns cause such fluid shifts. Plastic surgeons are trained to treat such problems.

Health risks of liposuction can be major, including death, heart attack, stroke, septic shock, necrotizing fasciitis, pneumonia, deep vein thrombosis and pulmonary embolism, wound infection, bleeding and shock. Fat embolism is uncommon. All are relatively uncommon, but all need to be disclosed. There are a number of minor and/or aesthetic risks, including irregularities/asymmetry, laxity, scars, discoloration and need for revision.

Standard of Practice

Liposuction

In respect of volume, removing a maximum of 5000cc's of total aspirate during a single liposuction is the standard of practice in Ontario and is a guideline of the ASPS, which all reasonable physicians should follow.

This was published in 2003 (exhibit #54) as a result of a task force (from a number of disciplines), which had looked into the issue because of increasing morbidity and

mortality as a result of liposuction. They reviewed the literature, discussed the relative merits, and looked at surveys and meta-analyses in making the determination that this was a reasonable guideline for safety. It is the adopted standard for medical legal liability, insurance carriage, and certification of surgical facilities.

In Ontario, 95% of liposuction is done by plastic surgeons and all are aware of the guidelines. It is used in education/residency training and is the standard of practice in ambulatory facilities in Ontario.

In the USA, guidelines vary from state to state given free market aesthetic medicine.

The AACS uses a guideline of 5000cc's of fat. The AACS guideline has no relevance to the standard of practice in Ontario. They are not equally acceptable guidelines to the ASPS guidelines. There is no trend to the measurement of fat over total aspirate. In fact, the ASPS updated patient safety guidelines of 2009 reaffirm the measurement of total aspirate. It is untrue that they are both respected guidelines.

Dr. GH agreed that guidelines are just guidelines. They may become standards of care for various reasons and should be considered within reason when dealing with patients. Plastic surgeons may occasionally exceed the guidelines, but rarely. He testified that the updated ASPS patient safety guidelines apply to all physicians performing cosmetic surgery, not just plastic surgeons, and are the standard of practice in Ontario.

Factors to be considered when deciding on the volume of aspirate to be removed include: the kind of liposuction to be done to minimize trauma; the BMI; age; and, co-morbidities. Anytime you have a risk factor, you would reduce the amount of total aspirate removed. The volume of total aspirate should also be reduced if a combination of procedures is planned, such as liposuction and abdominoplasty, or liposuction and breast lift or augmentation.

Dr. Yazdanfar is not a plastic surgeon, but has been trained to do liposuction and is a member of the AACS. She has no real training in the management of fluid shifts/burns. Dr. GH testified that Dr. Yazdanfar should have been following the ASPS guidelines regarding the volume of aspirate to be removed in liposuction surgery.

Breast Augmentation Techniques

Most breast augmentations (99%) in Ontario are performed by plastic surgeons. The standard of care taught in Ontario is that you need to visualize the pocket and cauterize large vessels or they will retract and could bleed later.

Using tumescence is a recognized tool, however, blunt blind dissection and tumescence is not a substitute for cautery. Many surgeons will use blunt dissection and electrocautery.

Dr. GH reviewed the breast augmentation technique used by Dr. Yazdanfar (tumescent technique) and indicated that it was a valid technique in clinical practice if used in combination with direct visualization and cautery. If the tumescent anesthetic technique is used to create the pocket without meticulously cauterizing vessels as you go, this would fall below standard, putting the patient at higher risk for substantial hematoma. Depending on the studies you read, the rate of hematomas requiring surgical drainage generally is 1 to 5%. The rate of capsular contracture could be estimated fairly to range from 5 to 20%.

The technique of using tumescent anesthesia as a substitute for electrocautery is taught in a lot of USA based courses within a number of societies; this is done on an awake patient and can sometimes eliminate the need for an anesthetist. This has arisen as many seeking to do breast surgery in the USA are not able to secure an anesthetist, as they do not have a certified facility or insurance coverage to have general anesthesia.

The technique as performed by Dr. Yazdanfar does not have much logic to it. There are nominal benefits (slight reduction in bruising, slight benefit in pain control), but once a general anesthetic is used, the advantages are lost and the risk of substantial bleeding

accrues. He is aware of possibly two physicians in Ontario who use tumescent anesthesia with meticulous electrocautery dissection.

The courses teaching the tumescent technique describe the use of a blunt pocket retractor where vessels may be sheared or retracted and then the surgeon looks in to see if there are active bleeders. You put in the implant and hope that no vessel is sheared or that, if it starts to bleed, the implant pressure will control the bleeding.

After seeing the video (exhibit #173) of Dr. Yazdanfar performing breast augmentation, Dr. GH testified that the video was incomplete and could not be used in ascertaining whether she met the standard of practice. It was not clear how the pocket was created, or that there was direct visualization of the pocket for hemostasis. Washing out the wound, in his opinion, was not adequate.

Informed Consent

The standard of practice in respect of informed consent involves verbal disclosure of all risks, the asking of questions, and recording this in the written record. A stack of paper initialed and signed is not informed consent.

It is the standard of practice to discuss serious complications of the proposed surgery and to ensure the patient understands.

In respect of Dr. Yazdanfar's practice, there was no evidence that there was a discussion of serious cardiovascular, pulmonary or mortality issues, but the minor issues were well documented.

Pre-operative Care

He would normally investigate anyone over the age of 50 for cardiac issues, but does not believe that to do such an investigation is required to meet the standard of care.

Payment/Deposit

In cosmetic surgical practice, a deposit is required. A cancellation fee is also involved. Dr. GH asks for 30% if the surgery is planned for three weeks out or less, which can be refunded only if a significant medical event or reason exists.

This is a common approach. He agreed that there is a huge range in fees, as there is in the legal profession.

Recordkeeping

Based on the chart of Krista Stryland, Dr. Yazdanfar's charting was reasonable up to the RR record, where it is far below standard. There is no formal documentation by the RR nurse; no contemporaneous report by the surgeon of an adverse event that may or may not be happening; and, very poor documentation by the anesthetist making it difficult to ascertain what happened.

This does not meet the standard of practice. Given the contents of the note written by Nurse Q, which was an account of what happened in the Krista Stryland matter, Dr. GH found it unbelievable that it was not a part of the chart.

Krista Stryland

Ms Stryland had suction assisted liposuction of the anterior abdomen, upper and lower back and thighs with Smartlipo used during brief periods. She had multiple sites treated and surgery lasted just over three hours. She was not terribly large and 6.6 litres of total aspirate was a very large amount for her. There was no physiological advantage of Smartlipo.

Dr. Yazdanfar did not maintain the standard of practice by removing a volume of aspirate exceeding accepted guidelines. This patient was lighter than an average 70-75 kg liposuction patient, and the volume, if changed, should have been reduced. This highlights a fundamental weakness of Dr. Yazdanfar's training in managing sick people

with volume disorders and reflects a lack of knowledge and a fundamental lack of judgment and understanding.

In respect to her treatment post-operatively in the RR, Dr. Yazdanfar failed to maintain the standard of practice. When a patient who has had stable blood pressure, heart rate and oxygenation during surgery upon reaching the RR has a BP of 60/40, any trained surgeon would ask what is happening, know that the patient was in serious trouble, and that a cause needs to be found. At this level, the amount of blood circulating does not sustain life for long. The patient is unstable, in hemodynamic shock, and nothing else matters.

In a private clinic setting, the surgeon has the relationship with the patient and should recognize that he/she has done something to precipitate shock. The list of complications is real and includes simple intra-abdominal organ penetration, blunt trauma to the spleen, penetration of the cannula into the mediastinum, and collapsed lung. You need to apply your diagnostic skills along with the anesthetist and, if the anesthetist is not getting it, you figure it out. In terms of relying on her anesthetist, he indicated that this should be limited to a very brief period and, if a standard response of an increase in blood pressure and mental state to a bolus of crystalloid is not seen, the surgeon needs to take control. Dr. Yazdanfar did not respond appropriately and abdicated all responsibility to the anesthetist, when it was clear he had no clue what he was doing.

Dr. GH testified, though not malicious, Dr. Yazdanfar did not have enough training to recognize quickly or have a high suspicion for early signs of surgical shock and treat a condition that was induced on the operating table. In her failure to carry out any meaningful evaluation, and in abdicating responsibility to the anesthetist, she failed to meet the standard of practice.

While patients can die after any surgery, in this case the patient was small, had 6.6 litres of aspirate removed, and was taken to a RR where the lead surgeon had very little, if any, input into her management. The approach, the amount removed, and the post-operative care directly led to the patient’s death.

Dr. Yazdanfar went to the OR to start a new case without asking about the status of the patient in shock, or the response to initial management. If it is assumed that Dr. Yazdanfar never knew her patient was in shock and started the next case, waiting a brief period of time would meet the standard if the anesthetist says he has given the patient some volume and they will see. However, after fifteen to twenty minutes with no response, Dr. Yazdanfar should have stopped the liposuction procedure she was doing and gone next door to assess the patient in shock.

Dr. Yazdanfar should have recognized that she did not have the skills to manage this in her facility and 911 should have been called. The likely cause was that the surgeon induced the problem and no surgical assessment was done. This comes nowhere near the standard and is not what a trained surgeon would do.

Dr. GH reviewed the Coroner's report, which he found to be valuable (exhibit #79). He placed little or no weight on an attachment to the report as it was wrong and was not done by someone who practised liposuction.

Dr. GH was recalled to give reply evidence as there was new evidence suggesting that Dr. Yazdanfar may not have been aware of her patient's condition until 3:17 p.m. on September 20, 2007. He believed her actions in returning to the OR were unacceptable. The patient was two hours post large volume liposuction where a dark infranatant aspirate was observed, suggesting more than the usual bleeding. There were three IV's going, she was hypotensive and oozing dark fluid. Hypovolemic shock should have been considered. She was intubated and unresponsive and 911 should have been called.

A cursory glance in less than thirty seconds would not help. To ascertain a splenic injury, she would have to take down the garment. It was clear Dr. Yazdanfar had no appreciation of the severity of the situation, relied too much on the anesthesiologist, and showed a complete lack of understanding of what was happening. The use of vasopressin, with or

without inotropes, might have been beneficial. The thirty minutes between 3:17 and 3:50 resulted in a delay which could have affected the outcome.

Francine Mendelson

Ms Mendelson had suction assisted liposuction from her abdomen and upper and lower back (30-40% of her BSA) in two and one half hours. Smartlipo would not have had a significant effect on the procedure. A Candycane cannula, which is aggressively configured, was used. With the laser equipment available in 2007, which was low power, the estimated lasing time for the lower abdomen alone to be effective would be one hour to one hour and twenty minutes, and then gentle aspiration would be thirty to forty minutes for the lower abdomen alone. She had too large an area done in too short a time to have been effective. Smartlipo was used simply as a marketing tool and provided her with no physiological advantages whatsoever.

He testified that the removal of 8.8 litres of total aspirate in a 66 year old woman with a family history of cardiac disease and, then, sending her home is unacceptable and does not meet the standard of practice.

In respect to informed consent, Dr. Yazdanfar fell below the standard of practice, as there is no evidence that she discussed all of the serious complications, including heart attack, stroke, hypovolemic shock, pulmonary embolism and death. She did not discuss age or large volumes of aspirate as risk factors, and she was obliged to do so. She did not inform the patient that she would exceed the accepted standard for volume. The patient must have this information to make an informed decision. There were no contemporaneous notes detailing serious risks or her patient's affirmation.

In respect of her pre-operative evaluations, Dr. Yazdanfar arguably would have met the standard of care, though Dr. GH says he would have done a stress test. He strongly disagreed that she was a good candidate for the procedure that she had.

In respect of the post-operative care of Ms Mendelson, Dr. GH testified that Dr. Yazdanfar failed to meet the standard of practice when she did not keep her in a monitored setting overnight. The fact that her daughter removed the binder in the first 24 hours to wash and dry it is not preferred. However, the biggest risk is fainting, and this removal of the binder would not contribute to massive blood loss. It was highly improbable that removal of the binder contributed to subsequent events.

Dr. GH testified that Dr. Yazdanfar fell below the standard of practice when she did not refer Ms Mendelson immediately to the emergency room for investigation of an ECG, which showed ischaemic change to rule out a treatable cardiac event. She had symptoms of weakness and palpitations, a history of removing a lot of fluid in an older woman, a large drop in hemoglobin and an ECG that may represent ischaemia; the only reasonable action was to refer her immediately to hospital for assessment. What Dr. Yazdanfar did was neither reasonable, nor common sense management of the patient.

Ms QR

Dr. Yazdanfar performed a subglandular augmentation mammoplasty on this patient, using her usual technique. She uses tumescent solution infiltration and creates a pocket after a blind dissection, and no simultaneous use of electrocautery. This would mean a higher risk of hematoma and is below the standard of practice. The tumescent solution may be somewhat beneficial in post-operative pain control, but it makes little sense to use a general anesthesia and not do electrocautery. It speaks to a lack of surgical training and it is hard to argue for pain control. Furthermore, the use of Marcaine is dangerous with nominal benefits. In the technique she uses, general anesthetic increases risk, as does the lack of cautery.

Dr. GH was questioned regarding the recommendations for a patient with ptotic or droopy breasts. He testified that one option would be mastopexy and small implants, another is augmentation (stretching, pain and bottoming out may occur). The standard of practice is for the patient to be afforded the opportunity to decide following a discussion of the options, whether you are trained in the procedure or not.

Dr. GH – Credibility Assessment

The Committee was impressed with the depth of knowledge exhibited by Dr. GH. He spoke authoritatively with respect to liposuction. He was clearly familiar with the standards in Ontario and elsewhere, and his testimony was of value. His opinion on matters at issue was clear and unequivocal. His experience with respect to breast augmentation was helpful to the Committee. His evidence, though critical of Dr. Yazdanfar, was unbiased and fair and was accepted by the Committee.

Mr. P

At the request of the College and uncontested by the defence, the Committee accepted Mr. P to give expert evidence in forensic document examination.

Mr. P examined the TCC medical chart of Krista Stryland. Among the conclusions reached by Mr. P are the following:

The results of the indentation analysis establish conclusively that documents have been removed from the patient's file. With respect to the indentations discovered on page D12, the content and date establish that D38 and D39, Dr. C's resuscitation note, are a substitute for a document dated September 20, 2007.

There is strong support for the view that the author of D38 and D39 wrote the unsourced handwriting that is indented onto page D12.

The indentations on D12 dated September 20, 2007, clearly refer to the same events as those written about on pages 38 and 39. There is some difference in recorded times (14:35 indented on D12, and 14:45 in the record). The information is not exactly the same, for example, 72-84 / min on the indentation and 96-108/ min in the medical record.

Indentation analysis reveals indentations from some, but not all, of the writing on the RR record is indented on to the fat extraction form and others (first three columns except for HR 76 not indented). Mr. P was recalled to give further evidence as the nurse who made the RR record changed her evidence as to how the entries on the record were made. He did further analysis of the RR record and respective indentation analysis.

Mr. P concluded that there was strong support that the person who wrote in the pre-operative vitals wrote in the data at the bottom of the page (RR vitals). Pen pressure in all six columns at the bottom of the RR record is sufficient to indent. The information on the bottom was written in at least two episodes; he could not say how much time elapsed between these episodes. There was no difference in the writing fluency observed in the six columns. There is nothing to suggest left hand writing. This is not definitive as this indicates only that there were no characteristics seen in those who are left handed. Ms Nurse Q is right handed with some proficiency with her left hand;

Mr. P was unable to conclusively say the times written at the top of the graph were done by the same person as entries at the bottom. He did not accept they could be written by Nurse J as the writing fluency is very different, even though a formal analysis was not done.

There is very strong support for the position that, when the first two columns and a portion of the third column of the RR record were written, there was no document from the patient’s chart immediately beneath it. The remaining data in the six columns along the bottom of the RR record were written when there were at least three other documents positioned immediately beneath it.

He testified that the indentations made are not consistent with the evidence of the nurse that the RR record was alone on a clipboard when she entered the vitals.

Mr. P – Credibility Assessment

The Committee accepted Mr. P's evidence as credible. He provided helpful information about the way entries were made on the RR record. In addition, Dr. C's resuscitation note in the medical record replaced notes that he had made earlier and that were partially indented; this is consistent with Dr. C's evidence.

Dr. O

Background

Dr. O is an American surgeon, holding Board certification in Cosmetic Surgery, Facial Plastic and Reconstructive Surgery and Otolaryngology, who currently practises in California. His practice is 95-97% cosmetic. He is the current President of the American Academy of Cosmetic Surgery (AACS) and has been involved with that organization for a number of years.

He had a research interest in liposuction and tumescent anesthesia. He has done 3000 liposuction cases over the past fifteen years. He has written editorials and editorial reviews, but has not published in peer reviewed journals, or contributed to textbooks. He uses the tumescent technique for breast augmentation. He teaches plastic and cosmetic surgery (face work, liposuction and breast surgery) in the USA.

The Committee determined that Dr. O was qualified to give expert evidence in tumescent liposuction and guidelines in the USA.

In respect of the AACS, there are 2500 members and a number of categories of membership from Fellows to Allied Health Professionals. He is not sure of Dr. Yazdanfar's category, but she would not be a voting member or Fellow, as they are required to be Board certified surgeons. The AACS is not recognized by the ABMS.

Dr. O is not a member of any Canadian organizations. He has had no training in Canada. He is not aware of any Canadian guidelines or how liposuction is performed in Ontario.

In the USA, there are three widely accepted guidelines (AACS, ASPS, ASDS) and there are some states, such as Florida, which have developed regulations limiting the volumes of fat extracted. He does not know how rigidly they are followed. He testified that all regulations use the amount of fat, not total aspirate. However, he was taken to the California regulation on Liposuction Extraction and Post-operative Standards currently in place and agreed that the measurement of 5000cc's was for total aspirate, not fat.

He performs surgery at an accredited facility and testified that he complies with the standards in place in California.

Dr. O indicated that all guidelines, except the ASPS, measure total fat and that he believes that total fat is a better measure of tissue trauma.

Liposuction

The history of liposuction was reviewed, including the contribution of Dr. LR who advanced the tumescent technique. Dr. O is familiar with the ASPS Practice Advisory on Liposuction. There is much debate regarding the use of fat or total aspirate to measure volume.

Dr. O follows the AACS guidelines and agrees that failing to consider co-morbidity, number of areas to be treated, percent BSA and percent of body weight would be considered a failure to meet the standard of care. His interpretation is that volume could be modified up or down depending on these factors. He said that, most of the time, in a perfectly healthy male, we might take out 7000cc's, then maybe not 7000cc's, maybe 6000cc's. Following this, he said pretty much the highest we would go is 5000 to 5500cc's.

When asked about the relevance of age, Dr. O first said it would not be considered and then agreed that it would be a consideration. He does not operate on smokers as the complication rate is much higher. Patients with a high BMI may face more risks. He agreed that death can result from liposuction, even if the surgeon does everything right.

Dr. O did not agree that patients could only accept the risk of death from liposuction if told. He does not feel he has an obligation to discuss the risk of death with his liposuction patients and does not do so. He recognizes that pulmonary embolism, fat embolism, and stroke are potential complications of liposuction and does not feel he has an obligation to inform patients (shock is contained in his consent form).

Dr. O does not believe that to discharge a patient alone after liposuction would necessarily breach the standard of care in the U.S.A.

Smartlipo is a laser light technique used to make the skin contract better. It slows you down and is not really helpful. In terms of cannulas used, everyone has a favorite and whether it is aggressive, or not, is a function of who is doing it. He thinks the Candycane cannula works best.

In Florida, as a result of seven or eight deaths in 1998-1999, regulations were made limiting the volume of fat extracted at liposuction in the office setting. In addition, when liposuction is combined with another procedure, the volume of fat extracted is limited to 1000cc’s.

In respect to Dr. Yazdanfar’s education, Dr. O opined that it meets and exceeds the standard of those doing liposuction.

He testified that Dr. Yazdanfar’s pre-operative evaluation processes are very adequate and charting is excellent. Her liposuction technique completely meets the standard of care and is similar to his own.

Informed consent was adequately explained and documented, and certainly meets the standard of care. Liposuction is a major surgical procedure. He does not dwell on death and most do not separately document this.

Dr. O opined that there was nothing in respect of Dr. Yazdanfar's treatment of her patients that violates the standard of care.

Krista Stryland

In respect to her consent process, method of payment and cancellation fee, and pre-operative care, Dr. Yazdanfar met and exceeded the standard of care for documentation and assessment of the patient.

In terms of the liposuction, the amount removed was consistent with current practice and the total aspirate had nothing to do with her death.

Dr. O questioned the accuracy of the RR record, but accepted the anesthetic record during the procedure. If the BP in the RR record is believed, the patient would be in extremis, or at the brink of death, by 13:20. To do nothing at that point would be below standard. A low BP of 60 is inconsistent with a normal heart rate. If the BP were at 60, you would instantaneously start to do a differential diagnosis (heart attack, tamponade, ongoing bleeding, pulmonary embolism). You would do a relevant examination (chest exam, mental status, etc.). He believed that the anesthetist needed to recognize that he had a critical patient and that he was in charge.

When the patient was intubated, 911 should have been called, probably a lot earlier. He agreed that urine output was low and could indicate shock, and that it was possible that this could be related to the liposuction, among other things. This was a preventable death if ACLS had been followed. Dr. Yazdanfar did not make a note, most would.

Dr. O believed Ms Stryland was an excellent candidate for liposuction and that the number of body parts treated and the number of incisions was within standard and had no effect on the outcome.

He did not agree that the amount of aspirate was related to fluid shifts. With proper technique, you do not have a lot of blood loss. There was no cause for her coagulopathy. Fluid was not the issue. If fluid shift was the cause, there would be many more liposuction deaths.

Dr. Yazdanfar, having commenced the next surgery, had a prime obligation to the patient under surgery. A value judgment was required and the best thing to do is to finish quickly. Her job, in hindsight, was to intervene if she believed the anesthetist was not doing enough.

As a surgeon, Dr. O would have considered a pressor drug, but he did not believe that Dr. Yazdanfar fell below standard.

In his opinion, everyone should have made a note that same day and all should be filed in the chart.

It was his opinion that Dr. Yazdanfar had nothing to do with this patient's death. She could have gone to the hospital in the ambulance, but did not fall below standard by not going. She sent the chart extracts and the nurse, which was adequate. She had an obligation to her patient in the OR.

Francine Mendelson

Dr. O was of the view that age was not a determinant factor and that liposuction could be done on healthy patients in their 80's. On pre-operative assessment, he would have assessed her as ASA II, given her history of smoking, but he considered her a good candidate for liposuction. The diagnostic tests were probably more than most would do and, in the absence of a significant history, a stress test was not needed.

Dr. Yazdanfar's consent and booking/payment processes were all adequate and met the standard of care.

In respect to the volume of fat removed, 5050cc's and total aspirate 8800cc's, these are within the range of what he would do and are considered safe amounts. She had circumferential abdominal liposuction and, in his experience, about 60% of patients would have this procedure.

In respect of the post-operative care of this patient, Dr. Yazdanfar's care was completely adequate. His practice is to change dressings (towels) four or five times in the first twenty-four hours, as it can be messy. Leaving the binder in place helps to obliterate the dead space and promotes healing. If they do not compress, they need to eat and drink, as they are in negative fluid balance.

Dr. O later stated that compression is crucial and the fact that Dr. AC changed her mother's garment a number of times exposed her to risks, including death. He felt Dr. AC caused the problem post-operatively by giving her mother nonsteroidals and removing her compression garment. He described the risk as beyond comprehension. While he agreed that removing the compression garment could result in aesthetic problems and you could die, he thought that it might be too graphic to tell patients.

Dr. O gave evidence that liposuction is a wonderful technique and that the next day most patients feel great. About 10% will feel bad. Tylenol or propoxyphene is used for post-operative pain. If patients are given NSAIDS every four hours, they would bleed.

When asked how he would respond to a change in ECG after liposuction, Dr. O responded that he would get a cardiologist's opinion or send the patient to her family doctor, or the emergency room, or to a Kaiser centre if appropriate. Later, when asked, Dr. O did not agree that the patient should be sent to the emergency department and waiting two days would not be below standard in California. Dr. O did not agree with Dr.

A that Dr. Yazdanfar waited too long, however, upon reviewing Dr. SP's (a cardiologist) comments, he changed his mind. He agreed that this was not acceptable and did not meet the standard of care.

Ms MP

Dr. O said that Dr. Yazdanfar's informed consent and disclosure documentation were excellent. He said that her liposuction procedure was excellently performed and documented.

Pre-operative history, physical examination and lab work were completely acceptable.

At five days post-op, Dr. O thought her pictures were great, and that the complaints of scars were in keeping, as Asian patients tend to hold pigment a little longer. The vast majority of patients, >99%, use only Tylenol for pain. Two to four percent have a lot of pain. He felt Dr. Yazdanfar did nothing to cause the pain, quite the opposite. If the patient was in excruciating pain, it would have been documented in the chart.

The booking and payment processes are completely consistent with others.

In regard to the patients included in her cosmetic surgery practice from 2005 to 2007, Dr. O did not review their charts. He still indicated that Dr. A's position was untenable and not supported by fact.

Dr. O admitted, under cross-examination, that he had been disciplined by the California Board for improper delegation of responsibility and gross negligence.

Dr. O – Credibility Assessment

The Committee had serious reservations regarding the evidence given by Dr. O. While accepted to give expert opinion on U.S. guidelines, he was not familiar with or accurate regarding the guidelines of California, where he practises. His evidence in describing

volumes was imprecise and inconsistent. He gave opinions without foundation and his frequent use of superlatives in describing Dr. Yazdanfar's practice did not reflect a balanced review. His evidence that patients do not need to be told about serious risks was rejected by the Committee.

His evidence was given in a manner which was less than objective and biased to the defence. Given the above, the Committee gave little weight to his evidence.

Dr. K

Background

Dr. K is a medical graduate of an Ontario university (1961), with a Fellowship in the Royal College of Physicians and Surgeons (plastic surgery) 1967. Since 2000, he has been Professor Emeritus in plastic surgery. He stopped hospital surgical practice in 2002/2003. He stopped performing surgery in 2002. He has been an examiner for the Royal College in plastic surgery and chief examiner. He has been accepted as an expert witness by courts in Ontario in aesthetic surgery, including breast surgery.

The Committee accepted Dr. K to give expert opinion evidence in plastic surgery and aesthetic surgery, including liposuction, and to give expert evidence on the standard of practice in breast augmentation in Ontario.

Liposuction

Dr. K's work included tumescent liposuction up until 2002. He estimated that, when he was performing liposuction, he performed five to ten procedures per year. He was not aware of the AACS guidelines until this hearing, but was aware of the ASPS guidelines (exhibit #54), which he said are the ones we follow in Ontario. He was not aware of the ASPS 2009 update. He has never used Smartlipo. At the present time, he does mostly hand consultations, which is one of his special interests.

Dr. K opined that liposuction is quite simple and does not require much experience, but that complications can be complex. He agreed that liposuction can cause massive trauma to subcutaneous tissue and that this increases with more sites.

Training

Dr. K was familiar with the Royal College objectives in Plastic Surgery and agreed that residency involves five years of study. Two years are spent doing general surgery, ICU, burn rotation, ENT and others; these are integral building blocks of Plastic Surgery. Dr. K stated that not all plastic surgeons are trained cosmetic surgeons, and that plastic surgeons are not the only certified surgeons doing cosmetic surgery.

Dr. K agreed that residency is fundamental to competency and he was familiar, in detail, with the Royal College objectives in plastic surgery. Core training includes how to recognize and deal with very sick people, including fluid and electrolyte management, shock, trauma, burns, emergency priorities and the full spectrum of complications. While Dr. Yazdanfar has taken many courses on liposuction and breast augmentation, she does not have the same experience as a resident would have.

Dr. K agreed with Dr. GH that the diagnosis and management of very sick patients is learned in residency, and that doctors should practise commensurate with their training. He agreed that part of good judgment is to know one's limitations. He testified that Dr. Yazdanfar's position, that her knowledge, training and experience were equivalent to that of a surgical residency, indicated that she does not recognize her own limitations.

Breast augmentation

Dr. K has experience in breast augmentation and has taught this to plastic surgical residents. He has no personal experience doing tumescent breast augmentation, never taught it, and believes that it is not taught in Ontario, at least not in Toronto. He was aware of this being used in breast reductions. He was not familiar with this technique in augmentation until this hearing, though he has now seen a video of Dr. Yazdanfar performing this procedure and has seen the publication of Dr. Z.

Dr. K carried out an interview with Dr. Yazdanfar, which he described as an oral examination, and was happy with her answers (pass with honours). He was happy with her pre and post-operative knowledge, but has not observed her doing liposuction. He was of the opinion that she was operating well within guidelines. He found her pre-operative care thorough and her post-operative policy okay. Patients were re-examined before discharge and kept for four to five hours. He concluded her knowledge base was quite good and her disclosure thorough. He made some suggestions for change of forms, regarding separation of elements of functional inquiry and consent, and subdividing complications into major and minor, which he believes she implemented.

Standard of Practice

Informed Consent

In Dr. K's opinion, TCC patients were properly informed. All material risks were disclosed. He did not believe that it was necessary to include that a patient could die, but that discussing anesthetic risks and risk of pulmonary embolism would satisfy the standard. He agreed that patients must understand serious risks, especially if surgery is elective. He believed Dr. Yazdanfar's forms listed pulmonary embolism, heart attack and stroke. Forms that do not list serious risks, he agreed, were not acceptable. He was then taken to the forms initialed and signed by Francine Mendelson in 2007 and agreed that these serious risks were not noted. He relied on Dr. Yazdanfar's word that she discussed serious risks and, if she did not, this would not meet the standard of practice.

Choice of implant size should be a shared decision of the physician and the patient, and the patient should be told that large prostheses will descend with time (increased risk of bottoming out) and this should be documented.

Booking/Payment and Cancellation Policy

The $500.00 deposit is reasonable. The 50% non refundable policy does not breach any standard and is used by most freestanding clinics, though the amount may vary.

Pre-operative Assessment

Liposuction -The same standard is used as for other surgeries. Dr. Yazdanfar's history and physical is quite sufficient. In hospital, patients over 60 usually need an internal medicine consult. Dr. K was of the opinion that Dr. Yazdanfar was fully within acceptable limits. Her patient selection was not below standard in the charts he reviewed. Overall, he believed she was quite competent. Her skill, knowledge and judgment were totally acceptable.

Breast Augmentation - With breast augmentation, as with liposuction, Dr. Yazdanfar's pre-operative assessment was totally acceptable. Her treatment plan and selection criteria (from Dr. K's interview with her) were based on good knowledge. She was well informed regarding mastopexy, including possible complications and expectations. He agreed that it was necessary to do a proper assessment, identify the problem, identify the goals, and discuss and document all options.

Combined procedures - Where liposuction and tummy tuck are combined, Dr. Yazdanfar discloses the risks of liposuction. The other operating surgeon has the responsibility to address the risks of the other surgery, and he should record it. He may delegate that to Dr. Yazdanfar, but is still responsible.

Dr. K indicated that the ASA classification is the responsibility of the anesthetist. Where the patient was category 3, the anesthetist would speak to the surgeon about canceling or investigation. Normally, the surgeon would not look at the ASA classification. He later said most surgeons would question the anesthetist where there was ASA 3. In respect of Ms ST, who was ASA 3, because of increased risk (BMI 40, hypothyroidism, combined surgery), Dr. K agreed that her surgery should have been done in a hospital.

Performance of Surgery/ Operating Room Procedure:

The operating surgeon is in charge in all respects in the OR. In cosmetic surgical practice in free standing sites, family doctors can and do surgically assist. Dr. Yazdanfar, he felt, would be an excellent surgical assistant.

Liposuction - Plastic Surgeons follow the ASPS guidelines for volume of 5000cc's of total aspirate. This is what he followed in practice. He believes that the AACS standard of five litres of fat is also an acceptable guideline. He agreed that large volume liposuction was 5000cc's or greater of total aspirate and, if more is removed, it should be done in a hospital or at a licensed facility with overnight care. Guidelines are not regulations and should be interpreted as safe and correct practice.

Dr. K was of the view that the measurement of fat was a more accurate measure of tissue damage, and that the trend is to measure fat.

Dr. K disagreed with Dr. GH that almost all liposuction in Ontario is done by plastic surgeons. There are no statistics available and there are a number of surgeons, ENTs and dermatologists, who do some.

Dr. K agreed that the AACS guidelines are more liberal and allow a much larger procedure. He disagreed with some aspects of these guidelines, as he believes that the number of areas treated and the percent body surface area treated are not relevant. On these points, he disagrees with Dr. Yazdanfar, Dr. O, Dr. GH, Dr. A and Dr. LR. He agreed that he might be mistaken, and that he would defer to Dr. LR. He said later that he was not too sure about percent body surface area, and that he would partially agree that it should be considered. He agreed that liposuction can be potentially lethal and that it is perceived as benign by patients, and that the surgeon has an obligation to ensure they understand. He agreed that liposuction can create massive trauma to subcutaneous tissue and this increases with the number of sites treated.

Dr. K believes Dr. Yazdanfar did not fall below standard in her practice of liposuction.

Breast Augmentation - There is no one standard accepted procedure; augmentation can be done in many ways, not all of which are taught. Tumescent technique is not taught, as it is new and is just a variation. He has reviewed pre and post-operative pictures of Dr. Yazdanfar's patients and a video of her doing a procedure. This video (made March 24,

2006) was produced later for the Committee. The technique demonstrated on the video shows Dr. Yazdanfar creating the pocket by blunt dissection. There was no electrocautery dissection as done by Dr. A and Dr. GH. Dr. Yazdanfar uses a lighted retractor, blunt dissection, not a blind pocket, electrocautery for blood vessels, and visualizes the pocket, which is acceptable. Some use electrocautery to dissect, others don't.

Dr. K is familiar with the tumescent technique and used it for over fifteen years in breast reduction. There are no increased risks and more advantages than disadvantages, and he did not view the tumescent technique as experimental.

The tumescent technique used by Dr. Z is no different than Dr. Yazdanfar's, except that she uses general anesthesia.

The benefits of tumescence are decreased bleeding and better post-operative pain control. Whether a general anesthesia is used or not does not change his opinion that the operation is acceptable. He does not believe that risk of hematoma is increased, but risk is reduced.

Implants of 550cc's or greater are heavy and can cause droopiness, but there is no contraindication in the literature. They may be indicated in certain circumstances if the skin is of good quality and can support it.

Combined Procedures - In the performance of combined breast augmentation and liposuction, Dr. Yazdanfar was not below standard. In participating in liposuction and tummy tuck, she was within standard as the liposuction was not in the abdominal flap area.

Dr. K referred to two journal articles (Aesthetic Surgery Journal 2004, exhibits #169 and #170), which demonstrated by retrospective review that there was no increased morbidity by adding liposuction, and disagreed with Dr. A that there was increased risk with combining procedures based on these studies. He was not aware of references advising

limits of 500-1000cc's. He did not agree with Dr. A that, in combining breast augmentation and liposuction, Dr. Yazdanfar lacked knowledge, skill or judgment.

Post-operative Assessment

Liposuction - Dr. K opined that Dr. Yazdanfar was well within standard for both immediate care (she examines the patient before the patient leaves) and later post-operative follow-up. Her judgment and skill are well within standard.

Breast Augmentation - Knowledge, skill and judgment in the immediate post-operative period were quite adequate. Dr. Yazdanfar's post-operative follow-up notes are quite comprehensive and meaningful. He discussed complications with her and felt everything was within standards.

Recordkeeping

Dr. Yazdanfar's recordkeeping was within acceptable standards

Krista Stryland

Based on his chart review and interview, consent was obtained in an acceptable manner.

Booking and payment arrangements were not below standard.

Volume removed was acceptable.

Recordkeeping in the RR was below standard and it was the nurse's, not the surgeon's, responsibility. Later, Dr. K agreed that Dr. Yazdanfar was responsible for the complete and accurate record and that she should have made a note. He believes the RR record is untrustworthy and that it would be impossible for the blood pressure and the heart rate to correlate. He believes she went into shock at 2:45 and that Dr. C's notes are more believable.

Dr. K disagreed with the diagnosis of hypovolemic shock from fluid shift, indicating that she was in perfect fluid balance leaving the OR. Low urine volume was from decreased hydration. There was no connection between total aspirate and outcome.
He believes the qualifications of the operating surgeon had nothing to do with it.

Dr. K believes that the surgeon would rely on the anesthetist as to when to start the next case. Once the case starts, the surgeon is responsible for the patient on the table; the anesthetist is responsible for the RR patient. In this matter, however, Dr. Yazdanfar could have stopped the surgery at no risk to the patient.

When reintubation was required, the surgeon should end the surgery and assist the anesthetist. Dr. Yazdanfar needed to rule out surgical insult by examination looking for active bleeding, which would take minutes/seconds. The anesthetist is the decision maker, with the surgeon taking over if the anesthetist is not doing the job. He agreed that, when intubation was required, 911 should have been called; if Dr. C did not make the call, she needed to do so. He also agreed that failing to do so was below the standard of practice.

Dr. K indicated that, if there had been intervention earlier, the outcome may have been different. He does not believe a lack of knowledge, skill or judgment of Dr. Yazdanfar contributed to the death of Ms Stryland. He agreed in cross examination that, given the description of the events in the RR, Dr. Yazdanfar should have stayed with Ms Stryland and, in returning to the OR to do seven more minutes of liposuction, she fell below the standard of practice.

While initially attributing mismanagement to the anesthetist and RR nurse, Dr. K, in his later testimony, includes Dr. Yazdanfar as well. He agreed that the liposuction surgery led to complications, which caused Ms Stryland’s death.

The most responsible physician in the RR is the anesthetist, but there is also shared responsibility with the surgeon. Dr. K was of the opinion that neither the technique nor

the amount of fluid removed caused the outcome. He believed that the complication was from a fat embolism inducing mechanical or biochemical changes. Tissue injury occurs with the infiltration of tumescent fluid and the use of the cannula. He was aware that the Coroner's report showed no fat embolism, but opined that you cannot see biochemical changes.

Francine Mendelson

Pre-operative assessment - Dr. K stated that overall the assessment was quite good. There were no material risks except for age. While not perfect, Ms Mendelson was a suitable candidate. He noted that, in hospital for those over 60, a medical consult is needed. He believed Dr. Yazdanfar performed this and that, in hospital, either a family doctor or internist would do it. He agreed that she could have been offered smaller liposuctions under local anaesthesia and that would have less risk. This would depend on the amount of fat to be removed.

Booking and payment arrangements were acceptable.

Operative Procedure - Even though 8.8 litres of total aspirate was removed (5050cc's of fat), Dr. K believed that Dr. Yazdanfar did not breach the standard of practice.

Post-operative care - Ms Mendelson was kept for six hours. Dr. K would have admitted her for monitoring for 24 hours. The ignoring of the instructions with respect to keeping the garment on could have resulted in more blood loss and the fall in hemoglobin. Even one dose of an NSAID could have done this as well.

Follow-up was quite adequate, but Dr. Yazdanfar should have insisted she go to emergency when the ECG result was known.

Except for the same day discharge, Dr. K felt she was treated appropriately. On cross examination, after reading the cardiologist's report Dr. K agreed Dr. Yazdanfar fell below the standard of practice and demonstrated a lack of knowledge, skill and judgment in not

acting immediately on the ECG report. He agreed that describing the treatment of Francine Mendelson as frankly excellent in his report was an overstatement.

Ms MP

Regarding this patient, Dr. K indicated there was nothing different about informed consent that breached standards. The liposuction was within acceptable limits. Total aspirate was 7150cc's (3800cc's fat). He believes this meets standard as the bottom line is fat.

Booking and payment arrangements, post-operative care and follow-up are all adequate.

There is no evidence of lack of knowledge, skill, judgment or disregard of the welfare of the patient.

Combined Procedure Patients

Patients Ms UK, Ms ST, Ms TJ - In respect of informed consent and pre-operative assessment, Dr. Yazdanfar was well within the standard of practice.

Booking, payment and post-operative care are all within acceptable limits.

Patients in Cosmetic Surgery Practice 2005 to 2007

Pre-operative assessment, booking and payment, and informed consent are all the same and quite proper.

Patient Ms JR - 5675cc's fat removed from 83 kg patient. Time spent in RR was 3:45. He could have been admitted but was okay.

Patient Ms KO - 5100cc's fat in 81 kg patient. 2:40 in RR. He did not believe that 100cc's mattered that much.

Patient Mr. TC- 5875cc's fat in 118kg patient. 4:40 in RR. He considered this acceptable for the patient's size; having him come back for an additional procedure increases anesthetic risk and cost.

Patient Mr. PK - large man 116kg. 7900cc's. One month later, 6600cc's. Dr. K seemed confused initially regarding the amount removed as there were two separate liposuction surgeries, but he felt this was well within the standard of practice. On cross examination, he agreed that to discharge the patient unaccompanied, and not signing that this was against medical advice, was below standard.

Patient Mr. PC - 5450cc's fat removed, total aspirate 8800cc's. He believed she met the standard of practice.

Patient Mr. RZ - 240kg. 6175cc's total fat, 9525cc's total aspirate. This was a big patient, fully recovered and well within normal limits.

Patients Ms CX/Ms DW - Dr. K agreed that discharging two patients, who just had surgery, together in each others care, did not meet the standard of practice.

Dr. K agreed that, in believing it was safe to discharge Mr. RZ alone by taxi, Dr. Yazdanfar demonstrated a lack of knowledge, skill or judgment. Similarly with other patients discharged by taxi, it was not safe. They needed to sign that discharge was against medical advice, which would be the standard of practice.

Ms QR

In respect of informed consent, there was satisfactory documentation and a note that Dr. Yazdanfar discussed complications.

Her choice in recommending augmentation mammoplasty and not mastopexy was quite acceptable. Scars were avoided and mastopexy could be done later. On cross examination, Dr. K agreed that mastopexy was an option and that not discussing the risks

and benefits of mastopexy with and without augmentation would not meet the standard of practice.

With respect to informing Ms QR about increased risks with large implants, Dr. K indicated that recently no correlation between large implant size and capsular contracture has been shown. The other complication of bottoming out needs to be discussed as something further may be needed in the future. This needs to be explained and documented to meet the standard of practice.

Breast augmentation - Dr. Yazdanfar performed the augmentation procedure according to standards.

Booking and payment arrangements were well within standard.

Post-operative care - Dr. K opined that the range of options for capsular contracture, when it developed, was reasonable, including capsulectomy and replacement with smaller implants. The procedure performed was quite acceptable. On cross examination, Dr. K agreed that capsulotomy was an option and that not providing this option fell below standard.

There was no lack of knowledge, skill or judgment.

Ms WX

Informed consent - This was obtained as in the other cases.

Breast augmentation - This patient had misshapen breasts, with bottoming out more on the right side and her nipples were laterally placed. She needed a repair of the inframammary fold and she wanted larger breasts. She had her implants replaced in a different pocket. There was no breach of standard in selecting implant size or in the manner of performance of the procedure.

On cross examination, Dr. K indicated that the patient should have been told that, with her type of breastbone, correction of the position of the nipples could not be done. This needs to be documented or would not meet the standard of practice.

Post-operative management - When she returned a year later, Dr. Yazdanfar did not feel there was bottoming out and advised no more surgery, which is just what he would have done. He believes her treatment was within acceptable standards.

However, on cross-examination, Dr. K disagreed with Dr. Yazdanfar in that he believed that, after surgery, the patient had bottomed out again on the right side.

Ms GR

Booking, payment and consent was handled the same as other patients.

Dr. K opined that the post-operative hematoma which developed was not a reflection of knowledge, skill or judgment, but is a common complication. It requires evacuation sooner than later.

There was no breach of standards in any way.

Dr. K – Credibility Assessment

Dr. K responded to questions asked though, in some cases, not directly (when asked whether Dr. Yazdanfar's training was sufficient to be safe, he responded that her training was impressive). He consulted his notes frequently and needed to rely on them. His memory was imprecise.

Dr. K supported Dr. Yazdanfar's standard of practice as acceptable, though there were areas of concern which he excused or afforded little importance, such as exceeding recommended liposuction volumes. There were a number of inconsistencies in his testimony. He said that Dr. Yazdanfar was well within guidelines in her liposuction, but

then agreed there was a failure to meet the standard of practice in the Stryland case when Dr. Yazdanfar failed to call 911, when Ms Stryland was intubated and when she left Ms Stryland to do more liposuction. He said he believed Dr. Yazdanfar's follow-up care was adequate and then agreed she fell below standard in the Francine Mendelson case when she did not act immediately upon receiving the abnormal ECG results, and when she discharged two patients to each other's care (Ms CX and Ms DW). He was inconsistent in his opinion that Francine Mendelson should be kept overnight, but not other large volume cases.

Dr. K agreed it was an overstatement to say surgery had nothing to do with Ms Stryland's death and that he was mistaken in saying that Dr. Yazdanfar's forms listed specific serious risks when they did not. It was clear that he knew a great deal about training for plastic surgery, but the Committee took care to view his evidence in light of the inconsistencies, which became evident in cross examination.

Dr. L

Background

Dr. L is a graduate of a university in the USA, School of Medicine (1995). He is certified by the American Board of Oral and Maxillofacial Surgery (2000) and the American Board of Cosmetic Surgery (2000). He also holds a Doctor of Dental Surgery degree (1991) from a college of Dentistry. He opened his own cosmetic surgery clinic in 1998. He has done more than 3000 breast augmentations and more than 3000 liposuction surgeries.

The Committee accepted Dr. L to give expert evidence on cosmetic breast surgery, including the AACS breast augmentation guidelines.

Dr. L's overall opinion of Dr. Yazdanfar's care regarding breast augmentation after a chart review was that she did a "good job" with recordkeeping. Her diagrams, measurements and charting were good. Her diagnostic assessment was good. She

understood treatment options and made appropriate decisions. He felt her combination of breast augmentation with other procedures was reasonable. Complications were not related to lack of knowledge, skill or judgment.

Informed consent

In regard to informed consent, Dr. Yazdanfar's forms were more thorough than most.

Dr. L agreed on cross examination that a proper assessment would include: the presenting problem; a canvassing of the surgical options within reason; goals of the surgery; and, goals of the patient. A discussion of the pros and cons should happen and ideally be documented as much as possible. In respect of implants, patients need to know the potential risks and placement pros and cons. The choice of implants is made by the patient within reason, and he agreed that patients should realize the advantages of a conservative selection

Dr. L agreed that his website indicates there is more rippling and capsular contracture with larger implants; only recently has he seen any evidence otherwise. He agreed that there is an increased risk of bottoming out with large implants and that it also depends on the laxity of the patient's tissue. There is a line at which the weight of the implant would overwhelm the tissue support. Bottoming out occurs with over dissection, naturally, and relates to the size of implants and tissue characteristics. Patients with pre-existing droop receiving subglandular implants should be told that a large implant risks more droop.

Payment Policy

Dr. Yazdanfar's payment policies are similar to his own (except that his forms just say non refundable, not no matter what). He assumed that Dr. Yazdanfar would refund the money if the patient was sick or otherwise in crisis.

Post-operative Care

Dr. Yazdanfar's discharge policy documents that patients need to be in the care of someone.

Her follow-up visits are better than most.

Dr. L believed, based on a review of her charts, that Dr. Yazdanfar met the standard of care and did not demonstrate a lack of knowledge, skill or judgment.

Training

With respect to Dr. Yazdanfar's training, Dr. L felt she would satisfy the AACS guidelines. Complications are a big part of breast surgery and are covered in lectures and a section dealing with complications at the end of the AACS courses. Dr. Yazdanfar came to at least one of his courses and, back in 2003, she came to his clinic and shadowed for a week. This was not a personal training program created for her. Doctors usually phone ahead and come when there are procedures of interest to them.

Breast surgery technique

Dr. L has been using the tumescent technique for thirteen years for all forms of breast surgery, with lower complication rates than national averages. Not everyone uses it, but it is an acceptable technique and used by a majority of cosmetic surgeons in the U.S.A. He was not aware to what extent it is used in Canada. The mechanics of breast augmentation do not change whether a local or general anesthetic is used.

The tumescent solution Dr. L uses is similar to that used by Dr. Yazdanfar, though he uses a slightly lower volume and higher concentration. Close to half his patients have multiple surgeries. The benefits of using the tumescent technique include longer lasting post-operative pain control, lower blood pressure, which may indirectly lower the hematoma risk, less need for overall general anesthesia medications, and it helps to dissect the tissue plane.

Dr. L was surprised that Dr. K was not aware of the technique. He agreed that if Drs. A, K and GH say this technique is not standard in Ontario practice that he could not say otherwise.

AACS Breast Augmentation Guidelines

In regard to breast augmentation guidelines, Dr. L said that it could not be assumed that these were designed for those with some sort of surgical residency, even though the wording talks about "a surgeon's post residency training, experience".

Ms QR

Pre-operative Care

Ms QR had grade one or mild ptosis and wanted to be larger. Appropriate surgery based on her complaint was done. Her options were an augmentation alone or a lift alone, or potentially a lift with an implant. Dr. L agreed that there should be a full discussion of options with pros and cons, and ideally recorded. The AACS guidelines say all options should be discussed and documented. As she wanted volume, augmentation was appropriate.

Informed consent was well obtained based on the chart, though Dr. L agreed that a discussion of a breast lift is not specifically documented and "ideally" should have been. He agreed he would defer to Dr. K with respect to whether it would meet the standard of practice in Ontario.

Dr. L agreed that the patient should have been told that Dr. Yazdanfar did not do breast lifts or that another doctor would do it.

Dr. L felt that, based on the charts he reviewed and the fact that lifts were covered in the courses she took, Dr. Yazdanfar had a good understanding of breast lifts. He agreed with Drs. A and GH that mastopexy does not necessarily mean an unacceptable scar.

In respect of implant size, large implants can result in increased complications if the tissue cannot support them. In respect of Ms QR's height, weight and frame, 550cc implants were reasonable. He agreed that, with large implants, bottoming out and sagging should be discussed, as well as the possible need for further surgery.

A list of the items of concern to Dr. A were read and he agreed with the following: that mastopexy, location of scars with mastopexy, mastopexy and augmentation should be discussed; that implant size is not entirely the patient's responsibility; that pros and cons of large implant size should be discussed; that capsular contracture is not rare; and, that capsulotomy is an option for capsular contracture.

Dr. L disagreed with Dr. A's conclusion that she fell below standard, and that a large volume implant was most responsible for the problems.

Operative Care

Performance of breast augmentation based on the technique as demonstrated on the video and described in the OR report is standard. Cautery is available and cautery tips are counted.

Post-operative Care

This patient developed capsular contracture, a complication all cosmetic surgeons have to deal with. The options for treatment include capsulectomy, which is difficult and carries more risk but is more definitive. Capsulotomy is simpler and provides softening but with a high risk of recurrence. Both options need to be discussed with pros and cons. No discussion is recorded in the chart. Dr. L agreed that a failure to do so would not meet the standard of care.

Dr. L indicated management of capsular contracture was very challenging and difficult. Regarding using a smaller implant in the pocket, he indicated that this is done and cited the example of a radiated breast.

Her follow-up care was fine.

Dr. L felt there was nothing to suggest incompetence.

Ms WX

Pre-operative Care

She came wanting to know if her appearance could be corrected. She was a complex and challenging patient presenting with old implants, which had bottomed out (R>L), and had moved down and laterally. She had a wide sternum and was extremely bottomed out. He definitely agreed with Dr. K that this was not an easy patient and there were many options, and some things were not correctable.

Dr. L felt Dr. Yazdanfar did a good job of informed consent. He said "everyone tries to give the most reasonable options and they are not the same for every patient."

The options were to (i) remove the implants (ii) remove the implants and put in a new pocket (iii) capsulorraphy, which he described as an internal lift or cinching it up. Dr. L did not think a skin tightening procedure would be a good option. He believed Dr. Yazdanfar covered the options based on the follow-up note made in July 2008. He agreed there was no clear description and no pros and cons documented. She could have done better.

Uneven nipples and rippling and higher risk of bottoming out with large implants needed to be discussed. He agreed that implant migration could have been foreseen and the patient should have been told.

Operative Care

Dr. Yazdanfar's performance of breast surgery sounded standard. Marcaine needs to be used with care, but is used by many as it prolongs pain relief. Based on her operative report, Dr. Yazdanfar checks for hemostasis and irrigates to look for oozing.

Post-operative Care

Dr. L agreed with Dr. A that, at one year, there was some bottoming out. The right implant had dropped; it could be cinched up again but the result was reasonable.

Dr. L believed that if the patient had complained of pain it would have been recorded, as it is easier to write about than options. He agreed that it was possible that she told Dr. Yazdanfar about the pain and it was not recorded, as Ms WX said in her testimony and in her letter, and as it was the reason she went to Dr. TZ. He believed that if the patient was having pain in January 2008, it would be unlikely that she would agree to her pictures being used for internet advertising as noted in the chart. He placed more credence in the chart.

At one year, the result was not perfect. Dr. L questioned recurrence of bottoming out and noted that recurrence was even more complex to deal with than the initial problem.

General Comments

Hematoma occurs in 1-3% of breast augmentations. His is <1%. He said the lowest rate was with the tumescent technique. Dr. L took issue with Dr. A's opinion that large implants increased risk of hematoma and bleeding. Average size is 300-550cc's and he felt size had nothing to do with hematomas.

In respect of the combination cases (Ms TJ, Ms UK), Dr. L thought the management was reasonable.

Dr. L said that Dr. GH's description of blood vessels 3-3.5mm seemed exaggerated. In general, with blunt dissection, the vessels are pushed aside and compressed with less tearing and less need for cautery. Dr. Yazdanfar has cautery on hand and uses it. With respect to use of cautery, there is no set standard in respect of doing it right away, or waiting and watching. In respect of blunt dissection, he testified that everyone does it and that he teaches a variety of techniques with some component of blunt/blind dissection. Cautery is always available. He felt that excessive cautery could increase inflammation and result in increased chance of capsular contracture.

Dr. L – Credibility Assessment

Dr. L gave evidence that the Committee found credible and helpful in regards to his knowledge in the field of cosmetic breast surgery, as practised in the U.S.A.

Dr. N

Background

Dr. N is a board certified surgeon who specializes in cosmetic surgery and practises in Indiana. He has a cosmetic surgery clinic certified by the AAAHCF. He was initially trained as a vascular surgeon but has, since 1980, been doing liposuction and breast augmentation. He is a member of the American Board of Cosmetic Surgery (ABCS). To be certified by the ABCS, a surgeon must have completed one of seven recognized surgical residency programs and then completed further training.

Dr. N was accepted by the Committee to give expert opinion evidence on liposuction and breast augmentation.

AACS

Dr. N described the AACS as an organization purely devoted to education of physicians for cosmetic surgery. The mission statement is to promote patient safety through physician education. There are approximately 2500 members, with 50 to 100 being Canadian. There are different classes of membership. To be a Fellow, a surgeon must be Board certified in a surgical specialty; only Fellows may vote. Dr. Yazdanfar, because of her training, could not be a Fellow. The AACS has a pathway to learning comprised of didactic, then workshop and finally proctored training. He considered the AACS the "educational arm of cosmetic surgery" in the U.S.A.

Dr. N has taught many courses, which included didactic sessions, live workshops and laboratory cadaver dissections. The subject material includes breast augmentation

surgery, mastopexy, informed consent and complications. He believes the standard of professional practice is the same in Canada as in the U.S.A.

Dr. Yazdanfar

Four to five years ago, Dr. Yazdanfar approached him and asked him to be her preceptor, as she had applied for a change of scope of practice. He was approved by the CPSO a few years ago to be a preceptor for Dr. Yazdanfar for breast augmentation. She did all three levels of the pathway to learning and was tested on anatomy, options and complications of breast augmentation.

Her preceptorship was 1:1 training in Indiana for which she was not charged. She was involved with thirty-five to forty cases. He indicated that a big portion of the time was spent on what can go wrong and how to fix it. She came down several times after that and he came to visit the TCC on one occasion. His opinion after that visit was that he felt comfortable that she had good knowledge, good technique and her facility was adequate.

Dr. N indicated, as did Dr. L, that he believed her to be within the AACS standard and would not be here if he thought otherwise, as this would reflect on the AACS, which is his passion.

Liposuction

AACS liposuction guidelines speak of a maximum volume of 5000cc's of fat which can be safely removed. Volumes exceeding this should be done in select patients with no co-morbidity in an approved operating facility.

If over 6000cc's is taken out (megaliposuction), it should be done in a hospital, restricted to experienced surgeons performing clinical research and under the supervision of an institutional review board.

Dr. N is aware of the ASPS guidelines for volume of 5000cc's of total aspirate in an out-patient setting, unless patients are kept overnight, noting that, then, there is no limit. It

was his opinion that the AACS guidelines were more conservative because they do not exceed six litres. He did agree that the ASPS guidelines allowed a smaller amount of fat to be removed than the AACS in an out-patient setting. Other factors need to be considered, including the percent body weight, percent body surface area treated and number of areas treated, that would downgrade the maximum volume. In respect of Dr. Yazdanfar's liposuction surgery, he opined that her surgical skill and knowledge was within standard. Liposuction on morbidly obese patients should be done in a hospital. He did not agree with Dr. A in describing liposuction done by Dr. Yazdanfar as aggressive. He uses aggressive to refer to liposuction over 6000cc's of fat, which should be done in a hospital as there is a high risk of morbidity and mortality. He considers liposuction to be safe, but agreed it can be dangerous.

Dr. N was aware of specific regulations in some states related to liposuction, which were put in place after deaths. He described this as a knee jerk response. He testified that some regulations specify the volume as total aspirate, others as fat, and that the amount permitted varies between 4000cc's and 5000cc's.

Breast Augmentation

The majority of breast augmentations are done under general anesthesia, whether tumescence is used or not. Breast augmentation surgery, as performed by Dr. Yazdanfar, utilizes blunt dissection, and he believes it is safer, easier and less traumatic and offers good access to the avascular plane. Dr. N recognizes that others may have a different view and that both may get equally good results.

Dr. N felt there was more trauma and bleeding potential using cutting/cutting cautery. He uses cautery on blood vessels when necessary, as does Dr. Yazdanfar. He does not use the tumescent technique but uses 60cc's of fluid in each breast. Dr. Yazdanfar uses 150-250cc's, which produces some hydrodissection and helps with post- operative pain and bleeding. He later agreed this was 350-400cc's. He described the tumescent technique as a tool rather than a technique, and that the amount of fluid he uses differs from Dr.

Yazdanfar in that she uses a higher volume with relatively lower drug concentrations. He does not use the tumescent technique and she did not learn it from him.

The tumescent technique is taught in the U.S.A. and he was surprised that Dr. K had not heard of it in breast augmentation. Dr. N believes about half his faculty use the tumescent technique. He felt there were three benefits: (i) helps to dissect; (ii) decreases post-operative pain; and, (iii) cuts down on post-operative bleeding. He disagreed with Dr. GH that there was the potential for increased bleeding.

The skin incision and blunt dissection is done by separation with scissors and using retractors. Using her finger, Dr. Yazdanfar creates a pocket and opens up the avascular plane and puts in a sizer. After removing the sizer, she uses a lighted retractor, examines the pocket and irrigates to ensure there are no bleeding points which need cautery. She sits the patient up to check for symmetry. Dr. N felt her knowledge, skill and judgment in the performance of breast augmentation was excellent.

Dr. N disagreed with Dr. GH in respect of potential for increased hematoma formation with the tumescent technique. He described the procedure while viewing the video of Dr. Yazdanfar doing breast augmentation. He believed the technique used was the same as that used by Dr. A, except for the tumescence.

Dr. N believed Dr. Yazdanfar's practice was excellent and well within the standard, and she had the requisite knowledge, skill and judgment.

Dr. N agreed that the choice of implant size is a joint decision. In a patient with some lax skin and a little bit of droopiness, where the surgeon does not want to do a mastopexy, or where the patient does not want a mastopexy, the surgeon has to put in a bigger volume implant.

In respect of mastopexy, Dr. N agreed with Dr. A that there are a number of options for scars that a physician who was informed about mastopexy should know about.

Patients in Cosmetic Surgery Practice from 2005 to 2007

Liposuction

Dr. N said he did not find that Dr. Yazdanfar removed more than 5000cc's fat in patients with co-morbidities after reviewing forty charts. A BMI of 35 would be a co-morbidity. He was then taken to cases (Mr. TC, Mr. RZ), which he agreed did not meet AACS guidelines.

Dr. N later said he did not think there was any problem with the patient cases that he examined. He was taken to another case (Mr. RZ) of megaliposuction and he agreed that this case did not meet AACS guidelines.

Informed Consent

Dr. N opined that the informed consent process looked well done from review of Dr. Yazdanfar's charts and was better than 70-80% of the charts of other surgeons he has seen. Death and fat embolism are not often seen listed. Most of the other serious complications (heart attack, stroke) occur from anesthesia, and he goes through all that with patients. Dr. Yazdanfar said she discussed risks, benefits and alternatives and there was ample opportunity to ask questions.

Dr. N agreed that, as volume increases, so does risk. He agreed that serious risks from liposuction include: death; heart attack; stroke; cardiac events; pulmonary embolism; DVT; fat embolism; and, shock. As a surgeon, he must discuss the procedure, alternative procedures or some of them, and the risks and complications with patients to give them sufficient information to make an informed decision. He needs to make sure the patient understands and has the opportunity to ask questions. He agreed this would be the standard of care. Discussions should be documented.

Informed consent is a process which must be explained and understood.

Dr. N believed that patients want to know enough of risks to know whether they can make a decision about serious surgery. There is no way every single complication can be covered. He indicated there was some data to illustrate that patients do not recall all they are told, which is why doctors are told to document that they did explain things to patients.

In regard to breast augmentation, if there are several options, they need to be discussed with risks and benefits of each and then documented. He usually gives his patients two or three options which he thinks will work best for them.

Discharge Policy

Dr. N agreed that discharge policy should include discharge with an escort and a monitor for 24 hours. He agreed that the plan should not be for two surgical patients to be discharged to each other's care.

Krista Stryland

Pre-operative assessment was not below standard.

Performance of surgery, including the volume removed, was within standard, as was the number of body parts treated. The use of Smartlipo was appropriate, though Dr. N noted that its use may impact on safe volumes, but there are no studies one way or another. He did not believe this to be aggressive liposuction. In his view, the patient was fine and her vitals were okay when she woke up from surgery.

Post-operative events were of unknown cause. Dr. N believed death was due to DIC, which could have been caused by fat emboli, prolonged shock or hemodilution. There was no surgical bleeding or perforation. He believed the Coroner overestimated the percent of body surface area treated, which he thought was likely 20%. He disagreed with the Coroner's diagnosis of hypovolemic shock. It was difficult for him to attribute the cause of death to fluid shift. He also felt that iatrogenic damage was improbable.

Dr. N disregarded the RR record as inaccurate, because of the heart rate of 68 in the face of a BP of 60/20, and he believed no anesthesiologist would leave a patient in such a state. He indicated he would place more weight on the doctor (C) and the nurse who did the transfer and what they said, over the record made by another nurse.

Dr. N agreed that if the surgeon was aware of a BP of 60/30, a surgical cause should be ruled out. With those BP levels, he would expect the anesthesiologist to remain at the bedside until the patient was stable. He believes the anesthesiologist is the most responsible physician in the RR, except if there was a wound or dressing problem or something like that. He is most qualified to manage fluids and he would never question this (and has not in 40 years of practice), unless the anesthetist was inept. He did not rely on the note of Nurse Q as she did not take responsibility for its accuracy and there was some inflammatory stuff from the hospital. He thought the note was written when she was upset and the facts were not right.

Dr. N disagreed with Dr. O about the need to call 911 when the patient was intubated, indicating that some time could be given for the BP to recover. He admitted the patient was in dire straits at 3:17 and that Dr. Yazdanfar should have known her patient was in dire straits. He agreed that in his report he said that in fact Dr. Yazdanfar called 911 the moment the patient was in dire straits. He testified that a few moments could be given to stabilize and then said this could be fifteen to twenty minutes. As Dr. Yazdanfar relied on Dr. C, believing him to be competent, Dr. N did not feel that Dr. Yazdanfar had breached the standard. He agreed it was the surgeon’s responsibility to look for a surgical problem, or a reason for the low blood pressure.

Dr. N agreed that everyone should have made a note for the chart, including Dr. Yazdanfar. They should have signed and dated it as soon as possible.

Dr. N disagreed with Dr. A in respect of the need for Dr. Yazdanfar to accompany the patient to hospital.

Francine Mendelson

Dr. N believed that this patient was an excellent candidate for liposuction.

He further stated that the performance of liposuction by Dr. Yazdanfar was within the standard of care.

Dr. N believed that the post-operative/follow-up care was appropriate. In particular, he stood by the advice that Dr. Yazdanfar gave regarding the ECG. Under cross examination, he agreed that Dr. Yazdanfar should have sent the patient to hospital upon receipt of the ECG.

Ms Mendelson's fall in hemoglobin would not have alarmed him too much. He would have expected her to drop from 14.5 to 11-12, which in part would be hemodilutional. The garment molds the body, compresses the tissue reducing bleeding in the subcutaneous space, reduces discomfort aiding the patient to move about, and helps to move the fluid out through the lymphatics. He does not have patients remove the garment for three days. He believed the removal of the garment repeatedly (every hour) in this case, and taking nonsteroidals, may have had an effect on the fall of hemoglobin. He did not, however, feel it necessary to forewarn the patient of serious consequences if the garment was removed. It was sufficient that they know it should not be removed and have an instruction sheet.

Dr. N disagreed with Dr. A that Dr. Yazdanfar put the patient at risk of harm. She took a lot of precautions, including keeping patients for a length of time before discharge.

Dr. N – Credibility Assessment

Dr. N admitted coming to testify on behalf of Dr. Yazdanfar, believing that she followed the AACS guidelines. He was able to provide the Committee with a description of how cosmetic surgery is practised in the U.S.A.

There were a number of internal inconsistencies in his testimony. He testified that Dr. Yazdanfar's post-operative care of Francine Mendelson was appropriate, and then agreed under cross examination that she should have been sent to hospital. He believed Dr. Yazdanfar to be practising within the AACS standard, and then agreed that she was not when taken to the cases of Mr. TC and Mr. RZ. In describing the cases he examined, he gave evidence that contradicted the guidelines that he follows (not really considering obesity as a co-morbidity, and saying Dr. Yazdanfar was within guidelines when she removed over 6000cc's of fat). The Committee was of the view that he had not been objective in his review.

Dr. N's evidence was often imprecise in areas he considered unimportant, saying his practice was to keep patients one to two hours then two to three hours, and referring to fifteen to twenty minutes as a few moments. In many instances, it appeared he was fencing with counsel using descriptions such as "a little teeny plaque in one small vessel", or "no drastic ECG change, just some minor T wave inversion" in downplaying Ms Mendelson's post-operative care.

The Committee was disappointed to hear Dr. N refer to regulations, which emerged after the deaths of liposuction patients, as a knee jerk reaction without reflection on how certain practices may have caused the deaths. In light of all of the above, the Committee placed limited reliance on his evidence.

Dr. GI

Background

Dr. GI is an anesthesiologist who was certified by the Royal College in 2005. Over the past five years, he has done hundreds of liposuction cases (about 10% of his practice). These are done at a Toronto area hospital and a private plastic surgery clinic (Dr. FX). Eighty percent of cases are done in hospital and 20% in the private clinic. Breast augmentation cases are also about 10%, and are usually done in clinics. Capsulectomies are usually done in hospital, as they are covered under OHIP.

The Committee accepted Dr. GI to give expert opinion evidence in anesthesia in the hospital and out patient setting, including anesthesia to cosmetic surgery patients.

Dr. GI opined that the most responsible physician in the RR is the anesthesiologist, as in the Canadian Anaesthesiologists' Society (CAS) guidelines. A nurse with any concern would first ask the anesthesiologist, who would notify the surgeon and go and see the patient. They work as a team. Normally, in resuscitation, the anesthesiologist would give direction, as they are better trained. The professional obligation of the anesthesiologist is to provide peri-operative care whether paid for, or not. It is the professional responsibility of the RR nurse to make proper detailed records.

In regard to his training, if liposuction is greater than three litres of fat, general anesthesia is used for the comfort of the patient.

Dr. GI gave evidence that a BP of 80 is low for a young woman, and that he would hesitate to start a further surgery but that, if the BP was in the high eighties or low nineties, it is more acceptable. If the systolic is in the nineties, it is quite appropriate.

Krista Stryland

In this case, he opined that Dr. C should not have left the patient, until he deemed it safe. He did not use vasopressors, or make a systematic diagnosis. He failed to recognize the need for blood products and fast lab results, and to transfer early. The problem was in the RR. There were poor /scant records, there was no hand over of care, and they were too slow to recognize the problems.

Dr. GI was of the opinion that fat embolus and DIC were the most likely cause of death, even though he was aware of the forensic pathology (Coroner's) report. He did not believe there was evidence of hypovolemic shock. He believed that tissue injury from liposuction as a cause was extremely improbable, as much more would be seen with all the liposuction being done, and that any fluid shift would take hours or days. He

acknowledged that the Coroner had considered fat embolism and fat embolism syndrome, tested for this and concluded fat embolism was not present. Dr. GI still felt that fat embolism was the most likely cause given the scenario.

Dr. GI agreed with Dr. A that there was a strong disconnect between reporting of the vital signs on the RR record and the evidence of witnesses.

BP recorded at the end of surgery was 110/70 based on the intraoperative record.
He believes the BP's on the RR record are inaccurate (low probability of being true). He now believes the values reported are medically unsupportable, though he did not state this in his report. The BP could possibly be accurate, but not the heart rate. The heart rate does not fit, nor does the record of being on room air with low pO2.

In regard to the drugs used to reverse anesthetic agents, neostigmine can slow the heart rate; Ms Stryland received 5mgm, which is the maximum dose. Atropine is used to counteract this. Ms Stryland received both neostigmine and atropine. The pharmacokinetics indicate that, for neostigmine, the onset is one to two minutes, maximum at five to seven minutes, and maximum decrease of HR is fifteen minutes, then the HR starts to go up. Atropine lasts two to four hours.

In the face of very low blood pressure, you may have poor perfusion and inaccurate heart rate readings from the pulse oximeter. If the BP was 60/30, you would not expect to get a reading and would need to do an arterial blood gas. He believed that a blood pressure that low for three hours was not survivable and was inconsistent with the clinical description of the patient.

In respect of the volume of urine obtained at catheterization, Dr. GI agreed that it was abnormally low and could be related to hypotension and hypovolemia. Normally, he would expect a total of 150-350cc of urine to be formed over five hours (30-70cc/hr).

Dr. GI believed it inconceivable that Dr. C would proceed with the next surgery if the BP was that low.

If the BP was correct, the patient would be expected to be cold, clammy, diaphoretic and close to unconsciousness (not conversant). He indicated she was talking constantly but later agreed that he did not know what she said or who did the talking, and that young people with their reserve could be talking in the first hour.

After 2:45, with sudden shock, the anesthesiologist must stay. A differential diagnosis was needed. Dr. C should have considered 911. He looked after the airway and circulation, but did not use vasopressors. Giving the anesthesiologist fifteen to thirty minutes is reasonable. Dr. GI agreed that to intubate is serious and that, if you don't know what is going on, 911 should be called. He agreed that, in trauma cases, patients can crash quickly with movement.

If any physician were needed in the ambulance transport, the anesthesiologist was the one to go.

Dr. GI was of the opinion that nothing Dr. Yazdanfar had failed to do caused Ms Stryland's death. He agreed that liposuction surgery can be stopped immediately with no risk to the patient. He agreed that if the anesthesiologist is leaving the OR to check BP's, the surgeon needs to inquire what is going on. Both the surgeon and the anesthesiologist need to know what the aspirated fluid looks like. He agreed that surgeons need to recognize and treat surgical complications, including fluid loss and shock.

Dr. GI found Dr. C's treatment to be disturbing and inappropriate, lacking knowledge and/or judgment, and this would apply to Dr. Yazdanfar if she knew. He stated, however, in reply, that if Dr. Yazdanfar said she relied on what Dr. C said and this reassured her, he would not say she lacked knowledge or judgment.

Dr. GI disagreed with Dr. A that blood loss or fluid shift following large volume liposuction resulted in hypotension and shock. No vascular injury or major blood loss was noted. Fluid shifts take hours to days, not minutes to hours. While possible, he felt this highly improbable.

Dr. GI opined that Dr. GH was exaggerating in saying that fluid shifts are managed minute to minute and his position that he was in charge overstated his skills. Dr. GI was of the view that shock induced on the operating table was unbelievable. He disagreed that there was inadequate fluid replacement intraoperatively. He disagreed with Dr. GH in comparing liposuction to burns; both involve fluid shifts, but not to the same extent.

Francine Mendelson

Dr. GI disagreed with Dr. A that this patient had significant co-morbidities and needed to be referred for a cardiac work-up. He cited the American Heart Association and American College of Cardiology guidelines for pre-operative evaluation before non-cardiac surgery, which he said indicate that Francine Mendelson would not have qualified for any type of pre-operative cardiac testing. He believed that her pre-operative work-up was thorough and complete.

Dr. GI anticipated a 10-15% drop in Hgb and believed that the 25-30% drop could have been affected by taking anti-inflammatory medication, or removing her compression garment frequently.

Dr. GI believed the ECG results indicated the patient was in need of urgent, not emergency care.

Dr. GI – Credibility Assessment

Dr. GI provided the Committee with useful information related to the role of the anesthesiologist in cosmetic surgery. His evidence was clear. He admitted changing his opinion regarding the accuracy of the RR values from the time of his report. His evidence

on neostigmine and atropine pharmacology was inconsistent with that of Dr. T and the research evidence submitted.

Dr. GI opined that Dr Yazdanfar met the standard of care, yet agreed that if the anesthesiologist is leaving the OR to check the BP's, the surgeon needs to inquire and needs to be able to recognize and manage surgically related problems.

Dr. T

Dr. T was called to give reply evidence and was accepted by the Committee to give expert evidence in anesthesia.

Dr. T was asked whether it was medically impossible to have BP of 60/30 and a HR of 68 as shown on the RR record, as this evidence was given by the defence experts. This was new evidence and had not been part of any of the experts' reports and was unanticipated.

Dr. T testified that a HR of 68 is lower than expected, but not impossible. The HR may not be a true reading, there may be an arrythmia such as heart block, or drugs can be implicated.

Neostigmine, an anticholinergic drug used in reversal of anesthesia, causes a decreased HR. Atropine is given to counteract this side effect. He said Dr. GI erred in the pharmacodynamics of these drugs and cited an article (exhibit #204) on this point. The duration of action of neostigmine is one to two hours and atropine up to thirty minutes.

If the BP is very low, the pulse oximeter may not accurately reflect the true HR. In his opinion, in this case, even though Ms Stryland may have had some neostigmine effect, he believed it was more likely to be an incorrect pulse oximeter reading.

Dr. T did not agree that, with a BP of 60/30, the patient would be unconscious; they can still be talking and awake in his experience (ectopic pregnancies/ruptured aneurysm),

even though not for long. It is possible. He agreed that the vitals did not match a patient described as joking, talking, wanting to eat and drink and not clammy. It is not, however, uncommon for a patient to try to sit up and then pass out.

Dr. T did not agree that, with vitals as recorded between 13:15-14:45, this could not sustain life. Healthy patients can lose 40% of their blood volume without losing consciousness and, in this case, there were interventions to keep the BP up, which would allow her to survive ninety minutes in shock.

Dr. T believed that 911 should have been called when reintubation was required, as there is no way to diagnose and treat properly in the setting of the TCC.

Dr. T – Credibility Assessment

Dr. T gave helpful information to the panel regarding the scope of clinical manifestations of patients with abnormally low blood pressures, effect of drugs on HR and possible explanations for the vitals noted. The Committee noted the conflicting opinions between Dr. GI and Dr. T with regard to the effect of drugs used to reverse anesthetic agents. The Committee also had in evidence a published article relevant to the subject (exhibit #204), which supported the opinion of Dr. T. Given the totality of the evidence of the reasonableness of Dr. T's testimony, his evidence was accepted over that of Dr. GI in respect of this pharmacology.

ISSUES

The Standard of Practice

In relation to the allegations, the Discipline Committee was required to consider the standard of practice in Ontario in the following areas:

- informed consent in the cosmetic surgical setting;
- liposuction surgery in the out-patient setting;

- breast augmentation and, in particular, whether the technique known as the "tumescent technique" is within the standard of practice; and,
- booking and payment requirements in the practice of cosmetic surgery.

THE ALLEGATIONS

The Committee was faced with many and complex allegations related to a number of patients, which are set out as follows:

In the treatment of Krista Stryland

Dr. Yazdanfar is incompetent and failed to maintain the standard of practice of the profession in a number of ways, including but not limited to:

a) failing to obtain informed consent;
b) her performance of the liposuction;
c) her post-operative care and treatment;
d) her record keeping relating to Ms Stryland's medical chart; and,
e) her clinic's booking procedures and payment requirements.

Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct in a number of ways, including but not limited to:

a) commencing liposuction on another patient while Ms Stryland was unstable and/or failing to abort the liposuction on the other patient after learning of Ms Stryland's unstable and/or deteriorating condition;
b) failing to accompany Ms Stryland to the hospital with the ambulance or to ensure that someone with appropriate knowledge of Ms Stryland's case accompanied the patient;
c) knowingly breaching the acceptable standards of practice with respect to the performance of liposuction; and,

d) the manner she dealt with the booking and payment requirements for Ms Stryland's cosmetic surgery.

In the treatment of Francine Mendelson

Dr. Yazdanfar is incompetent and failed to maintain the standard of practice in a number of ways, including but not limited to:

a) her pre-operative evaluation;
b) her failure to obtain informed consent;
c) her clinic's booking procedures and payment requirements;
d) her performance of the liposuction; and,
e) her post-operative care and treatment.

Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct in a number of ways, including but not limited to:

a) knowingly breaching the acceptable standards of practice with respect to her performance of liposuction;
b) the manner in which she dealt with booking and payment requirements for Ms Mendelson's cosmetic surgery.

In the treatment of Ms MP

Dr. Yazdanfar is incompetent and failed to maintain the standard of practice in a number of ways including but not limited to:

a) failing to obtain informed consent;
b) her performance of the liposuction;
c) her clinic's booking procedures and payment requirements; and,
d) her post-operative care.

Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct including but not limited to:

a) knowingly breaching the acceptable standards of practice with respect to her performance of liposuction; and,
b) the manner in which she dealt with booking and payment requirements for Ms MP's cosmetic surgery.

In the treatment of Ms QR

Dr. Yazdanfar is incompetent, failed to maintain the standard of practice of the profession and/or engaged in disgraceful, dishonourable or unprofessional conduct in a number of ways, including but not limited to:

a) failing to obtain informed consent;
b) failing to provide the patient with a proper choice of procedures, but focusing only on, and inappropriately selecting, the procedure that Dr. Yazdanfar performs;
c) failing to advise that she did not perform one of the requested procedures, and implying both in person and on her website that she does perform that procedure;
d) failing to perform the breast augmentation in an appropriate manner;
e) failing to adequately advise the patient of increased complications with increased implant size;
f) failing to select, assist in selecting, and failing to take responsibility for the selection of appropriate implant size;
g) in her clinic's booking procedures and payment arrangements;
h) in her lack of knowledge of mastopexy;
i) offering an inappropriate manner of correcting the first operation (use of smaller implants in the same pocket); and,
j) dealing in an unprofessional way with the patient and her family members when they came to discuss the procedures, after the patient received them.

In the treatment of Ms WX

Dr. Yazdanfar is incompetent, failed to maintain the standard of practice of the profession and/or engaged in disgraceful, dishonourable or unprofessional conduct in a number of ways, including but not limited to:

a) failing to obtain informed consent;
b) failing to formulate an appropriate treatment plan in that she failed to adequately advise about and explore all possible options for dealing with the patient's presenting complaint;
c) failing to adequately advise the patient of increased complications with increased implant size;
d) failing to select, assist the patient in selecting, and failing to take responsibility for the selection of the appropriate implant size;
e) failing to perform breast augmentation in an appropriate manner;
f) failing to deal appropriately with post-operative concerns and problems experienced by the patient;
g) failing to make appropriate treatment decisions and recommendations;
h) failing to recognize and appropriately manage complications; and,
i) engaging in unprofessional communications with the patient.

In the treatment of Patients in Cosmetic Surgery Practice from 2005 to 2007 and a Patient in 2008 (Ms GR)

Dr. Yazdanfar is incompetent and failed to maintain the standard of practice in a number of respects, including but not limited to:

a) her performance of breast augmentation and liposuction;
b) her engagement as a co-surgeon in the combination procedures of liposuction and abdominoplasty;
c) her pre-operative evaluations;

d) her failure to obtain informed consent;
e) her clinic's booking procedures and payment arrangements; and,
f) her post-operative care and treatment.

Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct in a number of ways, including but not limited to:

a) permitting, supporting or directing her clinic staff's communication with Ms GR;
b) knowingly breaching the acceptable standards of practice with respect to her performance of liposuction; and,
c) the manner in which she dealt with booking and payment requirements for cosmetic surgery.

Advertising

a) Dr. Yazdanfar contravened Ontario Regulation 114/94 made under the *Medicine Act*, 1991;
b) Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct through posting advertising on the Toronto Cosmetic Clinic website, which is misleading or deceptive and which contains testimonials and/or superlative statements about her cosmetic practice.

DECISION AND REASONS

The Committee sets out its decision and reasons as follows:

I. Applicable legislation, legal principles, general principles

II. Standard of Practice

i) Informed Consent
ii) Liposuction in Ontario in the Out-patient Setting

iii) Breast Augmentation in Ontario (technique)

iv) Booking and Payment Arrangements

III. Allegations in respect of Patients

A. Krista Stryland

B. Francine Mendelson

C. Ms MP

D. Ms QR

E. Ms WX

F. Patients seen in Dr. Yazdanfar's cosmetic practice from 2005-2007 and Patient in 2008 (s.75 patients, Ms GR)

IV. Allegations related to Advertising

V. Incompetence

I. Applicable Legislation, Legal Principles and General Principles

Burden and Standard of Proof

The College has the burden of proving the allegations of professional misconduct and incompetence against the member. The standard of proof to be met is on a balance of probabilities. In *F. H. v. McDougall* (2008), the Supreme Court of Canada stated that there is only one standard of proof in civil matters, and that is the balance of probabilities. This judgment emphasized that evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test. The Committee, therefore, is required to scrutinize the evidence before it with care to determine whether it is more likely than not that the allegations have been proved.

Failure to Maintain the Standard of Practice

A failure to maintain the standard of practice is an act of professional misconduct under paragraph 1(1)2 of O. Reg. 856/93. The standard of practice has been defined as the standard which is reasonably expected of the ordinary, competent practitioner in the member's field of practice. It is not necessary to find that harm has been done in order to find that there has been a failure to maintain the standard of practice.

As a general principle, the Committee recognizes that the standard of practice may be established on the basis of the evidence of experts, advisory notices published by the College or pertinent regulations that apply to the member. In some circumstances, there may be guidelines published in particular areas of practice. In Ontario and throughout Canada, guidelines based on strong scientific scrutiny and defined levels of evidence are accorded great weight.

The Committee notes that a failure to meet standards may occur where an individual act does not of itself constitute a violation of the standard of practice, but where the cumulative effect of a number of acts amounts to conduct which falls below the standard of care accepted by the profession.

In the matter before the Committee, there was dispute in some areas as to the accepted standard of practice. The Committee considered guidelines from different organizations that were placed in evidence. The usual purpose of such guidelines is to promote safe and consistent patient care. Guidelines also inform the standard of practice. The Committee received evidence from many experts in the field. The Committee determined that these, and other factors, required consideration and gave weight to the following:

- Opinion evidence of experts in the field;
- Published guidelines from various bodies;
- Current practice patterns;
- Teaching in Canadian residency programs;
- Geographic/jurisdictional issues; and,

- Physician-specific and setting-specific factors.

Central to the matter before the Committee is the issue of the standard of practice in the care and treatment of patients undergoing liposuction surgery and breast augmentation in Ontario; each is addressed separately in the decision and reasons. In addition, informed consent and booking and payment arrangements in the cosmetic surgery setting are considered.

The Committee was aware of its duty to review all of the evidence and arguments of both parties, to decide what the standards of practice were based on the evidence admitted, and to determine whether Dr. Yazdanfar failed to maintain the standard of practice as alleged in the Notice of Hearing.

Incompetence

To make a finding of incompetence under s.52 of the Code, the Committee must be satisfied that the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that the member is unfit to practise or that his or her practice should be restricted.

To prove an allegation of incompetence, the College must establish that:

(i) the alleged incompetence relates to a member's professional care of a patient;

(ii) in his/her professional care of a patient, the member displayed a lack of knowledge, skill or judgment; and,

(iii) the lack of knowledge, skill or judgment was of a nature or to an extent that demonstrates that the member is unfit to practise or that the member's practice should be restricted.

Incompetence differs from professional misconduct in that a finding of professional misconduct will be based on events that have occurred in the past. Incompetence is assessed based on the member's care of patients in the past, but the Committee must also assess the member's present status, i.e., is the member unfit to practise or should the member's practice be restricted.

The Committee is aware that under the Code a panel of the Discipline Committee can make a finding of incompetence, yet determine that the member can still practise in some restricted fashion.

Advertising

Under s.6(1) of Ontario Regulation 114/94 of the *Medicine Act, 1991*, a member may communicate any factual, accurate and verifiable information that a reasonable person would consider material in the choice of a physician. Under s.6(2), information communicated under subsection (1) must not:

(a) be false, misleading or deceptive by the inclusion or omission of any information;
(b) contain a testimonial or any comparative or superlative statements; or
(c) contain any reference to a specific drug, appliance or equipment.

Disgraceful, dishonorable or unprofessional conduct

Under s.33 of Ontario Regulation 856/93, a finding of professional misconduct may be made where there is 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.

II. Standard of Practice

i) Informed Consent – Standard of Practice in Ontario

The *Health Care Consent Act, 1996* sets out the law to be applied in this matter.

The following elements are required for consent to treatment:

1. The consent must be related to treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be given through misrepresentation or fraud.

A consent to treatment is informed if, before giving it:

a) the person received information that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and,
b) the person received responses to his or her requests for additional information about those matters.

Those matters include:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of treatment.
5. Alternative courses of action.
6. The likely consequences of not having treatment.

Consent to treatment may be expressed or implied.

In the cosmetic surgery setting, the Committee accepts that an explanation of risks must include rare but serious complications, and that a patient must be informed of choices or options with their respective pros and cons within reason.

The Committee accepted the following as fact:

- On the first visit to the TCC, a patient is seen by a patient consultant. At this time, there is a discussion of the procedure of interest, payment requirements, risks (to a variable degree), recovery times and a brief discussion of medical history. An estimate of the surgical fee is provided.

- If the prospective patient wishes to proceed, he/she is given a package of forms, including a pre-surgery health questionnaire and consent forms, which they are asked to fill out and initial. Patients are asked not to initial if they have a question. There are specific consent forms, which focus on liposuction/breast augmentation, depending on the procedure of interest. These forms detail the common complications, potential complications and sequelae.

- General risks inherent in all surgical procedures and anesthesia administration are included in the consent forms. The risks of death, stroke, heart attack, shock and pulmonary or fat embolism were not included in the forms until sometime after the Stryland death.

- Patients wishing to proceed make a deposit and are booked for a pre-operative assessment with Dr. Yazdanfar.

- At the pre-operative assessment visit, in addition to a medical history, physical examination and review of laboratory work, there is a discussion with Dr. Yazdanfar of the risks using the forms as a guide and any questions are addressed. When this has been completed, Dr. Yazdanfar writes in the medical record under risks discussed, “in detail”.

The position of the College, based upon expert evidence and the medical records, is that patients have not been informed of the serious risks of the procedures they are to undergo.

Dr. Yazdanfar's position is that she covers the serious potential risks in her discussion with her patients when she covers general risks of all surgical procedures, including anesthetic risks.

The Committee had evidence from multiple experts, numerous patients, Dr. Yazdanfar and the TCC medical records, all of which were relevant to this issue.

In reviewing the evidence, in particular the evidence given by patients, it was clear that those seeking cosmetic surgical procedures are willing patients, often wanting to proceed. They arrive determined to proceed and some pay little attention to checking off items indicating they clearly understand. The Committee was of the view that most patients acknowledge a remote risk of dying when undergoing surgery under general anesthesia. A number indicated a desire for the doctor to be as aggressive as possible to achieve the desired aesthetic results. Arriving with the perception of minimal risk and high expectations, it appeared that the desire of some patients for aesthetic results led them to downplay or minimize the serious risks of the surgery.

It was clear to the Committee that Dr. Yazdanfar had turned her mind to the consent process. Specific forms emphasizing the risks, which accompany breast augmentation (capsular contracture and infection) and others addressing risks of liposuction, are used in addition to more general forms. While it is true a relatively large number of forms are provided, there is ample time for patients to ask questions of staff or seek assistance if they do not understand. They are asked specifically not to initial if they have questions so that the doctor can address these items.

Patients have the opportunity to explore and read the documents thoroughly. It was Dr. Yazdanfar's evidence, undisturbed in days of cross examination that, in the pre-operative assessment, she takes time and thoroughly reviews these forms with patients. At that time, she covers the serious risks and that some may be fatal (including heart attack,

stroke and death - rare but can occur). She indicates that she has done so by entering "in detail" contemporaneously in the medical record and does not itemize these risks further.

Both College and defence experts agreed that informed consent in the elective cosmetic surgery setting is particularly important, as the surgical procedures are not medically necessary.

The expert evidence of Dr. GH is that the standard of practice for consent is the verbal disclosure of all material risks, the asking of questions and the recording of this in the written record. A stack of paper initialed and signed is not informed consent. Dr. GH concluded that, on review of the medical record, there was no evidence that such a discussion took place, though minor issues were well documented.

Dr. A was of the view that, in most cases, patients were not properly informed of the serious risks, bleeding was minimized and the consent process was not customized.

Experts for both the College and the member agreed that reliance upon a stack of forms does not meet the standard of care, and that a meaningful discussion of the serious risks attending the procedure must occur. In opining that Dr. Yazdanfar breached the standard, both College experts relied on the absence of a specific notation of the serious risks in the medical record.

The Committee also had evidence of what is included in the medical records of plastic surgeons, and their individual practices on the recording of risks vary considerably in this respect.

Even though the recording of the risks discussed is inherent to the informed consent process, the issue before the Committee is whether it is more likely than not that Dr. Yazdanfar had a meaningful discussion with her patients about serious risks of the surgery. The Committee considered the evidence of Dr. Yazdanfar, and other evidence from patients, that a discussion occurred and that a contemporaneous note was made.

There was a great deal of evidence provided by patients regarding what they were told about risks. However, most had no clear recollection. The Committee was of the view that to place reliance on testimony that death was never mentioned, when details of the process of consent could not be remembered, was unjustified. Faulty memory for detail after several years is understandable. However, the Committee gave weight to some patients' recollections of descriptions of "blood clots traveling, heart attack and death" as evidence supporting that discussions of serious risks had transpired. One patient described a discussion involving bits of fat floating, which suggested to the Committee a discussion had taken place to cover the risk of fat embolus.

Dr. Yazdanfar's consent process is not perfect. She should have recorded specifically the serious risks she covered. There was evidence that her patient consultant used subtle flattery, which can reinforce the minimization of risk in vulnerable patients. There is no question that some patients minimized their risk, influenced by their individual value system and a strong desire to proceed. There is no evidence that Dr. Yazdanfar intended to deceive, mislead, coerce or misinform her patients regarding the risks of surgery.

What is required to meet the standard is that the member makes the serious risks known in clear and understandable terms. After a review of all the relevant evidence, the Committee concluded that it had not been demonstrated that Dr. Yazdanfar's informed consent process, as it relates specifically to risks of surgery, fell below the standard of practice. In applying the legal test, the Committee was of the view that it was more likely than not that she covered the serious risks in her discussions with patients.

The Committee recognizes, however, that each patient is different and consent must adapt to individual patient needs. Material risks, personal risks and choices must all factor in obtaining informed consent in individual cases. In each case where there is an allegation of failure to obtain informed consent, the Committee considered all the relevant evidence in making its determination regarding specific patients, bearing in mind the above.

ii) Liposuction - Standard of Practice in Ontario in the Out-Patient Setting

The Committee received a great deal of information on the subject of liposuction surgery and accepted the following as fact:

- Tumescent liposuction is a procedure of infiltration of a solution into the subdermal compartment to the extent that the tissue becomes rigid to the touch or tumesced. Following infiltration, fluid containing fat is aspirated using a cannula and suction;
- Where more than three litres of fluid is removed, the procedure is usually done under general anesthesia for the comfort of the patient;
- Large volume liposuction is defined as the removal of 5000cc's or more of total aspirate;
- At the relevant time, there was no publication of guidelines or policies specifically for liposuction in Ontario;
- Liposuction training in Ontario is done in the course of plastic surgical residency programs;
- Other liposuction training programs exist outside this country;
- Liposuction surgery in Ontario is done in hospitals, independent health facilities (IHFs) offering plastic surgery, and in private clinics;
- There has been an increase in the amount of liposuction surgery performed in recent years;
- Risks of large volume liposuction include a number of frequently observed side effects and also more serious complications, including death;
- Risks increase with the amount of fluid removed; and,
- Risks increase with the number of sites treated and the percentage of body surface area treated.

In making its determination as to the accepted standard of practice in Ontario in the out-patient setting, the Committee considered the following factors to be relevant:

- Expert opinion evidence
- Existing guidelines
- Prevailing practice in Ontario
- Current teaching in residency programs/physician training
- Jurisdictional issues

Each is considered separately as follows:

a) Expert opinion evidence

The Committee heard evidence from expert witnesses from both parties. The College called two plastic surgeons from Ontario, the defence one plastic surgeon from Ontario and three cosmetic surgeons from the U.S.A.

All gave evidence in support of the guidelines, which they respectively followed. The Committee gave weight to that opinion evidence where expertise included the practice of liposuction in Ontario. This included the evidence of Dr. K, Dr. A and Dr. GH. Their evidence was consistent that plastic surgeons in Ontario follow the guidelines of the American Society of Plastic Surgery (ASPS) (exhibit #54).

The experts from the U.S.A. called by the defence supported the guidelines of the American Academy of Cosmetic Surgery (AACS), and were associated with that organization in some material way. All were board certified in a surgical specialty, but they had no knowledge or expertise with respect to the practice or standards in Ontario.

b) Existing guidelines

A number of different guidelines were placed in evidence. All of these guidelines address important aspects of liposuction, including volume aspirated (fat or total aspirate), and other considerations, such as the number of body parts treated, anesthesia to be used, post-operative care, multiple procedures and required training. In addition, a number of states in the U.S.A. have local state laws addressing liposuction, or have governing

medical bodies that have enacted legislation addressing liposuction. These are summarized, placing emphasis on volume aspirated.

American Society for Dermatological Surgery Guidelines (2006)

These guidelines reflect the views of the dermatological community in the U.S.A. Approximately 33% of liposuction surgeries in the U.S.A. are done by dermosurgeons. Local tumescent anesthesia only is used, unaccompanied by general anesthesia. This is an out-patient procedure performed in the office setting or ambulatory surgical centre. In respect of safety, it is recommended under the guidelines that removal of more than 4000cc's of fat be divided into more than one operative session. These guidelines indicate that physicians performing this procedure should have completed residency and be board certified in an appropriate specialty, and have liposuction surgery training during residency or a certificate of attendance at post-residency training. They particularly note that, "in the setting of general anesthesia, serious complications have been reported as a result of aggressive fat removal and excessive IV fluids".

American Society of Plastic Surgery Guidelines

As a result of a multidisciplinary task force, concerns about patient safety, and recognizing the change in the nature of liposuction from a minor surgical procedure to that of major surgery, the ASPS guidelines set out generally acceptable approaches and principles.

A Practice Advisory on Liposuction was published on April 15, 2004, Plastic and Reconstructive Surgery Vol. 113, No.5 (exhibit 54). This practice advisory is said to be based on a thorough evaluation of the present scientific literature and relevant clinical experience. It describes a range of generally acceptable approaches to diagnosis, and management or prevention of specific disease or conditions. This was updated in 2009. In respect of liposuction volume, they recommend that large volume liposuction, defined as greater than 5000cc's of total aspirate, should be performed in an acute care hospital or in a facility which is accredited or licensed. This was accepted to mean that 5000cc's of total aspirate was the limit in the out-patient setting. For patients undergoing large

volume liposuction, post-operative vital signs and urinary output should be monitored overnight in an appropriate facility with qualified and competent staff familiar with peri-operative care of the liposuction patient.

The ASPS guidelines address fluid management, specifically recognizing that profound metabolic alterations accompany large volume liposuction. The fluid and electrolyte balance is described as comparable to managing an acute burn, major abdominal operation or trauma.

The ASPS guidelines recognize that limited liposuction volumes can be done safely when combined with certain other procedures, but with some, such as abdominoplasty, serious complications have been reported and such combinations should be avoided.

The ASPS states that those doing liposuction must be trained as surgeons, as defined by one of the ten (10) surgical boards recognized by the American Board of Medical Specialties (ABMS). They go on to specify what further procedure-specific training is necessary, and note that physicians should operate only within their area of training and area of anatomic expertise as defined by their ABMS specialty. They note that those who perform liposuction without surgical training may not be as prepared as trained surgeons to handle unexpected complications.

The ASPS recognizes the importance of facility accreditation by national or state-recognized accrediting agencies.

American Society of Cosmetic Surgeons (AACS) 2006

These guidelines emanated from an Ad Hoc Committee of the American Society of Liposuction Surgery (ASLS) and the AACS.

The position of the AACS is that routine removal of up to 5000cc's of supernatant fat is safe. "Volumes exceeding 5000cc should be removed in select patients without co-morbidities and in an approved operating facility. Recommended maximum volumes

should be modified based on the number of body areas operated on, the percentage of body weight removed, and the percentage of body surface area covered by the surgery." Megaliposuction, defined as removal of 6000cc's of supernatant fat, should be restricted to experienced surgeons performing clinical research in a hospital setting, and under the supervision of an IRB (Institutional Review Board).

The AACS recommend that operating facilities have AAAHC certification or the equivalent.

These guidelines recognize that those practising liposuction should have adequate training. A list of the many ways of obtaining specific technical training in liposuction is included. These guidelines seem to imply, but do not clearly state, that all doing liposuction should be ABMS certified as follows:

"Surgeons of multiple specialties perform liposuction surgery. Qualified surgeons who practice liposuction surgery should have the necessary skills to perform the procedures and the knowledge to diagnose and manage cardiovascular, surgical or pharmacological complications that may arise."

"If residency experience is not adequate, the surgeon should complete the three levels of education."

This was interpreted by the experts from the U.S.A. to mean that surgical residency training was not a necessary prerequisite to be a qualified cosmetic surgeon.

<u>Alberta Standards and Guidelines (1999-1)</u>

The College of Physicians and Surgeons of Alberta is the only Canadian regulatory medical college to have addressed liposuction guidelines. Notably, they address the issue of volume to be allowed in the context of training and experience of the physician.

3.1.1 All physicians who perform liposuction shall:

1. Hold privileges in tumescent liposuction approved by the College

2.1 Eligibility for privileges in liposuction shall include a minimum of one year of general surgical or dermatological surgery training in an approved residency program, plus:

1. Evidence of adequate training in tumescent liposuction during a residency training program; or
2. Completion of postgraduate training in tumescent liposuction commensurate with the background of surgical training and experience of the applicant which is acceptable to the College

2.2 Conditions may be attached to privileges in tumescent liposuction restricting physicians to one or more of the following:

2.2.1 Specified anatomical sites;

2.2.2 Maximum volume of aspirate

2.2.3 Type of anesthesia

2.2.4 Technique

2.2.5 Maintenance of competence requirements

2.2.6 Periodic practice review.

<u>Independent Health Facilities: Clinical Practice Parameters and Facility Standards: Plastic Surgery (2002, 2009)</u>

These standards are included as they relate directly to licensed IHF's doing plastic surgery in Ontario.

The 2009 version is a comprehensive document and is the only version which addresses volume of aspirate in liposuction. No volumes in excess of 5000cc's should be performed. It is the view of the Committee that this is reasonably interpreted as 5000cc's of total aspirate, given the context.

"A physician practicing in a plastic surgery IHF holds the appropriate certification from the Royal College of Physicians and Surgeons of Canada (RCPSC)."

"Physicians operating in plastic surgery IHF's have privileges to perform the same surgery within a public hospital in the same geographical region. They must also have admitting privileges to such an institution or have access to appropriate referral by prior arrangement."

They also note at all Type 1, 2 and 3 facilities that a fully qualified certified surgeon is in charge of the entire operation in regards to staff and health records.

In respect of standards for Type 3 surgical facilities or those utilizing general or regional anesthesia, there are a number of standards listed among which are:

- That there be access to a hospital for transfer of emergency cases;
- That surgeons operating at the facility have admitting or operating privileges in a nearby hospital or access to appropriate referral by prior arrangement.

Discharge criteria include that patients are accompanied home by a responsible person following surgery, as their judgment and reaction time may be impaired.

Florida Administrative Code

The Committee received in evidence various state regulations and guidelines from State Boards of Medical Licensure (California, Ohio, Mississippi, Kentucky). The Florida regulations are included as these resulted from a response to a number of deaths from liposuction.

64B8-9 Standards of Practice for Medical Doctors

64B8-9.009 Standard of Care for Office Surgery

(d) In any liposuction procedure, the surgeon is responsible for determining the appropriate amount of supernatant fat to be removed from a particular patient. A maximum of 4000cc supernatant fat may be removed by liposuction in the office setting. A maximum of 50 mg/kg of Lidocaine can be injected for tumescent liposuction in the office setting.

(e) Liposuction may be performed in combination with another separate surgical procedure during a single Level II or Level III operation, only in the following circumstances:

1. When combined with abdominoplasty, liposuction may not exceed 1000cc of supernatant fat;
2. When liposuction is associated and directly related to another procedure, the liposuction may not exceed 1000cc of supernatant fat
3. Major liposuction in excess of 1000cc supernatant fat may not be performed in a remote location from any other procedure.

Summary

Some of the guidelines reviewed contained a disclaimer that they are not intended to define or serve as the standard of medical care. However, in general, guidelines assist to inform the standard of practice. They represent a guide for physicians and may be used in conjunction with other information to make a determination of the standard of practice to be applied.

The guidelines above are consistent that, as volume of aspirate increases, the risks to the patient increase. These guidelines speak to a range of volume values considered reasonable in the out patient setting. The most conservative value is 5000cc of total aspirate, as provided in the ASPS guidelines. This would represent no more than 4000cc of total fat.

Throughout the review of this material, there is a consistent thread of concern regarding volume removed, training of surgeons performing this procedure, the need for facility regulation and a functional relationship with a hospital.

c) Prevailing Practice

The Committee heard from Dr. GH that most (95%) of the liposuction surgery performed in Ontario is done by plastic surgeons. Dr. K questioned this percentage but gave no contrary data.

Drs. GH and A gave evidence, accepted by the Committee, that the ASPS guidelines are followed and considered the standard of practice when liposuction is performed in Ontario. Dr. K agreed this was the standard in Ontario; however, he gave the opinion that the AACS guidelines were also good guidelines. He did not reconcile in a satisfactory way the differences between the guidelines.

d) Current teaching in residency programs/physician training

Cosmetic surgery is part of the plastic surgery residency rotational training. The ASPS guidelines are taught to plastic surgery residents as the applicable guidelines for liposuction in the course of their training in Ontario residency programs. The AACS guidelines are not taught. Dr. K, who taught at one time, had not even heard of them before this hearing.

Physician training is an important issue as noted in all guidelines, the Alberta standards and the IHF standards. There are two components 1) appropriate skill in liposuction must be acquired and 2) there must be sufficient basic training in the management of post-operative complications to deal with crises when they arise.

The Committee concluded from the evidence that large volume liposuction carries with it sufficient risk to be considered major surgery. This is the description noted in the ASPS guidelines and is consistent with the understanding of the Committee from hearing the evidence of expert witnesses. The Committee finds that large volume liposuction is

potentially dangerous. Experts who gave evidence regarding liposuction, and Dr. Yazdanfar, agreed.

The Committee heard evidence from Dr. K that diagnosis and management of surgically related problems/critically ill patients is learned in surgical residency training.

e) Jurisdictional/geographic issues

Liposuction practice is more prevalent and more aggressive in the U.S.A. than in Ontario. In the U.S.A., liposuction and other cosmetic surgical procedures, are often combined and many are done in private surgical clinic settings. There are accreditation requirements for such facilities under the AAAHC and others agencies which speak to the need for public safety and confidence. The requirements for credentialing of those performing surgery in these facilities was not before the panel.

In Ontario, liposuction is performed in hospital settings, licensed IHFs (plastic surgery) and, as with the TCC, unlicensed private clinics. Until recently, there was no regulation which applied to the latter.

In the Ontario hospital setting, there are credentialing requirements for surgeons ensuring that physicians do only procedures they are properly qualified to do. Hospitals provide the availability of blood products and access to other services and personnel needed in the management of severe complications, along with quality assurance and management processes. Many of these safeguards exist as well in the IHF regulations. When cosmetic procedures are performed in hospitals there are separate reimbursement arrangements made with the institution and the doctor.

When medical problems or complications arise, regardless of where the cosmetic surgical procedure was done, patients are eligible for coverage under the public health care system.

Fat vs. total aspirate controversy

The Committee heard evidence that, for liposuction surgery, 5000cc's of total aspirate would equate to no more than 4000cc's of fat in the fluid aspirated, and usually less. On extraction, the fluid is a mixture of fat, infiltrate and other body fluids, which separate when allowed to stand, such that fat is usually measured after thirty minutes. Much time was spent making the case for whether total aspirate or total fat is a better measure of tissue trauma.

Evidence was presented that the following all contribute to trauma: number of body parts treated, the percent of body surface area, the number of passes made with the cannula, the skill of the surgeon, the amount of infiltrate, the volume of aspirate, and the duration of the procedure. The concern is patient safety. The surgical procedure is traumatic and the complications real.

The Committee takes no position on the debate whether fat or total aspirate is a better measure of tissue trauma. However, when making the decision when to stop the procedure, measurement of total aspirate is necessary because it is impossible to measure accurately the volume of fat at that time.

Position of the Parties

The College takes the position that the ASPS guidelines are the accepted standard of practice in Ontario.

The College's position is that 5000cc's of total aspirate is the maximum amount of fluid to be removed in a single liposuction episode in the out-patient setting.

The ASPS guidelines indicate that, for large volume liposuction, attention must be paid to increased risk of complications, and that monitoring overnight or for an extended period in an accredited facility is required.

The College relies on the opinion of its experts, Dr. A and Dr. GH, supported by some of the evidence of one defence expert, Dr. K.

The position of the member is that the AACS guidelines, which she follows, are also within the standard of practice. She relies on the expert opinion of the cosmetic surgeons from the U.S.A. and of Dr. K who also felt these guidelines were acceptable. She refers to the law regarding a respectable body of medical opinion, which she argues applies in this case. She also brings forward an argument based on the legal doctrine of detrimental reliance in respect of the College's communication with Dr. S and with herself directly.

Finding

The Committee has concluded that the guidelines produced by the American Society of Plastic Surgery (ASPS) represent the standard of practice for liposuction in Ontario in the out-patient setting.

In reaching this conclusion, the Committee had regard for the factors noted in the foregoing discussion and gave particular weight to the following.

The issue is the magnitude of liposuction permitted and patient safety. The Committee had evidence from numerous experts that the amount of aspirated fat allowed by the AACS guidelines (5000cc's of fat) permits a significantly larger surgical procedure than that deemed to be safely done under the ASPS guidelines (5000cc's of total aspirate).

The Committee heard evidence from a number of experts who had different views on how much fluid can be safely removed and how it should be expressed. The opinions of Dr. A, Dr. GH and Dr. K were given more weight, as they each brought unique and relevant experience related to practice in Ontario. Dr. A and Dr. GH currently practise cosmetic surgery. Dr. A teaches plastic surgery residents at an Ontario university and the ASPS guidelines are used in that context. The other experts in cosmetic surgery had no Canadian experience or knowledge regarding practice, but they felt that Ontario practice

was not materially different than American practice. All of the Canadian experts were in agreement that the ASPS guidelines represented the standard of practice in Ontario.

Large volume liposuction is fraught with complications, as clearly articulated by Dr. GH: “there are massive, potential, large volume shifts into the third space”. “The fluid that is shifting may have the effect of leaving an inadequate amount of intravascular fluid to supply your main organs. That can lead to multiple organ system failure or DIC.”

Dr. GH described the AACS as a group of like-minded individuals interested in sharing information. It is not recognized by the Royal College of Physicians and Surgeons of Canada. Like many such societies, it serves the interests of physicians with particular areas of interest. It brings together different physicians from different specialties, and many members who are not trained in recognized ABMS surgical subspecialties.

Dr. N described the AACS as an organization devoted to education of physicians for cosmetic surgery; the mission is to promote patient safety through physician education. According to Dr. O, there are different classes of membership which includes allied health professionals and about 2500 members. There may be 50 to 100 Canadian members.

It was argued on behalf of Dr. Yazdanfar that the law regarding a respectable body of medical opinion applies to the AACS, whose guidelines she follows. She states that plastic surgeons are not the only practitioners of cosmetic surgery in Ontario, and only plastic surgeons are eligible for membership in the ASPS.

College counsel argues that it is for the Committee to weigh conflicting testimony and that there was no evidence to support that the AACS guidelines have been established as a respectable body of medical opinion in Ontario.

The Committee rejects the argument put forth by the member on the following basis.

The alternate respected body of opinion must be held in Ontario; it is not reasonable to say that an opinion held in the USA, or elsewhere in the world, should be binding in Ontario. There is no evidence before the Committee that the AACS guidelines are accepted as standard by anyone in Ontario, other than the member. The evidence of Dr. K was contradictory on this point and not accepted. The Committee finds that the AACS guidelines do not represent the standard of practice in Ontario, either as a majority view or a respected body of minority opinion.

The Committee in making this determination was mindful of the *Brett* case.

Standards in the U.S.A. are not interchangeable with Ontario. The concept of health care in Ontario is fundamentally different from the American model. State laws and regulations relevant to volume issues in liposuction differ from state to state, some permitting volumes expressed by the AACS; others, such as Florida, clearly do not.

The legal concept of detrimental reliance means in brief that, if a representation is made by a person in authority with the intent that it be relied upon by the person to whom the representation is made, and it is relied upon, then the person in authority who made the representation cannot later act inconsistently with the representation. This is a shield for a person acting upon a representation to their detriment. The issue is fairness.

It is the position of the member that she relied on an undertaking made by Dr. S to the College to limit his liposuction volumes to 5000cc's of fat. In addition, the College expressly directed Dr. S to show the College's Order, also referring to a 5000cc fat limit, to the administrator of the clinic which, in this case, it was argued was the member's clinic. It was argued further that the member received a change of scope of practice for an educational program from the College, which she carried out in the U.S.A. This required an investment of considerable time and money.

The College submits that, in the public law/regulatory context, the doctrine cannot be used when the College has a duty to act in the public interest. Circumstances that could

create estoppel in private law will not do so in public law where the public policy embodied in the relevant legislation would be subverted. Furthermore, the College submits that, even though the doctrine noted does not apply in this case, the facts do not support it. The College never made any clear and unambiguous representation to Dr. Yazdanfar approving how she conducts her liposuction practice.

The Committee, after reviewing the evidence, rejected the position put forth by the member on the following basis:

- Dr. S was at the time a general surgeon;
- the undertaking referred to is a letter dated February 19, 2004 from Dr. S to Ms TF at the College and speaks to his decision to limit liposuction volumes to 5000cc of fat;
- the Order dated March 6, 2007, pursuant to s.37 of the Health Professions Procedural Code, was specifically directed to Dr. S;
- the Order related to Dr. S's liposuction practice volumes and required that all operating room personnel and clinic administration be aware of the limit;
- there was no evidence of Dr. S's exact work setting before the Committee other than Dr. Yazdanfar's evidence that "we hired him in 2005"; and,
- Dr. Yazdanfar agreed she knew that public policy is not made in this manner.

The Committee did not agree that Dr. Yazdanfar was entitled to assume that the s.37 Order specific to Dr. S applied to her. It was not a representation made to her.

In regard to the approval of an educational program related to Dr. Yazdanfar's change of scope request, this did not involve liposuction and was not considered relevant to the issue of liposuction standards. That Dr. Yazdanfar chose to invest her time and money in liposuction courses, while commendable, is not a material consideration.

iii) Breast Augmentation – Standard of Practice in Ontario (surgical technique)

In regard to breast augmentation surgery, the Committee accepted the following as fact:

- Breast augmentation surgery is usually performed under general anesthesia and is often done in out of hospital surgical facilities;
- Sharp dissection is an actual cutting of tissue or using a cutting cautery instrument;
- Blunt dissection means the tissue is separated by the finger or a blunt instrument and is used where a tissue plane exists;
- Both blunt and sharp dissection are often done in breast augmentation surgery;
- Incisions for breast augmentation are usually made in the periareolar area, though other options exist (inframammary fold, anterior axilla);
- Breast implants are usually placed in the subglandular, subpectoral or submuscular position. There are many types of implants and a number of sizes, shapes and textures;
- Dr. Yazdanfar performs breast augmentation using a technique known as the "tumescent technique";
- Hematoma is a major complication of breast augmentation surgery and a surgical emergency;
- Capsular contracture is a post-operative complication with a number of options for treatment;
- Bottoming out occurs when the implant is too heavy and descends over time;
- Capsulotomy and capsulectomy are surgical procedures used in capsular contracture;
- Mastopexy is a breast lift and is used to raise the nipple or tighten the skin of the breast to effect a more pleasing appearance; and,
- OHIP coverage extends to cover complications of breast augmentation surgery including capsulectomy, capsulotomy and hematoma management.

In making a determination with respect to the standard of practice in Ontario, the Committee notes that, as with many areas of medical practice in Ontario, there are no written standards for breast augmentation surgery. In coming to a determination of the standard of practice in Ontario, the Committee determined a number of factors to be relevant.

The following were examined by the Committee in coming to a decision as to the standard of practice for breast augmentation surgery in Ontario:

- Technique used
- Expert evidence
- Teaching and current practice
- Guidelines (AACS)
- Training and Scope

Each of these will be separately addressed.

a) Technique used

The technique of breast augmentation that meets the standard of practice in Ontario was described by Dr. A and Dr. GH as follows.

Breast augmentation is done under general anesthesia. The periareolar skin is infiltrated with a small amount of local anesthetic (i.e. 5cc's per side). A periareolar incision (usually) is made. A dissection is performed and a pocket for the implant is created using electrocautery to cauterize vessels as you go. Dr. GH does an electrocautery dissection. Dr. A says that surgeons usually use electrocautery to get down to the pocket using a cutting cautery instrument which, upon cutting through, leaves a dry plane. Hemostasis is checked for by direct visualization and bleeding vessels are cauterized. There is always some bleeding. The implant is inserted and the wound closed.

Tumescent technique

Breast augmentation done by Dr. Yazdanfar is also done under general anesthesia. She infiltrates 250-500cc of fluid containing local anesthetic and epinephrine into each breast through a stab wound incision on the lateral aspect of the breasts. A periareolar incision is made. Blunt dissection using a finger aided by hydrodissection is used to create the pocket which then is visualized for hemostasis. Cautery is used if needed to secure hemostasis. A sizer is inserted and inflated to the desired size. Following this, the wound is irrigated, the implant insertion is completed and the wound is closed. There is minimal use of cautery, reliance on hydrodissection and blind blunt dissection in the creation of a pocket.

All Canadian experts who have done this surgery agreed that cautery and direct visualization of the pocket are important to ensure hemostasis, given the risk of hematoma formation.

On viewing the video, which demonstrates Dr. Yazdanfar performing breast augmentation, Dr. GH noted flushing the pocket to assess hemostasis, but was unable to assess whether there was adequate visualization and appropriate use of cautery.

It is clear that there is a difference in the techniques described above.

b) Expert Evidence

Dr. A

Dr. A was of the view that Dr. Yazdanfar was performing breast augmentation using a non standard technique. His concern was for adequate hemostasis when the effects of the epinephrine wore off. He raised concern that the safety profile of her technique was unknown. He felt that the use of both local and general anesthesia in the manner described was not logical. Dr. A gave evidence that the rate of hematoma formation generally was 1-2% and that there was a huge range of capsular contracture rates, which he estimated to be 1-10%.

Dr. K

Dr. K gave evidence that the tumescent technique has been used for a number of years in breast reduction surgery, even though he was not aware of it being used in augmentation surgery until he was involved in this matter. He is not aware of this technique being taught in Ontario, at least not in Toronto.

Dr. K was of the opinion that breast augmentation was much more complicated than liposuction. He believes that breast augmentation can be done in many ways, not all of which are taught, and that the use of the tumescent technique is just a variation in the way of doing it. Dr. K gave evidence that some use cautery to dissect, others do not. Dr. Yazdanfar uses blunt dissection to complete the pocket, which is accepted. There are no increased risks and more advantages than disadvantages to the use of the tumescent technique. He did not view her technique as experimental.

Dr. GH

Dr. GH's view was different from Dr. A's, saying that the use of tumescence was a valid technique. However, he went on to say that the use of blunt blind dissection and tumescence is not a substitute for cautery and does not meet the standard of practice. Some blood vessels in the area are quite large, and if cautery is not used bleeding of a serious nature can follow. He agreed that there is some benefit of tumescence in post-operative pain control. This benefit is lost, he believes, when the risks of general anesthesia are added. He questioned the logic of using both general anesthesia and tumescent anesthesia concurrently.

He was familiar with courses teaching the tumescent technique and was critical of the use of a blunt pocket retractor which may shear vessels, as they may bleed later if the implant pressure does not control it. Once general anesthesia is used there is no reason not to use electrocautery. He was critical of the use of Marcaine in the fluid infiltrated. He estimated the rate of hematoma in breast augmentation surgery that required surgical management to be 1-5%. He estimated the capsular contracture rate to be 5-20%.

Dr. N

The technique used by Dr. N is not exactly the same as used by Dr. Yazdanfar. He uses approximately 60cc's of fluid in each breast, she uses more. He described using tumescence as a tool and stated that the tumescent technique is taught in the USA. He uses cautery on blood vessels when needed, and he understood Dr. Yazdanfar does as well. He believes that tumescence helps with dissection, decreases post-operative pain and reduces bleeding post-operatively.

Dr. N was of the opinion that blunt dissection was safer, easier and less traumatic. He felt there was more bleeding potential with the use of cutting or cutting cautery but agreed that others may have a different view. He disagreed with Dr. GH that there was an increased risk of hematoma formation using the tumescent technique. His rate is < 1%.

After removing the sizer, Dr. N testified that Dr. Yazdanfar examines the pocket with a lighted retractor and irrigates to ensure there are no bleeding points needing cautery.

Dr. L

Dr. L gave evidence that he has used the tumescent technique for thirteen years for all forms of breast surgery with lower complications rates than the national average. He said it was an acceptable technique used by a majority of cosmetic surgeons in the U.S.A. He was unaware of the extent of its use in Canada. He noted that he had seen reports of a lower capsular contracture rate with this technique. The mechanics of breast augmentation do not change.

Dr. L indicated the rate of hematoma formation to be 1-3%. He agreed that his website indicates that there is an increased risk of capsular contracture with larger implants; he has recently reviewed studies that showed no difference. Large implants have potentially more risk of rippling and bottoming out.

c) Teaching and current practice

The tumescent technique used by Dr. Yazdanfar is not the standard operation in Ontario and is not taught in residency.

Most (99%) of breast augmentation procedures in Ontario are done currently by plastic surgeons A recognized critical component is to visualize the pocket and cauterize large vessels, as they will retract and could bleed later.

The Committee reviewed the article by Dr. Z (exhibit #84) *Can J Plastic Surg* Vol 15, No 3 Autumn 2007. In this article, Dr. Z describes a tumescent technique he has been using in Ottawa for outpatient breast augmentation for over twelve years and over 300 cases. He notes this technique to be simple, safe and reliable. He does not use general anesthesia, which is different from the procedure used by Dr. Yazdanfar. While Dr. Z was not called to give evidence, it was clear to the Committee from the article filed that there were at least some aspects of the technique he uses that are similar to that used by Dr. Yazdanfar.

The Committee also had in evidence an article by Dr. HS (*Can J. Plast. Surg* Vol 3 No 2 summer 1995) describing a breast augmentation technique done using local anaesthetic. The report on 305 patients was of a low rate of capsular contracture (5/305 with an average follow-up duration of fourteen months). Three hematomas were noted.

d) Guidelines for Breast Augmentation (AACS 2002) - exhibit #179

The Committee reviewed these guidelines as they were the only written guidelines placed in evidence on this subject, but found them of little use in deciding the matter before it. These guidelines do not address the issue of the tumescent technique. They do confirm the evidence given by the experts in terms of pre-operative care. “Surgeons should discuss the various surgical options with patients along with what each option can achieve, the potential variable outcomes that may result, the risks associated with each option, the recovery time for each option and the recommendations. The medical record should document the thoroughness of the pre-operative counseling.”

In respect of training and education, a plain reading of the guidelines leads the reader to believe that breast augmentation surgery is learned as a post residency training experience. “Surgeons of various specialties perform breast augmentation surgery. Qualified surgeons who practice breast augmentation surgery must have the necessary skills to perform the procedures and the knowledge to diagnose and manage medical, surgical or pharmacological complications that may arise.” There is no clear statement that all who do this surgery should be board certified or board eligible in a surgical specialty.

Dr. L indicated that, in his view, Dr. Yazdanfar’s education would be considered sufficient to perform breast augmentation under these guidelines, even though she lacks surgical residency.

e) Training and Scope

Training

In Ontario, training in breast augmentation surgery is obtained in the course of plastic surgical residency. Training in this program, as was clear from the evidence of Dr. K, equips the doctor to manage complications and unexpected crises.

Dr. Yazdanfar’s training in 2003 involved a week of observation at Dr. L’s clinic. She attended a two day workshop with Dr. N in 2003; in 2004, she arranged for a two day personal training program with Dr. N and attended four days of workshop. In 2005, he came to Toronto for two days with her. Her C.V. lists a number of other sessions attended.

Dr. N gave evidence that while Dr. Yazdanfar did not learn the tumescent breast technique from him (he uses only about 60cc’s to infiltrate), it is taught at the AACS educational sessions and many of his colleagues use it. Dr. Yazdanfar gave evidence that, when she introduced breast augmentation surgery into her practice, she used 50-70cc’s of

fluid and that she has changed her technique with time using more fluid. She has stopped using Marcaine.

Scope

Dr. Yazdanfar sought a change of scope in practice from the College for breast augmentation. Dr. Yazdanfar said that this change in scope was approved by the CPSO after further training with Dr. N. The Committee understands that the purpose of the College policy on Change of Scope is to affirm technical skills, training and experience for those expanding their practice into new areas. It does not replace requirements for specialization as required by the Royal College of Physicians and Surgeons of Canada. The College relies on a physician's integrity, professionalism and judgment that he or she will practise within his or her limits in a responsible and safe manner.

Position of the Parties

The College takes the position that Dr. Yazdanfar falls below standard as she does not use a technique that is acceptable in Ontario. She does not use electrocautery dissection. The College argues that her method differs from Dr. Z in the way local anesthetic is used and the absence of general anesthetic. The College relies on the evidence of Dr. A and Dr. GH that the tumescent technique is not standard in Ontario and that it is not taught to residents.

Dr. Yazdanfar takes the position that the surgical technique she uses is not below the standard of practice. She cites the article of Dr. Z, a plastic surgeon practising in Ontario. She creates the pocket in an acceptable way and achieves proper hemostasis. She said that she uses cautery when necessary. Dr. Yazdanfar relies on the evidence of Dr. K and the experts in cosmetic surgery from the U.S.A. (Dr. L, Dr. N). She supports her case with a video of her performance of a breast augmentation and the scope of practice allowed by the College.

Finding

After a review of all the relevant evidence, the Committee has concluded that the use of tumescent technique in breast augmentation as practised by Dr. Yazdanfar is a variation in the operative technique, which is not sufficiently different from the standard operation to be considered a failure to maintain the standard of practice in Ontario. There was no evidence that Dr. Yazdanfar ignored the need to achieve hemostasis and she had cautery available for use as necessary.

Central to the College's argument is the degree to which Dr. Yazdanfar visually inspects the pocket and how electrocautery is used to achieve complete hemostasis in the tumescent technique. Drs. A and GH base their concerns on the exclusion of cautery and the different ways to create a pocket.

That there are differing ways to create the pocket was clear from the evidence as to practice both in Canada and the USA.

The Committee found that Dr. Yazdanfar uses a lighted retractor and electrocautery when needed in performing breast augmentation surgery. This conclusion is based on her evidence and evidence given by Dr. E who also works in her clinic, a video review, evidence from Dr. N of how she was taught and the fact that Bovie tips are out and available for use when needed, as recorded in the medical record.

While the tumescent technique is not the standard one performed by most plastic surgeons in Ontario, Dr. Yazdanfar was taught breast augmentation in a program that was approved by the College.

In respect of the need to inform patients that a non-standard technique was to be used, the Committee accepted that her discussion involved a thorough description of the technique that she used.

The Committee gave weight to the evidence of Dr. L, that the risks are no greater than, and more likely less, using the tumescent technique. There was no evidence produced to suggest that there was a higher risk of hematoma formation and some evidence to the contrary. There was speculation only that this might be so.

Surgical techniques evolve and changes are adopted from what is written in the literature, presented at meetings and by word of mouth. In Canada, there is great weight given to evidence based care. Evidence that the tumescent technique has been used by plastic surgeons in breast reduction surgery in Ontario was established. The Committee also had regard for the existence of published reports where tumescence in breast augmentation procedures was used in Canada.

That Dr. Yazdanfar used more fluid as time went on did not change the Committee's view, as there was no evidence produced to suggest that the technique was substantively different.

With respect to the use of Marcaine, Dr. A opines in relation to Ms QR and others that the tumescent solution contained Marcaine. Marcaine is a longlasting local anesthetic with side effects that are hard to treat, including seizures and arrhythmias, and should not be used. This is not standard procedure in Ontario. The Committee, however, had no evidence of how widespread the use of Marcaine in Ontario at the relevant time may have been, and notes that Dr. Yazdanfar testified that she has stopped using it.

There were contradictory opinions in respect of the risk of capsular contracture using the tumescent method. In respect of risk of capsular contracture increasing with implant size, the Committee accepted that some experts were of the view that it did but that this is anecdotal.

There is no question that Dr. Yazdanfar has developed a skill in breast augmentation surgery. The Committee recognizes the need to use this skill in the proper context in the interest of public safety. The skill acquired by Dr. Yazdanfar represents only a single

technique among a number of valid options for women desiring cosmetically enhanced breasts. Proper diagnosis and offering of options, along with safe management of operative and post-operative complications, are required, in addition to technical proficiency.

iv) Booking and Payment – Standard of Practice

The following was not disputed and was accepted as fact by the Committee:

- At the initial visit to the TCC, a patient consultant describes the booking and payment arrangements to the prospective patient;
- The patient, if wishing to proceed, is given a number of forms to read, fill out and sign. Among the forms is a sheet which includes the cost of the procedure and a payment agreement;
- The payment agreement specifies that there is a 50% non refundable cancellation fee (if patient changes her or his mind, regardless of the reason);
- The patient is then required to pay a non refundable deposit of $500.00, following which they are booked for a pre-operative appointment with Dr. Yazdanfar and for surgery usually one or two days later; and,
- The balance of the amount owing is due on the pre-operative assessment date.

Position of the Parties

The College takes the position that a 50% non refundable cancellation fee for any reason is excessive and breaches the standard of practice. The College relies on the expert evidence of Dr. A and Dr. GH and the testimony of numerous patients.

The College also believes the excessive amount of the cancellation fee vitiates the consent process, forcing patients to proceed because they do not wish to lose so much money; the College relies on the evidence of Ms GR and Mrs. HP in this regard.

The position of the member is that physicians doing cosmetic surgery all employ cancellation fees. The member takes the position that the College has failed to

demonstrate that the cancellation fee affected the voluntariness of patients' consents or breached the standard of practice.

Expert evidence

Dr. A

Dr. A agreed that it is usual for the full fee for cosmetic surgery to be paid up front. He did not argue about the need for a cancellation fee but felt that it should be nominal and that 50% was excessive. Dr. A does cosmetic procedures in hospital and, as a consequence, his personal experience does not include private surgical facilities. It was his view that patients would be influenced not to change their mind having made such a substantial commitment.

Dr. GH

Dr. GH works in a private surgical facility. A deposit is required. If surgery is cancelled (less than 3 weeks out), 30% of the fee is asked for. This can only be refunded if a significant medical event or reason exists. This is a common approach and there is a huge range of cancellation fees.

Dr. K

Dr. K gave evidence that a $500.00 deposit is reasonable. A nonrefundable policy, such as that of the TCC, is used by most freestanding clinics, though the amount may vary.

Defence witnesses

Dr. Yazdanfar

Dr Yazdanfar testified that there is no requirement to pay more than the $500.00 deposit if, after seeing her, the patient decides not to proceed. Filling out the form does not commit patients to pay if they cancel after meeting with her. If she decides the patient is not a good candidate, the patient is refunded the $500.00. She uses her discretion when

the matter of refunds comes up and has fully refunded payments when patients decided not to proceed in the past.

Ms GB

This witness has a number of administrative duties at the TCC. She testified that payment of $500.00 is required to see Dr. Yazdanfar and this is returned if she does not think they are a good candidate. Patients rarely pay in full before seeing Dr. Yazdanfar but do so when they decide to proceed.

Dr. F

Dr. F does cosmetic procedures at the TCC. He testified that he is aware of two of his patients who have had full refunds.

College witnesses

Ms GR

This patient testified she was seen at the TCC on May 13, 2008, seeking a breast lift and augmentation. She paid a $500.00 deposit and signed the forms, including the payment agreement. She was booked to see Dr. Yazdanfar on May 28, 2008, and then proceeded to breast augmentation surgery May 31, 2008. She paid in full May 28, 2008.

After her first visit, she became aware of the death of one of Dr. Yazdanfar's patients, and said that she was scared to go ahead. She did not want to lose the money and she decided to give Dr. Yazdanfar the benefit of the doubt and at least meet her to see if she was comfortable. She testified that, if she had not signed the form, she would not have had the surgery done by Dr. Yazdanfar.

Mrs. HP

This witness, the mother of Ms GR, testified that she accompanied her daughter to the pre-operative visit with Dr. Yazdanfar. Her daughter paid in full after they met with the doctor, before they left the TCC. She had found out a few things that really concerned her

about Dr. Yazdanfar before the surgery and advised her daughter not to go through with it.

Other patients

The College explored the payment arrangements with a number of patients, all of whom agreed they understood the 50% non refundable cancellation policy. There was some variation in terms of exactly when patients made their full payment as noted in the medical records; many did so just a day or two before their surgery.

After a review of the relevant evidence the Committee concluded that:

- The required deposit of $500.00 was a reasonable amount to require patients to pay to proceed for the pre-operative assessment with Dr. Yazdanfar;

- A cancellation fee is not outside the usual practice of cosmetic surgery though 50% is high;

- The costs and the cancellation fee were made clear to patients and there was convincing evidence that patients understood and agreed.

In the case of Ms GR, it was clear that the patient and her family harbour resentment towards Dr. Yazdanfar. While Ms GR claimed to be scared, she never inquired or asked Dr. Yazdanfar if she could delay/cancel her surgery, though she had time to do so as did her mother at the time of the pre-operative assessment. Ms GR said she would give the doctor the benefit of the doubt and it appeared clear to the Committee that after the meeting she decided to go ahead and then paid the fee owing in full. This appeared to be a voluntary decision. To that time, she had made no payment other than the deposit and the Committee did not believe it likely she was influenced to proceed by an agreement to refund 50% in circumstances where she had yet to make full payment.

Finding

While the process gave little time for patients to reflect after seeing Dr. Yazdanfar and before surgery, and the agreement could have been better worded, neither constituted a failure to maintain the standard of practice.

The Committee heard no credible evidence from patients that they felt exploited by the cancellation fee policy instituted at the TCC. No definition of a nominal fee was put forward and it was unclear where the bar would be set in terms of an acceptable cancellation fee.

There has been no evidence produced to persuade the Committee that there has been a failure to maintain the standard of practice in this respect.

Under these circumstances, the Committee makes a finding that the allegation of a failure to meet the standard of practice in respect of the booking and payment arrangements as alleged in this matter in relation to multiple patients has not been proved.

III. Allegations in respect of patients

A. Krista Stryland

The Committee accepted the following as fact:

Ms Stryland was seen at the TCC on August 30, 2007, for her first visit as she was interested in liposuction. She checked and signed the consent and payment forms. She saw Dr. Yazdanfar for her pre-op assessment on September 12, 2007. Her history indicated that she had a Caesarian section and a mini liposuction procedure done in the past. The chart notes “risks discussed” and that informed consent and adverse reactions were discussed “in detail”.

On September 20, 2007, Ms Stryland underwent large volume liposuction of the abdomen, love handles, lower back, and inner thighs using Smartlipo. Upon arrival at the TCC, she was taken to the change room and pre-op vitals and history were done. Surgery commenced at 10:00 a.m. and finished about 1:00 p.m. According to the operative record, 6000cc's of Klein's solution was infiltrated subcutaneously and a total aspirate of 6075cc's was removed, of which 2725cc's was fat. General anesthesia was administered by Dr. C and the anesthetic record shows steady normal BP readings throughout. The time of the last BP reading on the anesthetic record is inaccurate and was approximately 1:03 p.m. Surgery was described by all present as uneventful. During the procedure, 3400ml of Ringers Lactate solution was administered intravenously. Nothing abnormal was documented on the OR record.

About 1:08 p.m., the patient was transferred to a stretcher and moved to the RR by Nurse J and Dr. C. Dr. Yazdanfar followed the stretcher to the RR and went on to her office.

Recovery Room (RR) Events

The Committee accepts the following as accurate in respect to the RR events of that day. A security video of the hallway outside the RR only became available in the fall of 2009, after the commencement of these proceedings. After viewing this video, a number of witnesses found their memory of that day to be enhanced. The Committee limited the weight placed on the video to confirmation of the timing of particular actions, as it was clear that the video did not capture all movement in the hallway outside the RR and it captured none of the movement/actions in the RR.

At approximately 1:09, Ms Stryland is hooked up to the monitor by Nurse J and Dr. C. Dr. C stays to observe the first vitals, then leaves.

Between 1:14 and 1:20, Nurse J is mostly with Ms Stryland. There is a brief period of time when no one is monitoring Ms Stryland as Nurse Q takes a patient to the parking lot and Nurse J is seen in the hallway on video.

At 1:28 p.m., Dr. Yazdanfar passes through the RR, checks on Ms Stryland and goes on to mark the next patient for surgery. Nurse Q is in the RR doing paper work.

For a period of time between 1:40 to 1:46, no one was monitoring Ms Stryland as both nurses are seen in the prep room on video. This was when the fat measurement was undertaken.

During her stay in the RR between 1:15 and 2:45, Ms Stryland was significantly hypotensive; the BP values and when they were noted are at issue, and the testimony of witnesses and the RR record differ. Nurse Q was concerned and spoke to Nurse J about the low readings shortly upon returning from taking the first patient of the day to the parking lot.

During this period, Dr. C ordered a fluid bolus. Nurse J is back and forth between the OR and RR informing Dr. C of Ms Stryland's condition. By 2:38, Dr. C had left the OR and made at least two visits to the RR to assess Ms Stryland.

Ms Stryland's condition deteriorated abruptly at about 2:45 when she struggled to sit up and collapsed. Nurse Q sent Nurse J to get Dr. C urgently. The Committee placed more weight on the evidence of Dr. C and the nurses than on the video in accepting 2:45 as the time of collapse. Dr. C ordered a second and third IV be started, and he intubated the patient. The catheter yielded only 100cc's of urine. A pressure bag was used on at least one of the IV's. Much activity is observed in the hallway from 3:06 onward involving the nurses and Dr. C.

At 3:17 p.m., Dr. Yazdanfar first appears in the RR to check what is happening. She asks Dr. C if he needs anything from the crash cart. She sees her patient intubated, with three IV's running. At that time, Dr. Yazdanfar comes to the bedside, does a brief (30 second) examination, and observes more drainage/oozing of blood than usual. She asks Nurse J to get a second binder.

At 3:18, Dr. Yazdanfar returns to finish the case in the OR.

Dr. Yazdanfar comes back to the RR at 3:25 and is back and forth between the OR and RR until 3:34, when she has scrubbed out of surgery.

Dr. Yazdanfar called 911 at 3:51 p.m. and EMS arrived on scene at 3:57 p.m. Upon arrival, Ms Stryland had spontaneous but ineffectual breathing and no carotid pulse could be felt. EMS put on a cardiac monitor. Nurse Q was ventilating. At 4:05, Ms Stryland was vital signs absent (VSA) and CPR was started. At 4:08, she was transferred to the EMS stretcher. The Committee accepted these times as accurate based on the evidence of the EMS personnel and their documentation. Epinephrine and atropine were given and repeated several times.

Ms Stryland was transferred to the hospital by ambulance, accompanied by Nurse Q, where efforts at resuscitation were unsuccessful.

At no time did Dr. Yazdanfar speak to Mr. AB, who had arrived to pick up Ms Stryland. She indicated she did not call him later by reason of legal advice.

The Committee carefully examined relevant reports.

Report of the Post Mortem Examination (Forensic Pathology Unit, Office of the Chief Coroner)

Death was attributed to hypovolemic shock complicating liposuction. No precipitating cause for coagulopathy was identified. This was thought to have been likely due to fluid shifts during and after liposuction or due to the effects of tissue injury iatrogenically induced at the time of liposuction. Evidence for fat embolism was looked for in a number of organs and was not thought to be present.

The Committee accepted this as true and accurate regarding the cause of death of Ms Stryland.

Recovery Room (RR) Record

On plain reading, the RR record shows a series of very low BP's, which appear to reflect times from 1:15 to 2:45. The times entered along the top were claimed to be written in by Nurse J when she transferred the patient from the OR to the RR. The forensic examiner did not accept this. The blood pressure readings (demonstrating BP's in the range of 60/30) were written by Nurse Q. Heart rate (HR) was in normal range and specific oxygen concentrations were noted along with the rate of flow when the patient was on oxygen.

Nurse Q gave different versions of how and when these vitals were made, one version before viewing the security video which was the version given in her interview at the College in 2008, and another to the Committee in her oral evidence (both given under oath).

In her initial version, the readings and times are correct. In the second version, in her oral evidence, she said she made the notations of the readings when the EMS was there and while she was bagging the patient. She asked Nurse J for the RR record and was surprised when she found it to be blank. She said she scrolled back through the readings and wrote them down (in reverse order) from the monitor, except for the oxygen concentrations which she recalled from memory. She made the first two readings with her left hand and the rest with her right.

Nurse J testified that she estimated the initial BP reading in the mid 80's based on her reaction and that of Dr. C. She was responsible for Ms Stryland only for the first ten minutes of her RR time. She said she wrote in the times at the top of the graph on the RR record. Later before EMS arrived, Nurse Q asked her for the RR record and then commented that it was blank. Nurse J repeated that there were no vitals on the record at that time and that Nurse Q began to write them down while bagging the patient. She said she saw Nurse Q using both her right and left hands. She returned to the OR and then went out to await EMS.

The Committee notes that, in November 2009, both nurses were asked to provide a written statement to Dr. Yazdanfar's counsel. The nurses met together in a room to discuss discrepancies in the RR record.

The Committee had the forensic analysis report of Mr. P and his evidence on indentations, which established that the fat measurement sheet was beneath the RR record when the last three entries were made, and not when the first two entries and a portion of the third entry were made. He concluded that there were at least two separate writing episodes in creating that part of the document (the entering of the vital signs). The Committee found that the testimony of Nurse Q as to how she entered the vitals was inconsistent with the forensic report.

The Committee concluded that the vital signs noted on the RR record were accurate and taken from the monitor, and the corresponding times noted on the RR record were correct based upon:

- The indentations (forensic evidence) are inconsistent with the oral evidence of Nurse Q that she filled this out just before transfer and that it was on a clipboard;

- The indentations support that the first two and a portion of the third set of vital signs were made in a separate writing episode(s) prior to the fat extraction sheet being incorporated into the medical record, and the remainder made after the fat extraction sheet was placed into the chart and the RR record placed on top;

- Fat extraction measurements were made around 1:45, after which the fat extraction sheet would normally have been placed in the chart;

- The record was consistent with the interview evidence given by Nurse Q in her interview with the College in 2008, and she gave evidence that it was her belief at that time;

- The record is consistent with the personal log Nurse Q made later that evening. While the log was never intended to become part of the record, it is the closest thing to a recorded description of events;

- The record was consistent with the evidence given by Dr. C, that he was aware or believed he was aware of the abnormal vitals;

- The record is consistent with the indentation record of the notes made by Dr. C on September 20th and replaced later by his resuscitation note. The partial decipherment of his original notes suggests that something abnormal was going on earlier than 2:35, though it could not be deciphered;

- The BP values as reported before the arrival of EMS in Nurse Q's testimony are inconsistent with the values noted in Dr. C's resuscitation note;

- The record of vital signs ends at 2:45 which coincides with the collapse of the patient, following which Nurse Q said she was attending the patient and not making chart notations;

- Ms Nurse Q's oral evidence was judged to be unreliable given the many inconsistencies noted;

- The specific details recorded regarding oxygen saturation were such that the Committee did not believe that they could be recalled from memory as described in Ms Nurse Q's testimony;

- It was difficult for the Committee to accept that a nurse as well trained as Ms Nurse Q, who was on the second working day of her new job as RR nurse and who was present in the RR, would fail to make required notations on the chart, particularly when the readings were not normal;

- It is likely that Nurse Q wrote in the times across the top, given that one of the two nurses had to and given that the handwriting was so dissimilar to Nurse J's based on the comments of Mr. P;

- The small amount of urine obtained at catheterization supports a lengthy period of hypotension/hypovolemia consistent with the values on the RR record;

- The second version of events, as given by the nurses in their oral testimony, varied in respect of when the recording of the vitals occurred, with Nurse J saying this was before the EMS arrived and Nurse Q saying it was during the time EMS was there and moving the patient to their stretcher; and,

- The description of the contortions required to achieve the scrolling back, writing with the left hand then the right hand at a time when EMS was actively assessing and the nurse was bagging the patient was, in the Committee's view, not believable.

The Committee did take note of the comments of expert witnesses that there were inconsistencies between the BP and HR, making the record invalid. The influence of drugs used by the anesthesiologist was explored in detail, as was the limitation of the pulse oximeter. It was the view of the Committee that either or both could have had an influence on the HR and that the record could not be considered invalid for that reason.

The clinical picture of a patient described variably as groggy, conversing and asking for food, did not influence the Committee's conclusion. The Committee had regard for the evidence of Dr. T in this respect, given his relevant experience, and the evidence of Nurse J that the request for food was within the first ten minutes in the RR.

The Committee was aware that the nurses had a discussion about low BP and Nurse Q was reassured early in the recovery period. She had the opportunity to scroll back and

write down the vitals from the monitor when she returned to the RR around 1:20pm. Expecting the pressure to rise, she did not become concerned until it did not. It was not clear to her that she bore responsibility for care, though it should have been obvious. That she was not familiar with the informal type of handover that was typical at the TCC is clear.

The Committee was of the opinion that the RR record was grossly inadequate as it did not contain a written description of events, it lacked an accurate description of the clinical status of the patient, there were no contemporaneous notes by the doctors' responsible or nursing notes, and no accurate record of the fluid administered.

Personal Log of Nurse Q

While Nurse Q testified that this "log" was intended as a personal reflection, it is important to consider it given the dearth of information documented in the medical record. The Committee determined that this reflected Nurse Q's best recollection of the events of that day. In making this note in the evening of September 20th, Nurse Q left no question that the patient was hypotensive from the first reading taken in the RR and that "MD [meaning Dr. Yazdanfar] was aware".

At 2:45, the patient's condition worsens; this time is consistent with Dr. C's evidence and the accuracy of the time is noted in particular. Resuscitative efforts with reintubation followed. From then until the arrival of EMS, the vitals fluctuated according to her record, responding to the added fluids.

The description of the patient and her vitals at the time the EMS arrived is not consistent with EMS observations and their documentation. It is clear, however, that Ms Stryland was deteriorating at that time and about to go into cardiac arrest when the paramedics arrived. Nurse Q notes that there may be omissions and inaccuracies; nonetheless, this is the only documentary information as to the clinical status of the patient during much of the critical resuscitative period.

Dr. C's Resuscitation Note

This note was made the day after the death of Ms Stryland. Dr. C makes no mention of events before 2:45 p.m. when there was a sudden change in the status of the patient. The forensic report indicates that this note replaced notes that Dr. C made at the time of the resuscitation. The original notes were subsequently destroyed, though were indented onto pages of the chart and partially deciphered.

In his resuscitation note, he described the resuscitation efforts and indicated that the patient responded very quickly (three to five minutes). She was gagging on the endotracheal tube and her BP increased to 100/55. He described a second binder being put on and blood pressures ranging from 85 to 110 systolic over the next thirty-five to forty minutes, followed by a second collapse around 3:30, when blood was observed pooling on the stretcher. A third binder was put on, she was bolused through all three IV's and EMS was called. On arrival of EMS, he described the patient as having a BP of 100/55, HR of 110, respirations at 24/min., and gagging on the endotracheal tube.

While the note confirms the actions undertaken, there are a number of inconsistencies such as use of a third binder and a description of the patient upon arrival of EMS, which is different from the testimony and documents of EMS witnesses.

The Committee had regard for the forensic examination indicating that Dr. C had made contemporaneous notes, which he said he destroyed. The format suggested that these notes made reference to the time prior to 2:35, though no reference to this time period is made in Dr. C's final resuscitation note.

Dr. C

In contrast to the absence of information from 1:15 to 2:45 in the resuscitation note, Dr. C testified he was aware, or believed he was aware, of the low BP reading at 1:15, that he had ordered a bolus, received updates from the nurses and checked the patient a couple of times. He described her as pink, warm and conscious and did not think the situation alarming. Her BP readings did not improve. He believed Dr. Yazdanfar was aware of the

low BP readings and he believed he discussed with her that the patient looked better than her BP reading would suggest.

Dr. Yazdanfar

Dr. Yazdanfar said she checked Ms Stryland at 1:25-1:28. She said she did not see an abnormally low BP in the 60's. Following the viewing of the hallway video, she recalls a BP in the mid 80's. She described Ms Stryland as drowsy with her eyes open, and she did not speak.

While in the OR at about 2:35, she heard moaning; Nurse J came in and may have said the BP was a little low. She asked Dr. C to check on Ms Stryland. He reassured her on his return that she was fine. Around 3:10, Nurse J came in and got him again. This was when she first knew something was wrong. He came back and forth several times and spoke of intubation. She went to the RR a few minutes later and saw three IV's running with pressure bags. She said she did an independent examination, which took about 30 seconds, and had no diagnosis. She observed the fluid oozing to be bloodier than normal and ordered a second binder.

She returned to the OR and remained there seven minutes finishing up. Upon return to the RR, she came back and assisted in putting on the second garment. She asked Dr. C if Ms Stryland should go to hospital. She testified he said eventually for observation. Dr. Yazdanfar called 911 at 3:51. She agreed with the description of the EMS personnel in terms of her patient's appearance. She believed the BP was around 100 systolic and the patient was breathing on her own at the time they arrived.

Nurse Q and Nurse J

The Committee was faced with conflicting evidence from the nurses regarding the issues central to this matter. While they provide a number of details in respect to the unfolding events relating to the care of Ms Stryland, the Committee could not accept their oral evidence where it conflicted with the RR record.

The following sets out the Committee's view of the disputed events:

In this case, there was fingerpointing alleging dereliction of duty or failures of care by persons other than Dr. Yazdanfar. Our duty was to determine whether the allegations against Dr. Yazdanfar were made out. Other panels of this Committee or other Colleges may have the responsibility to determine allegations against others. We do not have the jurisdiction to do so and, as a matter of fairness, they did not have the opportunity to enter a defence in this hearing.

Central to the issues to be decided is what Dr. Yazdanfar knew about the events in the RR and when she knew it. The Committee accepts that Ms Stryland had very low blood pressure readings starting around 1:15 and recorded on the RR record. These would have been displayed on the monitor at the bedside. While Dr. Yazdanfar said she looked at the monitor and saw a reading in the 80's, the Committee did not accept this. She either did not see the reading or she was misled by the apparent clinical appearance of the patient and gave it no credence. The Committee is of the view that Dr. Yazdanfar was aware or should have been aware that her patient had an abnormally low blood pressure when she saw her at 1:28, and she should have deferred the next surgery until it was clear that the situation had normalized. Even if the BP had been in the mid eighties as Dr. Yazdanfar testified she recalled after seeing the video, she should have been alert to the development of serious problems and deferred the pending case. She had just performed large volume liposuction which was extensive for this patient and the fluid extracted was dark (as demonstrated in photographs).

While Dr. Yazdanfar was in the OR with the following case, the Committee concluded that she must have been aware that something abnormal was going on in the RR as there had been moaning from the patient, the nurse was in and out reporting to Dr. C and Dr. C had left the OR a number of times. The personal log of Nurse Q indicated Dr. Yazdanfar was aware of the low BP, as did the evidence given by Dr. C. Even Mr. H, the surgical assistant, recalled the nurse coming in to talk to Dr. Yazdanfar and Dr. C about Ms Stryland.

Dr. Yazdanfar should have found out exactly what was happening. As soon as there was any mention of intubation of Ms Stryland, she should have ended the other surgery. She did not leave until 3:17. Upon finding her patient intubated with three IV's running and lying in bloody fluid, she should have called 911 immediately, recognizing that her clinic was not able to manage the situation.

Dr. Yazdanfar did a token examination lasting thirty seconds, did not take down the garment and had no diagnosis or differential diagnosis. This response was wholly inadequate and, in the words of Dr. GH, "shows a complete lack of understanding of what is happening to the patient".

In essence, she ignored a critical situation. She returned to the OR to finish the other case, including doing more liposuction and putting on a garment, and left it to her anesthesiologist to manage Ms Stryland's serious condition.

Dr. Yazdanfar had completed ACLS training but failed to administer pressor drugs.

The Committee found that she did not know what to do as demonstrated by her failure to diagnose and act appropriately. She did not have the knowledge or confidence to know that Dr. C was unable to manage the problem.

Dr. Yazdanfar's admission of panic and the video of her pacing the hall speak to her inadequate response. As noted by Dr. K, trained surgeons are taught to think in such circumstances. The call to 911 was her only meaningful contribution to the resuscitation effort, and it was done too late.

The Committee was asked to accept that this sequence of events was just one of those things that can happen to any surgeon. We reject this theory. Dr. Yazdanfar performed large volume liposuction, a procedure accepted as major surgery and a potentially

dangerous operation, at multiple sites and exceeded volume standards acceptable for this patient.

Dr. Yazdanfar performed this liposuction procedure on Ms Stryland believing that she was trained to deal with the complications but she did not demonstrate the ability to do so. She did an inadequate assessment and failed to make a working diagnosis or to undertake any actions when she should have recognized that, when Dr. C had to reintubate the patient, the situation was serious. She should have arranged immediate transfer, given the limits of her facility to manage this condition.

Dr. Yazdanfar testified that she had done many such procedures. The Committee rejected the argument that she did not know something serious was occurring. The facility is compact. There were only two physicians who work as a team and nursing staff were in and out communicating freely.

The Committee found on the evidence that responsibility for the patient after surgery in recovery is shared, and that a surgeon cannot say, in the words of one expert, “not my problem”. Dr. Yazdanfar had a responsibility to this patient, which included care in the RR, as noted by the experts called by the College whose opinion as to the standard was accepted by the Committee, notwithstanding the role of the anesthesiologist.

Dr. Yazdanfar was woefully inadequate in dealing with critical post-operative complications and failed in her duty to the patient by abdicating all responsibility to Dr. C until it was clear the patient was close to dying. She simply was not trained for or up to the task of adequately caring for this patient.

Findings – Krista Stryland

The Committee sets out the findings in respect of the allegations made regarding this patient as follows:

Failing to Maintain the Standard of Practice

a) Failing to obtain informed consent

The Committee accepted that Ms Stryland was informed of the serious complications of liposuction by Dr. Yazdanfar who followed her usual consent process as outlined earlier in the reasons [p.193-198]. The Committee did not afford great weight to the hearsay testimony of Ms Stryland's friend, Ms CD, though it suggested a minimization of risk and a false sense of confidence.

The Committee finds that the allegation of failing to maintain the standard of practice regarding obtaining informed consent from Ms Stryland is not proved.

b) Performance of liposuction

The standard of practice accepted by this Committee is reflected in the ASPS guidelines, which indicate a maximum volume of 5000cc's of total aspirate in the out-patient setting [p.199-213]. The aspirate volume in this case significantly exceeded that volume (6075cc's total aspirate of which 2725cc's was fat). Many sites were treated as was a significant percentage of the body surface area. Under such circumstances, the maximum volume should have been reduced.

The Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on Ms Stryland is proved.

c) Post-operative care and treatment

Dr. Yazdanfar knew or should have known that Ms Stryland had an abnormally low blood pressure within the first thirty minutes after surgery. Dr. Yazdanfar failed to maintain the standard of practice when she started another elective case.

Dr. Yazdanfar failed to maintain the standard of practice when she delayed attending Ms Stryland, and inadequately assessed and failed to act at 3:17 when she was well aware, or should have been aware, of the seriousness of her condition.

Dr. Yazdanfar failed to call 911 immediately, though she knew or should have known that her facility was unequipped to render the care necessary when her patient clearly required blood products and needed to be in a hospital.

Dr. Yazdanfar failed to immediately terminate the surgery on the patient who followed Ms Stryland.

While she had ACLS training and drugs were available, Dr. Yazdanfar did not administer vasopressors or inotropes and abdicated all responsibility to her anesthesiologist.

The Committee found that Dr. Yazdanfar had a shared responsibility for the post-operative care of Ms Stryland. The Committee also found that she had no understanding of what was happening and placed too much reliance on her anesthesiologist.

The Committee finds the allegation of failing to maintain the standard of practice in the post-operative care of Ms Stryland is proved.

d) Record keeping

Dr. Yazdanfar, as the responsible surgeon, was required to make a note on the chart of this patient as soon as possible, accurately setting out the events as she knew them to be. She had time to do so after the patient was taken to hospital, but failed to do this. It is her professional duty and she had no valid reason not to do so.

The Committee assessed the record made in the RR to be grossly inadequate.

The Committee finds the allegation of failing to maintain the standard of practice in her record keeping relating to Ms Stryland is proved.

e) Booking and payment arrangements

In this case, the Committee had no reason to believe the arrangements were different than Dr. Yazdanfar's usual practice. The reasons set out in the discussion of the standard of practice regarding booking and payment arrangements earlier in our reasons apply [p.224-228].

The Committee finds that the allegation of failing to maintain the standard of practice in relation to Dr. Yazdanfar's clinic's booking and payment arrangements is not proved.

Disgraceful, Dishonourable or Unprofessional Conduct

a) Commencing liposuction on another patient while Ms Stryland was unstable and/or failing to abort the liposuction on the other patient after learning of Ms Stryland's unstable and/or deteriorating condition

The Committee accepted that Dr. Yazdanfar knew or should have known that Ms Stryland was unstable when she saw her patient in the recovery room at 1:28 pm on September 20, 2007, and that she should have deferred the next surgery until her patient was stable. Furthermore, when Dr. Yazdanfar learned that Ms Stryland required intubation, she should have ended immediately the surgery she was doing. The Committee sets out its reasons for this determination in its view of the disputed events [p.239-241].

We find, on the evidence, that Dr. Yazdanfar committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in commencing liposuction on another patient while Ms Stryland was unstable and/or failing to abort the liposuction on the other patient after learning of Ms Stryland's unstable and/or deteriorating condition.

b) Failing to accompany Ms Stryland to the hospital with the ambulance or to ensure that someone with appropriate knowledge of Ms Stryland's case accompanied the patient, and not keeping her family informed

While Dr. A was of the view that, given the serious nature of Ms Stryland's circumstances, Dr. Yazdanfar should have accompanied her patient to hospital, the Committee was not persuaded that her failure to do so constituted professional misconduct as alleged. Dr. Yazdanfar spoke to the EMS personnel, asked for reports to go with the patient and knew her recovery room nurse was going in the ambulance with the patient.

The College also requested a finding on the grounds that Dr. Yazdanfar did not keep Ms Stryland's family (Mr. AB) informed. Dr. A said she had the obligation to communicate with the family and she did not do so.

The clinic's communication with Mr. AB left much to be desired. However, Dr. Yazdanfar's failure to speak to Mr. AB was found not to constitute professional misconduct given the turmoil of the circumstances, the focus on providing emergency care to the patient, Dr. Yazdanfar's emotional state at the time and her later legal advice.

The Committee finds the allegation of engaging in disgraceful, dishonourable or unprofessional conduct by failing to accompany Ms Stryland to the hospital with the ambulance, or to ensure that someone with appropriate knowledge of Ms Stryland's case accompanied the patient, and failing to keep her family informed, is not proved.

c) In knowingly breaching the acceptable standards of practice with respect to her performance of liposuction

The Committee accepted that, in her performance of liposuction on Ms Stryland, Dr. Yazdanfar exceeded the volume (5000cc's total aspirate), which has been accepted by this Committee as the standard of practice in Ontario in the out-patient setting. This was the subject of a finding made of a failure to maintain the standard of practice.

The Committee further accepts that Dr. Yazdanfar was knowledgeable regarding liposuction. She was familiar with guidelines used by dermatologists and in Alberta, as well as the AACS guidelines, early in her liposuction practice, although these were not accepted by the Committee as the standard in Ontario. She knew there were other doctors and organizations that followed volume guidelines expressed as total aspirate and not total fat. She testified that she was not aware of the ASPS guideline specifics until her interview with Dr. A. The Committee concluded that Dr. Yazdanfar was aware of the existence of the ASPS guidelines that were followed by plastic surgeons doing cosmetic surgery in Ontario.

The Committee finds on the evidence that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in knowingly breaching the acceptable standards of practice with respect to her performance of liposuction.

d) The manner in which she dealt with the booking and payment requirements for Ms Stryland's cosmetic surgery

The Committee accepted that the booking and payment arrangements made with Ms Stryland were no different than Dr. Yazdanfar's usual practice. The factors considered by the Committee are set out earlier in our reasons [p.224-228].

In particular, the Committee notes that neither the requested deposit nor the cancellation fee is outside the usual for cosmetic surgery practice. The clinic's practice in respect of payment was made clear to patients. Even though the process allowed little time between the pre-operative assessment and the surgery for reflection, the Committee was not persuaded that Dr. Yazdanfar's process constituted professional misconduct as alleged.

The Committee finds the allegation that Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct in the manner in which she dealt with booking and payment requirements is not proved

B. Francine Mendelson

The Committee accepted the following as fact:

Ms Mendelson was first seen at the TCC accompanied by her daughter on June 20, 2007, when she was 66 years old, wanting liposuction and interested in Smartlipo. A day after meeting with the patient consultant (Ms D), she paid the deposit.

Ms Mendelson returned on June 28, 2007, and met again with Ms D to review and sign the consent and other papers. She initialed forms, which listed risks, but acknowledged barely looking at them. They discussed risk a little, but Ms D gave her the impression "that was not going to happen", and she felt confident.

Ms Mendelson and her daughter, Dr. AC, met with Dr. Yazdanfar on July 9, 2007, for a pre-operative assessment. A medical history was taken, a physical examination was performed and previously ordered laboratory investigations, which included an ECG and blood work, were reviewed. Risks were discussed. Payment was made in full. Ms Mendelson and her daughter left the clinic confident, to the extent that her daughter expressed some interest in having liposuction herself.

Liposuction surgery was performed on July 11, 2007, at which time 7000cc's of Klein solution was infiltrated and a total aspirate of 8800cc's was removed, including 5050cc's of fat. During the procedure, Ms Mendelson received 3300cc's of Ringers Lactate solution.

Ms Mendelson spent four hours and forty minutes in recovery and was discharged to her husband, Mr. NO.

Dr. AC came over to care for her mother the evening of July 11, 2007, during which time she removed the garment, washed and dried it several times as it was soaked, rebandaged her hourly and gave her mother analgesics.

Ms Mendelson was seen at the TCC on July 13, 2007, at which time Dr. Yazdanfar noted some prominence in the right lower quadrant and ordered an ultrasound examination of the area. Dr. Yazdanfar sent two of her staff to accompany the Mendelsons to the laboratory, though they went in separate vehicles.

Ms Mendelson was feeling better the next day when contacted by the clinic. At the next appointment on July 17, 2007, she was noting weakness and palpatations at night. A little pain was noted on palpation. An ECG and complete blood count were ordered with further follow-up in one week.

The ECG report was received at the TCC the evening of July 18, 2007, and was seen by Dr. Yazdanfar on the 19th; it showed serious changes suggesting antero-lateral ischemia, or a non Q wave myocardial infarction of uncertain age. Her pre-operative ECG had been normal.

Her blood work showed a Hgb of 9.2; her pre-operative Hgb was 14.5. Dr. Yazdanfar asked her staff to recall Ms Mendelson. On July 20, 2007, Dr. Yazdanfar was told by her staff that an appointment was arranged for the Tuesday of the next week.

Dr. Yazdanfar called Ms Mendelson on July 21, 2007 (Saturday) and discussed the ECG results. She was advised to go to the emergency room if she experienced symptoms and to follow-up with her family doctor about the ECG changes.

Ms Mendelson was seen by her family doctor on Monday, July 23, 2007, and was sent directly to the hospital, where she was admitted until July 27, 2007. Investigations included an angiogram, which showed mild coronary artery disease, and she was discharged home on a number of medications, including cardioprotective drugs.

Ms Mendelson and her daughter were seen again on August 8, 2007. They discussed what they thought was wrong with her care.

Failing to Maintain the Standard of Practice

a) Pre-operative evaluation

The Committee accepts that, in the context of cosmetic surgery, the pre-operative assessment must include a history, physical examination and laboratory investigations as appropriate for the patient and the procedure proposed. Goals and suitability of the treatment must be discussed.

The Committee is of the view in this case that the pre-operative assessment must include a proper screening of patients for concerns or premorbid factors. Other aspects which might be part of pre-operative assessment, such as a discussion of the influence of age, other risks, complications and options, are considered under informed consent.

The issue for the Committee is whether Dr. Yazdanfar fell below standard in failing to refer Ms Mendelson for a medical consultation prior to accepting to perform large volume liposuction on her.

The Committee accepted that a medical history and physical had been done by Dr. Yazdanfar and this is supported by the medical record. Where the patient indicated positive responses (smoking, high BP, etc.), Dr. Yazdanfar probed and based upon the response believed there was no material risk.

It was clear that Dr. Yazdanfar did not ignore Ms Mendelson’s past history, but explored this appropriately and decided there was no contraindication to surgery.

The Committee believed this was a thoughtful process as the detail in her history demonstrates. She probed Ms Mendelson’s medical history to rule out significant factors, noting a family history of a cardiac death at 75, past history of hypertension, exposure to cortisone and a history of smoking (quit 21 yrs ago). Appropriate investigations were ordered; results were normal and reviewed before surgery.

While Dr. A was of the view that a failure to refer for consultation was below standard, this was not supported by the evidence of Dr. K or Dr. GH. Dr. GI in his evidence referred to the American Heart Association and American College of Cardiology guidelines for pre-operative evaluation before non-cardiac surgery, and testified that Ms Mendelson would not have qualified for any type of pre-operative cardiac testing.

There was due diligence paid to her history. It was explored and not ignored and judged not to be material. The Committee preferred the evidence of the majority of the experts over that of Dr. A, whose view represented an ideal rather than the standard of practice.

The Committee finds the allegation of failing to meet the standard of practice in the pre-operative care of Ms Mendelson is not proved.

b) Failing to obtain informed consent

Ms Mendelson went through the usual consent process at the TCC as supported by the documentation in her medical record.

When Ms Mendelson gave her evidence before the Committee, it was evident that her memory was incomplete. She was determined to have the surgery done and it was clear she wanted to proceed notwithstanding the reluctance of her daughter (Dr. AC, DVM).

Her recall for specific risks discussed, though limited, did include a reasonable understanding of what she had to do to avoid deep vein thrombosis and subsequent pulmonary emboli. She did not fully describe the details of the discussion with Dr. Yazdanfar, though she said she was never told of a risk of death, heart problems or that her age was a factor. She did not think there was a discussion of increased risk with increased volume. The recollection of being “a great candidate” and a feeling of confidence was what she left with and what she clearly remembered.

Dr. AC describes the pre-operative assessment with Dr. Yazdanfar as a friendly meeting including a chart review, an indication of the volume to be removed, and a discussion of risks. There was no risk of death or cardiac complications mentioned. There was no mention of risk increasing with increased volume or with age. Though she had been concerned, she left feeling it would be no big deal.

Dr. Yazdanfar testified that she discussed risks fully with Ms Mendelson and her daughter at the pre-operative assessment. This included blood clots, fat emboli, heart attack and stroke and that she could die. Age did not come up, nor did she discuss increased risk with more body parts. Discussion of volume was limited to her limit being 5000cc's. She did not recall telling Ms Mendelson she was a great candidate or had great skin but may have used good in the context of the aesthetic result.

It was clear to the Committee from the evidence that the Mendelsons left with an understanding that did not reflect the real risk that this patient faced. They were led by their discussion with Dr. Yazdanfar to a degree of unjustified confidence, irrespective of whether the actual reference to death was made or not. Francine Mendelson was entitled to know that being 66 constituted an increased risk, that the risk increased as the volume increased and that there was an option to do two smaller procedures, as noted by Dr. K. This was not made clear to her and it was Dr. Yazdanfar's obligation to do so.

Although the serious risks were discussed, they were presented in such a manner that Ms Mendelson misunderstood the risk being faced. That she was a willing patient does not excuse the obligation of the physician to clearly inform. Using language such as you are a great candidate can result in patients failing to give due weight to the risks they face.

Material risks need to be clearly disclosed and both age and large volume in this patient were material risks. In arriving at this conclusion, the Committee had particular regard for the expert opinions of Dr. GH, Dr. A and Dr. K.

The Committee finds the allegation of failing to maintain the standard of practice in obtaining informed consent from Ms Mendelson is proved.

c) Booking procedures and payment requirements

The Committee accepted that the booking and payment requirements made with Ms Mendelson were no different than Dr. Yazdanfar's usual practice. The reasons set out in the discussion of the standard of practice regarding booking and payment arrangements earlier in our reasons apply [p.224-228].

The Committee finds the allegation of failing to maintain the standard of practice in her clinic's booking procedures and payment requirements is not proved.

d) Performance of liposuction

There is no dispute that Ms Mendelson had large volume liposuction performed with the removal of 8800cc's of total aspirate, which included 5050cc's of fat.

This exceeds the ASPS guidelines of 5000cc's of total aspirate, which has been accepted as the standard of practice in Ontario. It is excessive given the age of the patient. The Committee accepted Dr. A's opinion that this grossly violated patient safety and failed to maintain the standard of practice. This accorded with the opinion of Dr. GH, whose opinion the Committee also accepted.

The Committee finds that the allegation of failing to maintain the standard of practice in performance of liposuction is proved.

e) Post-operative care and treatment

The Committee determined there are two aspects to be addressed: (i) discharge arrangements; and, (ii) post-operative management.

(i) Discharge arrangements

Ms Mendelson was noted on the medical record to have remained in the TCC following large volume liposuction for almost five hours. She was discharged to the care of her husband who testified to her condition upon discharge as being groggy, incoherent and in pain. He expressed concern that he could not look after her. He thought she looked horrible and asked if she could stay for the night. He said they told him no, there were no facilities.

The patient herself has little recall of the trip home, other than pain. So much bloody fluid was coming from her that her husband had to cover the mattress. He did not know what to do and called his daughter. That evening, Dr. AC found her mother surrounded by bloody fluid, weak, and in pain. While they were given instructions to leave the garment on, these were not followed and the garment was removed for washing several times. Pain medication was given, but no one could recall precisely what drug was given (Tylenol/NSAIDs), other than it was alternated with the Percodan, which had been supplied by the clinic.

The Committee accepted this was an accurate description of events.

Dr. Yazdanfar has a discharge policy at the TCC, which requires that a patient be picked up by a responsible adult and be accompanied for the first 24 hours after liposuction surgery.

The ASPS guidelines indicate that patients who have large volume liposuction should be monitored in an accredited clinical setting overnight, with monitoring of post-operative vital signs and urine output by qualified and competent staff familiar with the peri-operative care of the liposuction patient.

This Committee has determined that the ASPS guidelines represent the standard of practice in Ontario, and this applies to discharge procedures. Dr. A, Dr. GH and Dr. K all

agree that the patient should have been kept overnight and monitored in keeping with the guidelines.

The Committee agrees and was particularly concerned that Ms Mendelson was discharged in what appeared to be unacceptable circumstances, in that she was an older patient, leaking bloody fluid, having undergone large volume liposuction at multiple sites involving a significant percent of her body surface area.

(ii) Post-operative management

While much time and evidence was directed to the care Ms Mendelson received from her family, the removing of the garment and possibly administering NSAID's, this is not an issue for the Committee.

Regardless of the cause of the anemia, it is Dr. Yazdanfar's response to an abnormal ECG that is at issue. That the anemia Ms Mendelson developed post-operatively could have been influenced by garment removal or drugs, at least to a degree, is accepted. However, evidence from Dr. Yazdanfar and Dr. GI indicates that a fall in Hgb is not unusual after large volume liposuction; physicians performing large volume liposuction must be aware of such problems and their significance.

Ms Mendelson was seen by Dr. Yazdanfar on July 17, 2007, with complaints of weakness and nocturnal palpitations on and off. A blood count and ECG were ordered. The ECG report was faxed to the TCC in the evening of July 18, 2007, and seen by Dr. Yazdanfar the next morning. The ECG report suggested ischemic change or a cardiac event. She requested her staff to recall Ms Mendelson and, when she followed up the next day (Friday, July 20, 2007), she noted that an appointment was set for the next week.

Dr. Yazdanfar spoke to Ms Mendelson on Saturday evening and advised her to go to the emergency if she had any cardiac symptoms and to follow-up the ECG with her family doctor. This was described as neither reasonable, nor common sense management, by Dr.

GH. She needed to go immediately to hospital for assessment. Dr. A and Dr. K agreed. In failing to tell Ms Mendelson to do so, Dr. Yazdanfar failed to exercise proper judgment and left her patient in an unsafe situation.

The Committee considered the evidence of Dr. GI and Dr. N but rejected that the distinction that they made between an urgent or emergent situation impacted the standard of care expected of Dr. Yazdanfar.

In both her discharge arrangements and her post-operative management, the Committee determined that Dr. Yazdanfar failed to maintain the standard of practice of the profession.

The Committee finds that the allegation of failure to meet the standard of practice in post-operative care and treatment is proved.

f) Communication with the patient and family

The College also requested a finding in respect of failure to maintain the standard of practice in communication with the patient and family.

There is no dispute that a meeting took place. Dr. AC pointed out areas of concern. Dr. Yazdanfar was described as defensive and offering that the complications were not due to her error. They were critical of the care received. No improper communication was evident.

The Committee finds that the allegation of failing to maintain the standard of practice in communication with the patient and family is not proved.

Disgraceful, Dishonourable or Unprofessional Conduct

a) Knowingly breaching the acceptable standards of practice with respect to her performance of liposuction

Earlier in its reasons, the Committee found that the ASPS guidelines reflected the standard of practice in Ontario with respect to volume of aspirate and consideration of factors that would require a reduction of the volume. The volume extracted in this case grossly exceeded the ASPS volume limits considered acceptable for this patient.

The Committee further concluded that Dr. Yazdanfar was aware of the existence of the ASPS guidelines (p.246).

Dr. Yazdanfar even exceeded the volume limits in the more liberal AACS guidelines for this patient, by going over 5000cc of fat and not reducing the amount of fluid removed given this patient's age, the number of sites which were done and the percent body surface area affected. Even though the AACS guidelines are not acceptable in Ontario, her conduct illustrates a lack of regard for any guidelines and a cavalier attitude to those she professed to follow

The member's position that the maximum volume was exceeded by a trivial amount, or that it did not really exceed the limit because of the canister liner, was not accepted by the Committee. Dr Yazdanfar went to what she describes as her limit, which in these circumstances was inappropriate and placed her patient at unnecessary increased risk. Her gross violation of the ASPS volume limit, including her disregard for the factors related to this patient that required a reduction of the volume of aspirate, constitutes disgraceful, dishonourable or unprofessional conduct.

The Committee finds that the allegation of disgraceful, dishonourable or unprofessional conduct in respect of knowingly breaching the acceptable standards of practice with respect to her performance of liposuction is proved.

b) Booking and payment requirements

The Committee accepted that the booking and payment arrangements made with Ms Mendelson were no different from Dr. Yazdanfar's usual practice. The factors considered by the Committee are set out earlier in our reasons [pages 224-228]. In particular, the Committee notes that neither the requested deposit nor the cancellation fee is outside the usual for cosmetic surgery practice. The clinic's practice in respect of payment was made clear to patients.

The Committee finds that the allegation of disgraceful, dishonourable or unprofessional conduct in respect of booking and payment requirements is not proved.

C. Ms MP

The Committee accepted the following as fact:

Ms MP is a 36 yr old patient, who was seen at the TCC on April 12, 2007, seeking liposuction. She met with the patient consultant and then filled out a number of forms and made a $500.00 deposit.

She was seen for a pre-operative examination by Dr. Yazdanfar on April 19, 2007, and she had large volume liposuction surgery performed on April 21, 2007. At that time, 7150cc's of total aspirate and 3800cc's of fat were removed.

Ms MP was discharged the same day after two hours and fifty minutes of recovery time. She was seen for follow-up on April 26, 2007, where it is commented in the chart that she is healing well and she is happy with the results.

Her last appointment was May 24, 2007, when the chart note indicates a complaint of scarring. Photographs of the patient demonstrate small hyperpigmented scars.

Ms MP wrote a letter of complaint to the College after hearing about the death of Ms Stryland.

Failing to Maintain the Standard of Practice

a) Failing to obtain informed consent

The Committee was faced with different versions of what transpired at the pre-operative assessment. The patient testified that medical risks were not discussed, and recollected little other than photographs being taken at the pre-operative assessment. The medical record is clear that a history and physical examination was undertaken and risks discussed "in detail". The recollection of Ms MP being told a maximum of seven litres would be removed, contradicts what Dr. Yazdanfar indicates she typically says to patients.

It was clear to the Committee that Ms MP's memory for the details of the discussion of risks could not be relied upon.

Bearing in mind the Committee's opinion on the standard of care in respect of informed consent [p.193-198] and the above, the Committee concluded that it was more likely than not that Dr. Yazdanfar had discussed the medical risks, including the serious risks of liposuction, with Ms MP.

The Committee finds that the allegation of failing to maintain the standard of practice in obtaining informed consent from Ms MP is not proved.

b) Performance of liposuction

The Committee had uncontested evidence that Dr. Yazdanfar removed 7150cc's of total aspirate, which exceed the 5000cc's total aspirate volume limit that the Committee has accepted is the standard of practice in the out-patient setting.

The Committee finds that the allegation of failing to maintain the standard of practice in performance of liposuction on Ms MP is proved.

c) Booking procedures and payment requirements

The Committee accepts that the usual payment arrangements at the TCC prevailed with Ms MP. The medical record notes a deposit on the initial visit and the balance paid by Medicard.

The reasons set out in the discussion of the standard of practice regarding booking and payment arrangements earlier in our reasons apply [p.224-228].

The Committee finds that the allegation of failing to maintain the standard of practice in respect to booking and payment requirements is not proved.

d) Post-operative care

The Committee has accepted the ASPS guidelines as reflecting the standard of practice in Ontario. These guidelines, and the evidence of the experts accepted by the Committee, specify that patients having large volume liposuction should be monitored overnight in an appropriate setting.

Ms MP had large volume liposuction considerably in excess of the permitted 5000cc's of total aspirate and, according to the medical record, was in the RR for close to three hours.

The patient's description of her post-operative condition is very different from what is recorded in her medical record. She testified that she was in a lot of pain, was swollen and bruised and that she had noticeable scarring and had to spend a month in bed. There is no indication in the medical record that she required a prolonged time in bed or experienced untoward pain when she attended for followup, though her complaints of scarring are documented.

Based on the totality of the evidence and a review of the post-operative photographs, the Committee gave little weight to the aspect of Ms MP's evidence relating to the extent of her post-operative condition.

Regardless of the post-operative condition, the Committee finds that Dr. Yazdanfar fell below the standard of practice by her premature discharge of this patient from the clinic in the circumstances.

The Committee finds that the allegation of failing to maintain the standard of practice in post-operative care of Ms MP is proved.

Disgraceful, Dishonourable or Unprofessional Conduct

a) Knowingly breaching the acceptable standards of practice with respect to her performance of liposuction

This allegation refers to performance of large volume liposuction in excess of the standard, which was subject to a finding of failure to meet the standard in the performance of liposuction on Ms MP.

The Committee concluded that Dr. Yazdanfar was aware of the existence of the ASPS guildelines used by plastic surgeons doing cosmetic surgery in Ontario (p.246).

The Committee finds that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in knowingly breaching the acceptable standards of practice with respect to her performance of liposuction.

b) Booking and payment requirements

The Committee accepts the arrangement made with Ms MP were no different than Dr. Yazdanfar's clinic's usual practice. The factors considered by the Committee are set out

earlier in our reasons [p.224-228]. In particular, the Committee notes that neither the requested deposit nor the cancellation fee is outside the usual for cosmetic surgery practice. The clinic's practice in respect of payment was made clear to patients.

The Committee finds that the allegation of disgraceful, dishonourable or unprofessional conduct in the manner in which Dr. Yazdanfar dealt with booking and payment requirements is not proved.

D. Ms QR

The Committee accepts the following as fact:

Ms QR was seen first at the TCC on July 14, 2008, complaining that her breasts had become droopy and had lost volume after having children. She attended with her sister seeking information on breast augmentation and breast lifts which, from her own research, she thought she would need. She had contacted the TCC earlier by email with questions about the costs of having a lift and augmentation together.

Her goal was to return to a large D or a small DD. She was told by Ms D, the patient consultant, that she would not need a lift as her nipples did not point to the floor.

She and her husband met with Dr. Yazdanfar on July 19, 2008. Dr. Yazdanfar informed them that a lift was unnecessary.

Ms QR had a subglandular breast augmentation procedure done July 22, 2008, and 550cc high profile gel implants were used. She attended for follow-up on July 26, 2008, at which time, she reported no problems.

In early August, Ms QR began to note pain in her breasts. This continued, hardening developed and she saw Dr. Yazdanfar on September 6, 2008, when capsular contracture

was diagnosed. When seen again on September 27, 2008, her symptoms had worsened and this was now a Baker's level 4.

Options for treatment were discussed and she proceeded to have a capsulectomy on October 11, 2008, with replacement using her original implants. She was charged only the anesthetic fee for this procedure.

The following week, Ms QR felt good but her symptoms recurred in mid November 2008.

Ms QR saw Dr. Yazdanfar again who questioned recurrent capsular contracture (grade II-III). There was a discussion of options if the capsule becomes tight. One of the options discussed was going with a smaller implant in the same pocket. She wanted another opinion and was subsequently seen by Dr. U and had her implants removed.

On February 16, 2009, she and her mother attended the TCC and had a meeting with Dr. Yazdanfar, which was confrontational.

Failing to Maintain the Standard of Practice and Disgraceful, Dishonourable or Unprofessional Conduct

a) Failing to obtain informed consent

The Committee accepts that it is more likely than not that Dr. Yazdanfar informed her patients of the serious side effects and complications. The medical record contains sufficient information for the Committee to conclude the usual process was followed in this case. The Committee accepts that Dr. Yazdanfar followed her usual consent process as outlined earlier in the reasons [p.193-198]**.**

However, the Committee notes there are special circumstances that require consideration in determining whether Dr. Yazdanfar fulfilled her obligation to obtain informed consent from Ms QR as follows:

- whether the patient had an adequate discussion of the reasonable options available to address her problem of droopy breasts with loss of volume and the pros and cons of each option;
- whether the patient was truly informed as to Dr. Yazdanfar's ability to provide all the options;
- whether the patient was sufficiently informed as to the complications of large implants; and,
- whether there was a full discussion of the options, including the advantages and disadvantages of each option, when the patient returned with capsular contracture.

Dr. A opined that Dr. Yazdanfar had failed to maintain the standard of practice in that there was no discussion of a breast lift when the patient first attended. He based this on the lack of a note in the medical record. Dr. K gave evidence that there were four options (lift alone, augmentation alone, lift and augmentation combined, lift and augmentation done sequentially) and all should have been discussed with the patient and documented. Dr. L and Dr. N agreed that surgeons should discuss reasonable surgical options.

The Committee accepted that, to maintain the standard of practice, a discussion of the reasonable options must take place. There were four reasonable options for Ms QR as noted above.

The Committee heard evidence from Dr. A that, if a physician does not offer one of the reasonable options available, the patient needs to be truly informed so that he or she may seek a further opinion, if appropriate. The Committee determined that Dr. Yazdanfar had an obligation to inform Ms QR that she would not be performing a breast lift if that was one of the reasonable options available for addressing her problems. Even though Dr. L could not speak to the standard of practice in Ontario, his view was that the surgeon should inform the patient that she does not do breast lifts in such circumstances.

In regard to implants and the risks associated with large implants with Ms QR, the experts are in agreement that droopiness and skin laxity are of concern and should be explained and documented (Dr. K, Dr. L, Dr. A). The Committee accepts that this discussion is necessary in order to meet the standard of practice.

The Committee heard testimony from Dr. A and Dr. K that capsulotomy was one of the reasonable options available to Ms QR when she developed capsular contracture. The Committee accepted a discussion of this option, including the advantages and disadvantages, would be required to maintain the standard of practice.

The evidence of the patient, her husband and sister is disputed by Dr. Yazdanfar, who gave conflicting testimony on how fully informed this patient was, including the degree to which options were discussed.

In her evidence in chief, Dr. Yazdanfar said she responded to the question from Ms QR about whether she needed a lift saying “That for the grade one or mild to moderate ptosis, a lot of women are happy with just the augment alone. The look they get from the fullness, and the little bit of the lift they get from it is…makes them happy without the extra scars of the lift.” She showed them two pictures of similar patients and Ms QR liked the look. That was where the discussion of the lift basically ended.

On cross examination, Dr. Yazdanfar agreed that a lift was an option for this patient as was a combination of augmentation and a lift, either combined or sequentially done. She said she discussed this option with Ms QR.

She did not discuss with them whether she had the ability to do lifts or not.

She was aware that Ms QR’s breasts had lost some support and that large heavy implants may cause problems over time. She said that Ms QR and Mr. UV were told that gravity will take its toll over time.

The Committee had in evidence the testimony of Ms QR, her sister and husband. The patient gave evidence supported by her sister that, at the first visit, they were told by Ms D, the patient consultant, that she absolutely did not need a lift as her nipples did not point to the floor. When seen for a pre-operative assessment, Ms QR and her husband asked again whether she needed a lift and Dr. Yazdanfar responded that, in her opinion, she did not. No explanation was given. Both Ms QR and her husband gave evidence that no risks related to size of implants were discussed.

The Committee accepted the version of events as described by Ms QR and her family as to the discussions that transpired. Their evidence on this issue was consistent, clear, and credible.

At the time of the first capsular contracture, Dr. Yazdanfar described three options. She testified that "[t]hey wanted to know what is the more definitive one. Already as I said, capsulotomy is an option that was even discussed in her pre-op, but I really believe that if you have a capsule, the most definitive way to ensure...do your best that it doesn't come back is to remove that capsule completely. And they wanted the most definitive. So, capsulectomy was my number one choice. The second good choice is changing pockets….Again, number three was to go a bit smaller. Remember...do a capsulectomy and go smaller…" It was clear to the Committee from Dr. Yazdanfar's testimony and the medical record that, although capsulotomy was referenced in the pre-operative consent for breast augmentation surgery, Dr. Yazdanfar discussed three options in relation to the first capsular contracture and capsulotomy was not one of them.

The Committee was persuaded on the evidence that Dr. Yazdanfar had not fulfilled her obligation to obtain informed consent in regard to this patient by her failure to discuss all reasonable options, her failure to inform her patient that she personally did not do breast lifts, which was a reasonable option, and by her failure to discuss the risks of large implants.

Therefore, the Committee finds the allegation of failure to maintain the standard of practice in failing to obtain informed consent is proved.

The Committee also finds that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional in failing to obtain informed consent.

b) Failing to provide the patient with a proper choice of procedures, but focusing on, and inappropriately selecting the procedure that she does

The issue before the Committee is whether, at the time of Ms QR's pre-operative assessment, she was told about the options in sufficient detail to make an informed decision, and whether the procedure offered was inappropriate given it was the only procedure Dr. Yazdanfar offered.

Ms QR and her husband maintain they asked Dr. Yazdanfar about whether Ms QR needed a lift and were told that Dr. Yazdanfar did not believe she did. No reason was given. Ms QR had seen Ms D, the patient consultant, on her initial visit and had been told by her that she absolutely did not need a lift as her nipples did not point to the floor. This is corroborated by Ms QR's sister, who accompanied her on that visit. At the time Ms QR and her husband attended Dr. Yazdanfar, they wanted to confirm that she did not need a lift.

Dr. Yazdanfar agreed they asked about a lift, but disagreed that Ms QR was interested in a lift. She interpreted Ms QR's question regarding a lift as being "on the side". The evidence of the patient and her husband, supported by the email communication, indicates they were interested. They go so far as to request the cost of a combined lift and augmentation.

Dr. Yazdanfar acknowledged that a breast lift was an appropriate option, as was an augmentation alone, and a lift and augmentation done together or sequentially. Dr.

Yazdanfar testified that she told Ms QR that, in her opinion, she does not need a lift as she has mild ptosis.

The standard of practice to be met is that the patient needs to be told the various surgical options and the pros and cons.

There were four options: augmentation alone, lift alone, augmentation and lift combined, or augmentation and lift sequentially. Dr. K said, if all four options were not given to the patient and the risks and benefits discussed and charted, it does not meet the standard.

The evidence of Ms QR and Mr. UV is clear that no meaningful discussion of breast lifts, or combined/sequential procedures took place. Dr. Yazdanfar was focused on volume. She offered that augmentation would address the patient's goal. It was her own evidence that they discussed it to the extent that when they asked about the need for a breast lift she said, "In my opinion, if you just do an augment this is the picture you get. I showed her pictures. She was happy with that."

On cross examination, in conflict with her earlier testimony, Dr. Yazdanfar testified that she had discussed the lift and the combined procedures and had given the patient the options.

In the Committee's view, a mere mention of the lift does not constitute the kind of fulsome discussion that is required to inform patients of the risks and benefits of the options. The evidence given by Ms QR and her husband is accepted by the Committee and is preferred to that of Dr. Yazdanfar's assertions that the patient was not interested in a lift and that she discussed the combined lift and augmentation procedure and lift alone as options.

The Committee was of the view that Ms QR and her husband were relatively well informed, even before coming to the TCC. Even so, Ms QR was entitled to have the options explained in sufficient detail so that she could make a reasoned choice as to the

procedure she wanted. She had only one option described. Dr. Yazdanfar had an obligation to explain mastopexy or lift and the combined procedures.

The medical record in the Ms GR matter, which documents options including a lift, was raised by counsel for Dr. Yazdanfar as an example of her practice. The Committee determined that the issue before it was the discussion that took place with the patient Ms QR and that Ms GR's chart was not helpful in determining what had transpired in the Ms QR matter.

The Committee finds that the allegation of failing to maintain the standard of practice by Dr. Yazdanfar's failure to provide the patient with a proper choice of procedures is proved.

The Committee also finds that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, by failing to provide the patient with a proper choice of procedures, but focusing on, and inappropriately selecting the procedure that she does**.**

c) Failing to advise the patient she did not perform one of the requested procedures and implied in person and on the website that she does perform that procedure

Ms QR and her husband were under the misconception from her website that Dr. Yazdanfar personally performed lifts as well as augmentation surgery. The website says that she frequently performs breast augmentation and liposuction as well as several other aesthetic procedures.

They were not informed during the pre-operative visits that Dr. Yazdanfar did not perform the breast lift operation and were surprised to find this out later. They knew from their research that a lift was an option, even inquired on email regarding the cost and, having received information from the TCC about cost, assumed reasonably in the circumstances that it was a procedure that Dr. Yazdanfar performed.

Dr. A indicates that patients need to be told of the options, their pros and cons and consequences, possible complications and the need for revisionary surgery. When a physician does not perform a procedure, which is a reasonable option, it cannot be left out, but needs to be discussed in a truly informative way to allow a patient to make a decision whether to seek care elsewhere. The Committee accepts that such a discussion is the standard of practice in Ontario and that it should have been made clear by Dr. Yazdanfar to her patient that she does not do the lift procedure and that it would be done by another surgeon.

Dr. Yazdanfar's evidence is clear. If patients ask, they are told she does not do breast lifts.

While physicians are not required to tell patients of all procedures they do not perform, if, as in this case, the procedure is a viable and relevant option, it should be disclosed. The Committee is of the view based on the above that Dr. Yazdanfar had an obligation to inform patients in such circumstances of the option of a breast lift and that she would not perform it.

The Committee finds the allegation of failing to maintain the standard of practice in failing to advise the patient she did not perform one of the requested procedures is proved.

The Committee also finds that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in failing to advise the patient she did not perform one of the requested procedures.

d) Failing to perform breast augmentation in an appropriate manner

The Committee in making a determination on the standard as it applies to breast augmentation (technique) has given reasons, which apply in this case [p.214-224]. It is

the opinion of the Committee that there are no special conditions which apply in the case of Ms QR which would alter that determination.

The Committee therefore finds the allegation of the failure to maintain the standard of practice by failure to perform breast augmentation in an appropriate manner is not proved.

The Committee also finds the allegation of disgraceful, dishonourable or unprofessional conduct as it relates to this allegation is not proved.

e) Failing to adequately advise the patient of increased complications with increased implant size

Dr. Yazdanfar testified that the implants chosen by Ms QR are large and heavy. She says she told Ms QR that gravity can cause them to drop and there is anecdotal evidence that there is increased risk of capsular contracture.

Ms QR gave evidence that a 500cc high profile cohesive gel implant was recommended by Ms D. She said Dr. Yazdanfar told her that a 550cc implant would fill the skin. No risk related to implant size was discussed.

It was clear to the Committee that this patient came with droopy breasts, that skin laxity existed and that these factors would affect the risk of future complications if large and heavy implants were used. As noted by Dr. A, with involutional changes, if a large implant is used, the skin will be too weak to hold and in future there will be inferior descent and the need for further surgery. Dr. GH also noted that stretching, pain and bottoming out may occur.

This was information that Ms QR and Mr. UV needed to have in order to make an informed choice. Such information may have affected their decision. Dr. K agreed that, with large implant size, bottoming out needs to be discussed, as something further may be needed in the future, and this needs to be explained and documented to meet the standard

of practice. Dr. A agreed and was of the opinion that Dr. Yazdanfar failed to maintain the standard of practice in this respect. Dr. L as well noted that with large implants bottoming out and sagging should be discussed, as well as the possible need for future surgery.

There were certainly factors that this patient and her husband should have been told before making a decision about implant size. The Committee was convinced by the evidence that they were not informed and should have been.

The Committee therefore finds the allegation of failure to meet the standard of practice in failing to inform the patient of increased complications with increased implant size is proved.

The Committee also finds that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in failing to inform the patient of increased complications with increased implant size.

f) Failing to select, assist patient in selecting, and taking responsibility for appropriate selection of implant size

The Committee accepted that Ms QR and her husband were shown a variety of implants, as is the usual practice of Dr. Yazdanfar. Dr. Yazdanfar did comment about the need to fill the skin. Her evidence is that it is the patient's choice as to what implant they want to have. In the last note on the medical record of Ms QR, Dr. Yazdanfar disclaims her responsibility for the choice of implants.

The Committee accepted the evidence of the experts who testified that this is a shared responsibility. This is not simply a matter of patient choice. Dr. A and Dr. K agree that it is a decision to be made jointly. Dr. A testified it was the physician's obligation to discuss the pros and cons of the implants.

In distancing herself from this decision, Dr. Yazdanfar has stepped back from the responsibility expected and shifted the onus to the patient. In failing in her duty to inform the patient, to warn about the added risks of implant size and not taking responsibility for the size chosen, she has essentially tried to avoid the possibility of being blamed for future related complications.

The Committee finds the allegation of failure to maintain the standard of practice in her failure to select, assist the patient in selecting and taking responsibility for appropriate selection of implant size is proved.

The Committee also finds that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in failing to select, assist the patient in selecting and taking responsibility for appropriate implant size selection.

g) Booking procedures and payment requirements

The Committee accepts that the booking and payment arrangements with Ms QR were no different than Dr. Yazdanfar's clinic's usual practice. The factors considered by the Committee are set out earlier in our reasons [p.224-228]. In particular, the Committee notes that neither the requested deposit nor the cancellation fee is outside the usual for cosmetic surgery practice. The clinic's practice in respect of payment was made clear to patients.

The Committee finds the allegation of failing to maintain the standard of practice regarding booking procedures and payment requirements is not proved.

The Committee also finds the allegation of disgraceful, dishonourable or unprofessional conduct regarding booking procedures and payment requirements is not proved.

h) Lack of knowledge of mastopexy (breast lift)

Dr. Yazdanfar gave evidence that she learned about mastopexy during the course of training at AACS educational events. Her evidence was that most of the augmentation courses have mastopexy components to them. Dr. N and Dr. L support that this subject is well covered.

The College relies on the evidence of Dr. A who formed his opinion based on the abbreviated discussion he had with Dr. Yazdanfar of possible areas of scarring with mastopexy. By stating that the procedure leaves a vertical scar, Dr. Yazdanfar did not make it clear to Dr. A that there were other incisional sites that were reasonable and that would not leave that particular scar. Dr. A also had problems with her assessment of ptosis, in that surgeons take more than the relation of the nipple to the inframammary fold under consideration when assessing for a mastopexy.

Dr. Yazdanfar, in her testimony at the hearing, appeared to be well informed in this respect and this was confirmed by Dr. K when he assessed her at an interview.

The Committee was not convinced that Dr. Yazdanfar was unaware of the various scars produced by mastopexy, though she does not perform this procedure herself, or that she lacked knowledge of assessing ptosis.

The Committee finds the allegation of failure to meet the standard of practice in her lack of knowledge of mastopexy is not proved.

The Committee finds the allegation of disgraceful, dishonourable or unprofessional conduct is not proved.

i) Offering an inappropriate manner of correcting the first operation (use of smaller implants in the same pocket)

At the time that Ms QR was diagnosed with capsular contracture (Baker 4) in September 2008, she saw Dr. Yazdanfar and the following options were offered to her:

1. That she have a capsulectomy with replacement of the implants at the same site
2. That she have a change in pocket site to under the muscle
3. That they do a capsulectomy, stay in the same pocket and use smaller implants. Dr. Yazdanfar testified that she intended this to mean 25-50cc smaller not 250cc.

Ms QR and Mr. UV understood that removal of capsules and implants completely was also an option. Dr. Yazdanfar told them that, with recurrence, sometimes the best option is to take the implants out.

Dr. Yazdanfar described capsulotomy to the Committee, was familiar with it and the way that tension is reduced by cutting the capsule. She indicated this is what is referred to in the pre-operative form where there is reference to the need for surgery where capsules need to be removed, or to release the tension. She did not offer capsulotomy as an option to Ms QR. She considered the capsulectomy a more definitive procedure.

Dr. A testified that option (3) was not realistic, a small implant in a large pocket may move, most likely laterally. Capsulotomy was not offered. He believed that she was not now an augmentation patient, but had developed a pathological condition requiring a reconstructive procedure, or removal, and is in the situation where this is covered under OHIP.

Dr. K gave evidence that he believed the range of options given to Ms QR was reasonable. He indicated that there is a risk of bleeding with capsulectomy, which is a more aggressive approach than capsulotomy. Capsulotomy should have been offered and, if it was not, it would fall below standard.

Capsulectomy was recommended and performed. With recurrence of her symptoms several months later, Dr. Yazdanfar did not recommend repeat capsulectomy, but the other options applied. She thought that a change to a submuscular pocket was an option. However, Ms QR believed that she would then need a lift and she did not want it. Dr. Yazdanfar goes on to discuss going smaller in the same pocket. She described this as "in essence" a capsulotomy where she is reducing tension.

Dr. L testified that the treatment of capsular contracture was challenging and difficult. While he could not speak to the standard of practice in Ontario, he felt Dr. Yazdanfar offered her patient reasonable treatment. He agreed that capsulectomy was more aggressive than capsulotomy. As to the option of using a smaller implant in the pocket, he indicated that she was a challenging patient and "you are looking for anything you can do to try to improve the results that is within reason".

While it is clear to the Committee that not all options were offered to Ms QR for her capsular contracture, the issue was whether option 3 (using smaller implants in the same pocket) was an acceptable option. The description of a capsulotomy was made clear to the Committee by Dr. A. The Committee did not accept Dr. Yazdanfar's evidence that what she proposed was "in essence" the same because of the release of tension. Furthermore, it appears never to have occurred to her that referral to a more experienced surgeon would be an option she should consider.

Dr. A's evidence was clear and he specifically addressed option 3, indicating that it was not a reasonable option and that the overdissected pocket would result in implant mobility and migration. Under cross-examination, he agreed that he may have heard of using a smaller implant with possible adjustments being done and that it had been done, but he did not agree with it. Dr. K opined that Dr. Yazdanfar had given Ms QR a reasonable range of options, including option 3; he could see no reason not to use a smaller implant. However, he did not address specifically Dr. A's opinion in this regard.

The Committee accepts Dr. A's evidence that the innovative option presented (smaller implants in the same pocket) was not an appropriate option. On the basis of the evidence, the Committee is satisfied that not all appropriate options were offered to Ms QR for treatment of her first capsular contracture.

The Committee finds the allegation of failure to meet the standard of practice in offering an inappropriate manner of correcting the first operation (use of smaller implants in the same pocket) is proved.

The Committee also finds that this conduct, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in offering an inappropriate manner of correcting the first operation.

j) In dealing with the patient and her family in an unprofessional way when they came to discuss the procedures after they had been done

There is no dispute that the meeting on September 16, 2009, between the patient, her mother and Dr. Yazdanfar went poorly. Ms QR wanted to have her money back for surgery that had not given her the results she wanted, and was attended by post-operative complications.

Dr. Yazdanfar wrote a contemporaneous note (September 16, 2009) describing the unfolding of the meeting, which is detailed. It realistically describes the areas that were troubling the patient, including complaining about rescheduling times, that Dr. Yazdanfar was not a plastic surgeon, questioning OHIP billing for part of the pre-operative assessment, and blaming the size of implants for the problem. Dr. Yazdanfar responded that patients choose the size and they take responsibility for their choice. She informed them the procedure was non refundable and this made Ms QR's mother even more upset and she threatened legal action.

Although the Committee understands the upset of the patient and her family in the circumstances, there is no evidence that Dr. Yazdanfar responded rudely or in an unprofessional manner, which would justify a finding of professional misconduct.

In summary, the Committee finds that the allegations of failure to meet the standard of practice and disgraceful, dishonourable or unprofessional conduct, in relation to dealing with the patient and her family in an unprofessional way when they came to discuss the procedures after they had been done, are not proved.

E. Ms WX

The Committee accepts the following as fact:

This 34 year old patient was seen at the TCC on August 22, 2007, by both the patient consultant, Ms D, and Dr. Yazdanfar. Ms D called Dr. Yazdanfar, which she does in some cases (if she red flags anything).

Ms WX had a past history of submuscular augmentation mammoplasty done in 2003.

Subsequently, she was in a serious motor vehicle accident which required many orthopedic procedures. She also commenced weight training. As a consequence, her implants had shifted and she wanted to know what could be done to improve the appearance.

Her original plastic surgeon had retired and she came to the TCC having heard about it from friends.

After seeing Ms D and Dr. Yazdanfar on August 22, 2007, she decided to proceed with removal of her old implants and breast augmentation and paid $9010.00, which was the full cost of the procedure.

She was seen again by Dr. Yazdanfar on August 29, 2007, to complete the pre-operative assessment.

Removal of the old implants and a subglandular augmentation mammoplasty using 550cc high profile implants was performed on August 30, 2007, using the usual “tumescent technique”.

The day after surgery, she developed a rash on her chest which was red and itchy and, when her symptoms worsened, she attended the local emergency room where she was advised to stop all medications and prednisone was started. She attended the TCC the next day and no alterations were made.

She attended for several follow-up visits and there is dispute between the parties as to her condition at those times.

On May 9, 2008, Ms WX saw Dr. TZ to see “if everything was okay”. She was noted at that time to have “bottoming out” of the right implant and asymmetry.

Ms WX last saw Dr. Yazdanfar on July 25, 2008, when the interview went badly. There was a confrontation and somewhat different descriptions of that encounter were given by those involved.

Dr. TZ subsequently removed the implants and later replaced them with a smaller size.

Failing to Maintain the Standard of Practice and Disgraceful, Dishonourable or Unprofessional Conduct

a) Obtaining informed consent

Ms WX testified that she came to the TCC to see if her situation could be corrected. She knew her implants, which were under the muscle, had shifted due to her weight training. Dr. Yazdanfar saw her that same day and said that the way this is corrected is to remove

the implant and replace it with a larger implant in order to fill the pocket created by the shifting, as well as to fill in between the breasts and give a fuller look. There was no discussion of a lift. She signed the consent forms she was given but had no recollection of review or discussion of them. She decided to proceed and paid in full that day.

Ms WX testified that Dr. Yazdanfar recommended new 550cc implants. While Ms WX was a bit concerned and had no intention of going any larger, Dr. Yazdanfar reassured her that in order to correct the shifting and give a fuller look, a large implant would be needed. Ms WX was concerned about stretching/damage, but was told “absolutely not” by Dr. Yazdanfar.

Dr. Yazdanfar testified in chief that Ms WX’ chief complaint was that she had small breasts and she wanted to go larger. On August 29, 2007, however, she notes on the medical record that the patient feels the implants are not placed properly. She said she discussed a lift, which would leave scars, and plication (raising the inframammary fold from the inside) where the success rate is not that high. The third choice was a larger implant and that was what Ms WX wanted. Dr. Yazdanfar made no contemporaneous note in the medical record of a discussion of these options. These options were noted in some detail in the medical record a year later at her last visit with Dr. Yazdanfar.

The 550cc implant was not one that Dr. Yazdanfar says that she chooses for patients. She said the choice was Ms WX. Dr. Yazdanfar said that she would have mentioned that large and heavy implants would exacerbate vertical descent.

The evidence of the experts was that this was a very difficult problem. Dr. A was of the view that there were many options (including no treatment) and Dr. Yazdanfar’s option was not a good one for this patient. She was already exhibiting droopiness, which would be exacerbated by larger implants. She was facing a number of potential problems including capsular contracture, hematoma formation, implant exposure, further descent of the breast and tertiary surgery in future. He believed that a 550cc implant was not in this patient’s interest, and that she should have been told. If she still requested it, the surgery

should be refused. He felt a smaller, possibly form stable or anatomically shaped implant, would have been more reasonable.

Dr. K also noted this to be a complicated case; one option was changing the pocket, another reconstructing the supporting structures using the capsule.

Dr. L described the patient as difficult and challenging. Even though he did not speak to the standard of practice in Ontario, he agreed that, within reason, the options and their pros and cons should have been discussed. One option was to remove the implants and redo later, another to remove the implant and create a new pocket, and the third was an internal lift. He believed that what Dr. Yazdanfar did was reasonable. In saying that she covered the options, Dr. L relied mainly on what she wrote in the chart at the very last visit. As she did not document the options or the pros and cons pre-operatively, he said she could have done better. He agreed that implant migration for this patient was predictable and she should have been told.

The Committee accepts the evidence from the medical record establishes that the usual consent process was followed. However, there were other issues relating to informed consent in this case that had to be considered. These included a full discussion of the problems facing this patient, options available to her and their pros and cons. This would include advice regarding implant size and the particular risks that this patient might experience.

Dr. Yazdanfar, in her testimony regarding the role of Ms D at the TCC, indicated that if Ms D red flags anything, she is called**.** Though it was said by the defence that they intended to call Ms D, they did not do so. The Committee therefore concluded that it was more likely than not that Ms D summoned Dr. Yazdanfar to see Ms WX on her first visit, as she recognized the complex nature of the patient’s condition and did not wish to bring her back needlessly.

The Committee finds that Ms WX left the TCC after her first visit on August 22, 2007, believing that Dr. Yazdanfar offered a solution for her problems. Her payment in full at the time of her first visit suggests that she was convinced by Dr. Yazdanfar that her problems could be dealt with.

A fulsome discussion of the problems she faced was necessary. The Committee believes that the advice given to Ms WX was focused on volume, and how much larger she would need to go to get the appearance she wanted. This was what Dr. Yazdanfar identified as the problem. She had small breasts and wanted larger ones. Dr. Yazdanfar gave evidence that a discussion of options occurred. The Committee does not accept the evidence of Dr. Yazdanfar that there was a discussion of the necessary relevant options. They are not documented on the chart and what is described in the chart is minimal, indicating a plan for implant exchange. The Committee determined that Dr. Yazdanfar moved quickly to deciding what she could do to improve this patient's appearance and her focus was on augmentation and not options.

The patient testified that a lift was not mentioned. There was no indication in her evidence that she understood the complexity of her situation. Dr. Yazdanfar, in her testimony, indicated that the patient would not want more scars given that she had so many. Dr. Yazdanfar's focus was clearly on volume, how much larger to fill in the volume left by the old implant, and address the volume loss in the upper breast to create a cleavage.

As a consequence, Ms WX did not have the information she needed to make an informed choice. It was Dr. Yazdanfar's obligation to provide her with such information and the Committee finds her failure to do so is a failure to maintain the standard of practice.

Ms WX left the TCC with the impression that Dr. Yazdanfar had a solution to her problem and no idea of the real risks of the course of action she was about to undertake, or that there were a number of options available to her.

Ms WX was a challenging case even for an experienced surgeon. Dr. A testified that the appropriate response was to inform the patient that there were options that she does not offer, and to recommend that the patient look into these options. Based on the evidence, the Committee is of the view that Dr. Yazdanfar should have recognized that the problems of this patient were of such a nature and degree that a referral to a more experienced surgeon would be in this patient's best interest. Having the patient acknowledge on a form that she can get another opinion does not fulfill Dr. Yazdanfar's obligation in this case. This was an option which should have been put to the patient and was not. Rather, surgery was expeditiously planned for a week later with little time for the patient to reflect, or to get another opinion if she wished.

In respect of the allegation of a failure to maintain the standard of practice in failing to obtain informed consent, the Committee finds this allegation is proved.

The Committee also finds that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in failing to obtain informed consent from Ms WX.

b) Failing to formulate an appropriate treatment plan, in that she failed to adequately advise about and explore all possible options for dealing with the patient's presenting complaint;

The Committee was not satisfied that Dr. Yazdanfar had done what was necessary to ensure Ms WX understood the full extent of her problems, or that there were a number of options she might realistically pursue.

The evidence from Dr. K was that there were some aspects of the patient's condition which could not be fixed and that the patient should have been told. While she was offered an option, that of a larger implant in a different pocket, the Committee finds that she was not told of the realistic options, which included doing nothing, removing her implants and redoing later, internal lift or capsulorraphy.

This case was not a simple breast augmentation but a complex case, as noted in the evidence of Dr. A, for which there were a number of options that Dr. Yazdanfar did not provide. While the diagram on the medical record documents the measurements, Dr. Yazdanfar makes no attempt in her plan to capture the complexity of this patient's condition and what would be in her present and future interest.

While Dr. Yazdanfar makes a very thorough note following the last visit of this patient, it is clear by that time that she has a hostile patient and that legal action may follow. The Committee did not accept that the comment made in that last note, to the effect she reminded the patient of what the presenting problems were or that options were discussed again, should be taken to confirm that all the options were presented pre-operatively.

In respect to the allegation of failing to maintain the standard of practice in failing to formulate an appropriate treatment plan, in that she failed to adequately advise about and explore all possible options for dealing with the patient's presenting complaint, the Committee finds this allegation is proved.

The Committee also finds that Dr. Yazdanfar had committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in failing to formulate an appropriate treatment plan.

c) Failing to adequately advise the patient of increased complications with increased implant size

Ms WX testified that she expressed concern about the large size implants but was advised that larger implants were needed to give her a fuller look. A larger size was necessary to fill in the pocket and bring the breasts together. She said Dr. Yazdanfar advised that she have a 550cc size implant. The patient raised concerns about heaviness and the possibility of damage, but says she was reassured "absolutely not" by Dr. Yazdanfar.

It appeared clear from the evidence of Dr. Yazdanfar that her focus was on her perception that the patient was complaining of small breasts and that implant change was something she could do. Further, large implants would be needed to create a cleavage and to address the physical situation with which she was faced. Most of the implant initially sat below the nipple and there was no volume on top. Dr. Yazdanfar testified that she already had 360cc implants and that Ms WX wanted to go bigger. Dr. Yazdanfar said she told Ms WX that wider implants, 350-400cc, would be good.

It seemed clear from the final note that Dr. Yazdanfar was of the view that replacing the implants with the same size and not going larger would require a lift as well. In going larger, even one cup size needed 200cc's and going up 25cc's in this patient would not make any difference.

The medical record made when she was seen by Dr. Yazdanfar pre-operatively nowhere describes the risks of implant migration, need for future surgery or other risks inherent with the use of large heavy implants. Dr. Yazdanfar indicates that she talks about the effects of gravity, but even this is not recorded.

The problems attending the use of heavy implants and their tendency to vertical descent in those with laxity or droopiness is evident in the testimony of the experts. The Committee accepted the evidence of Dr. A, that the physician should adequately advise the patient and explain the complications of the selection of large implants in these circumstances. The Committee accepted that a failure to do so is a failure to maintain the standard of practice. In this case, even though Dr. TZ was not called to testify or accepted to give expert evidence, his medical record for this patient corroborates that the implants were too heavy and large. When he replaced them, he used considerably smaller implants. In his notes, Dr. TZ states that he would not perform the surgery had the patient wished to go with the larger size.

The Committee was of the view that Dr. Yazdanfar had not explained the problems Ms WX might have in the future with the use of the implants that Ms WX had agreed to. The

standard of practice in Ontario is that the physician has an obligation to explain complications. The Committee accepts the evidence of Ms WX that she was influenced by Dr. Yazdanfar's reassurance and that she was not made aware of what problems might follow from the decision to have large implants.

In respect of the allegation of failing to maintain the standard of practice in failing to adequately advise the patient of increased complications with increased implant size, the Committee finds this allegation is proved.

The Committee also finds that Dr. Yazdanfar committed an act of professional misconduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in failing to adequately advise the patient of increased complications with increased implant size.

d) Failing to select, assist the patient in selecting, and failing to take responsibility for selection of the appropriate implant size.

The Committee finds that Dr. Yazdanfar did participate in the process of implant selection. The Committee accepts the evidence of Ms WX that she was told by Dr. Yazdanfar that she needed to have a large implant to create a cleavage and fill in the pocket, and that was something that Dr. Yazdanfar could do.

Dr. Yazdanfar gave evidence there was no contraindication to 550cc implants. It was clear that Dr. A and Dr. TZ had a different opinion.

The Committee concludes that Dr. Yazdanfar downplayed the complications that could reasonably be expected with the use of the large and heavy implants which were selected, and that these were not appropriate given the circumstances.

The evidence of Dr. L, that they would look good on such a patient, is not the issue. What the patient needed was a balanced opinion. The Committee accepts that the selection of implants is a shared responsibility and not simply a matter of patient choice. The standard

of practice requires the physician exercise professional judgment in this respect. The Committee concludes that the failure of Dr. Yazdanfar to accept responsibility for the decision to use what were acknowledged as large and heavy implants, with attendant complications, is a failure to maintain the standard of practice. The Committee did not accept that, just because it could be done and the patient was agreeable or even wanted it done, it should be done without the exercise of professional judgment.

In having the patient sign the agreement she did, Dr. Yazdanfar chose to distance herself from the decision and shift responsibility to the patient for any and all future problems. The form itself simply states the patient's selection and is clear. What is required, however, is that the physician inform the patient of the reasons for such a selection and the Committee finds she did not. Dr. Yazdanfar was convinced a large implant was possible and desirable for a number of reasons, but she did not give the complications specific to large implants due weight. It was Dr. Yazdanfar's obligation to ensure that Ms WX selected an implant size that was appropriate and, in failing to do so, she did not maintain the standard of practice.

The Committee finds the allegation in regard to a failure to maintain the standard of practice in failing to select, assist the patient in selecting, and failing to take responsibility for selection of the appropriate implant size is proved.

The Committee also finds that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in failing to select, assist the patient in selecting and failing to take responsibility for appropriate implace size selection.

e) Failing to perform breast augmentation in an appropriate manner

This Committee has determined that the use of the "tumescent technique" in breast augmentation does not constitute a failure to maintain the standard of practice. The reasons for this decision are set out in the standards Section II (iii) [p.214-224].

The Committee therefore finds the allegations in respect of failing to maintain the standard of practice and disgraceful, dishonourable or unprofessional conduct are not proved.

f) Failing to deal appropriately with post-operative concerns and problems experienced by the patient

The Committee focused on the management of post-operative concerns up to, but not including, the last visit of the patient. The issues related to the last visit are most appropriately addressed in allegations (g) (h) and (i).

The issue to be addressed here is whether Dr. Yazdanfar dealt appropriately with her patient's concerns when she was seen post-operatively on September 1, 2007, September 25, 2007, and January 14, 2008.

Visit of September 1, 2007

There is no question that Ms WX developed an allergic reaction after her breast augmentation. She had a rash, which was widespread, red, hot and very itchy and of a degree to take her to her local emergency department the morning of September 1, 2007. She was advised to stop all medication, including pain medication, and was started on prednisone.

Later that same day she saw Dr. Yazdanfar, who made no changes to the regimen she had been given. These findings are confirmed by the note in the medical record, which describes a possible Ancef allergy and comment is made to see family MD for referral to an allergist. No pain is recorded.

While the patient said she had pain, she admitted on cross examination that she had been through this operation before, and what she was experiencing was not unlike what she had previously experienced. The patient was clearly focused on the extensive rash and associated itching and burning.

There was no evidence to support an error in diagnosis, management or neglect of patient symptoms.

Visit of September 25, 2007

This was a one month follow-up visit, at which time, the medical record states that the patient is doing well, her rash has resolved, she has no pain and that her breasts are soft and non tender. The overall impression is that she is doing well.

Ms WX testified that she had a burning sensation in her breasts, she could not get in a comfortable position when sleeping, that she was living in a sports bra and that her nipples were painful, especially in cold weather. She was also concerned that her nipples were not even and the implants were shifting again.

Dr. Yazdanfar's opinion was that her results were good and post-operative instructions were reviewed.

The Committee viewed Dr. Yazdanfar's attempt to reassure the patient at this stage as reasonable. Continued observation was, in the view of the Committee, a reasonable course of action. The Committee accepted Dr. A's evidence on this.

Visit of January 14, 2008

The medical record notes no problems, and that the patient is well and happy. The breasts are non tender and soft. Dr. Yazdanfar describes this as a great result. Use of her pictures on the internet was discussed and recorded.

From Ms WX' evidence, it is clear she still has the aforementioned complaints and has become concerned and questioning of her confidence in Dr. Yazdanfar. She describes that she was embarrassed about the way her nipples pointed, to the extent that she had to wear pads in her sports bra. Clearly, she was disappointed in her results and concerned to

the extent that she was considering another opinion. She did not believe that Dr. Yazdanfar was acknowledging her complaints.

What actual pain she was having seemed to be related to weather and was not clearly identified to Dr. Yazdanfar or Dr. TZ when she attended his office, as it is recorded by neither of them. Her concern upon presentation to Dr. TZ on May 9, 2008, was whether everything was okay.

While Dr. Yazdanfar, in describing this as a great result, may have overstated, there is no indication that, at the January visit, she neglected to offer the patient needed treatment.

It was the patient's perception that Dr. Yazdanfar's reassurance reflected a disregard of her complaints. There is nothing about pain noted in the medical record. The Committee accepts that if the complaints were judged to be significant, they would likely have been recorded. It would further be unlikely in the face of significant complaints that the issue of using her photographs on the internet would be discussed.

The Committee was of the opinion that Dr. Yazdanfar's course of action could well have represented a view that the complaints were not unusual given her experience with augmentation patients, and that reassurance was appropriate.

The Committee finds the allegation of a failure to maintain the standard of practice in failing to deal appropriately with post-operative concerns and problems experienced by the patient is not proved.

In regard to the allegation of disgraceful, dishonourable or unprofessional conduct, the Committee also finds this allegation is not proved.

g) Failing to make appropriate treatment decisions and recommendations

Treatment decisions made by Dr. Yazdanfar relate to the initial procedure and to the recommendations made at the last visit. Dr. A testified that this was not the correct operation to offer this patient.

Treatment decision - initial procedure

The Committee accepted Dr. A's evidence that Dr. Yazdanfar fell below the standard of practice in her decision to manage this patient the way she did. She failed to make appropriate treatment decisions and recommendations. She used implants that were too large.

There was no evidence that the option to do nothing or to refer on to a surgeon with experience in difficult breast problems was given any regard.

Recommendations made at the last visit

Dr. Yazdanfar saw Ms WX for her last visit on July 25, 2008. The interview ended badly with the patient upset and being escorted to the door. By this time, Ms WX had completed her consultation with Dr. TZ and had come to understand that her implants were, in his opinion, too large and that he would in future consider removing them and, after a time, replacing them with a smaller size.

It appears from the note, which was made contemporaneously by Dr. Yazdanfar, that she was told the patient was not happy with the shape of her breasts. It is recorded that, as she was walking out, she complained of her breasts hurting at night; she had complained primarily of the appearance and, only occasionally, of discomfort.

The patient believed she had bottomed out on the right. Dr. Yazdanfar disagreed. Dr. Yazdanfar believed that the results were much better than what she started with. Options were discussed, including a lift, which she indicated would be done by another surgeon.

Dr. Yazdanfar said she would remove the implants if Ms WX didn't like the size, or really felt they were the cause of her pain.

Dr. Yazdanfar viewed the patient as angry and that she was influenced by her consultation with another doctor who was critical of what Dr. Yazdanfar had done.

The Committee accepted the evidence of Dr. A and Dr. K that the patient had bottomed out again on this occasion and the implants required removal. The situation had become more difficult than the initial presentation and clearly in the view of the Committee required the skills of an experienced breast surgeon.

The Committee was satisfied that Dr. Yazdanfar had failed to make appropriate treatment decisions and recommendation both on the initial and final visits, and finds the allegation of failing to maintain the standard of practice is proved.

The Committee also finds that Dr. Yazdanfar has committed an act of professional misconduct by conduct that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional, in failing to make appropriate treatment decisions and recommendations on the initial and final visits.

h) Failing to recognize and appropriately manage complications

At approximately one year after surgery, Dr. A was of the opinion that the patient had descent of the breasts, some deformity, and was complaining of symptoms likely related to her surgery. It was not a good result. Dr. K gave evidence that she had bottomed out on the right.

Ms WX' version of the last interview was that Dr. Yazdanfar thought she looked good and that she had done what she could, given what the patient presented with. Removal of the implants was discussed and that she would have to pay for it. Her description of Dr. Yazdanfar was "belligerent". She was upset and left in tears.

Dr. Yazdanfar made a long, contemporaneous note indicating her discussion with the patient. She did not agree that there was bottoming out on the right. There was no consideration of a referral, or that she informed the patient that her complications might be covered by OHIP. The Committee accepted the expert evidence that the patient had bottomed out, given the pain and the asymmetry.

The Committee accepts the standard of practice in these circumstances to require a proper diagnosis and a response which addresses the patient's concerns. The Committee, on the evidence before it, concludes that Dr. Yazdanfar failed to adequately diagnose the problem and did not respond to the patient's complaints with appropriate advice. It was clear to the Committee there was an inadequate response to the patient's problems at this juncture and this failed to maintain the standard of practice.

The Committee finds the allegation of a failure to maintain the standard of practice, by failing to recognize and appropriately manage complications, is proved.

The Committee finds that this conduct, having regard to all the circumstances, would reasonably be regarded by members as unprofessional.

i) Engaging in unprofessional communications with the patient

It was evident on review of the documentary evidence and testimony that Ms WX intention in the July 25, 2007, meeting was to address her concerns and the other advice she had been given.

She said she wanted to know what options Dr. Yazdanfar would give her. Without question, there was a point when the patient confronted Dr. Yazdanfar with the opinion of Dr. TZ which, to some extent, was critical.

That Dr. Yazdanfar was defensive, and tried to explain her position to the patient is understandable and is spelled out in detail in the note in the medical record.

The interview ended with an unhappy, angry and upset patient and with Dr. Yazdanfar unsuccessfully attempting to deal with the complaints.

The Committee understands that, in the course of physician/patient relations, situations arise where there is lack of agreement, unfulfilled expectations or a failure to communicate clearly. There was no evidence of rudeness, threats, verbal or other abuse.

The Committee also finds that the allegations of failing to maintain the standard and disgraceful, dishonourable or unprofessional conduct in this respect are not proved.

F. Patients in Cosmetic Surgery Practice from 2005 to 2007 and Patient in 2008

Failing to Maintain the Standard of Practice

a) Performance of liposuction and breast augmentation

The Committee first deals with those cases where liposuction was the sole procedure or combined with other procedures, and then addresses breast augmentation cases.

<u>Liposuction and Combined Procedure Cases</u>

Ms ZX

The Committee accepts the following as fact:

This 25 year old patient (71.5kg, 5ft.5in.) had large volume liposuction of the abdomen, love handles, lower back and inner thighs using Smartlipo at the TCC on August 4, 2007. Dr. Yazdanfar removed 7900cc's of total aspirate, which included 4600cc's of fat. She

was discharged after three hours and five minutes. The medical record supports that the usual informed consent process was followed.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario by this Committee, Dr. Yazdanfar failed to maintain the standard of practice in her performance of liposuction on this patient.

Mr. AZ

The Committee accepts the following as fact:

This 33 year old patient (92kg, 177cm) had large volume liposuction of the abdomen, lower back and love handles using Smartlipo on June 23, 2007. Dr. Yazdanfar removed 5250cc's of total aspirate, including 3050cc's of fat. He was discharged after two hours and fifty-five minutes.

The medical record supports that the usual consent process was followed. Mr. AZ testified that he could not recall any discussion of medical risks, and that there was no discussion of the risk of death, pulmonary embolism, fat embolism or shock. He did recall going over and initialing liposuction risks.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario by this Committee, Dr. Yazdanfar failed to maintain the standard of practice in her performance of liposuction on this patient.

Ms SJ

The Committee accepts the following as fact:

This 21 year old patient (54.6kg, 5ft.2in.) had large volume liposuction of the abdomen, love handles and lower back on June 30, 2007. Dr. Yazdanfar removed 5150cc's of total aspirate, including 2550cc's of fat. She was discharged after three hours and thirty minutes.

The medical record supports the usual informed consent process was followed.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario by this Committee, Dr. Yazdanfar failed to maintain the standard of practice in her performance of liposuction on this patient.

Ms TJ (Combined Procedure)

The Committee accepts the following as fact:

This 36 year old patient (60.7kg, 5ft.6in.) had subglandular augmentation mammoplasty with removal of old implants and liposuction done of the inner and outer thighs, love handles and lower back using Smartlipo. Total aspirate was 3150cc's. Her surgery, done under general anesthesia, lasted approximately three hours and fifteen minutes. Dr. Yazdanfar was the sole surgeon. She was discharged after five hours in recovery.

It was the expert evidence of Dr. A that this was a full liposuction done at multiple sites and that the combination of procedures done in this case did not meet the standard of practice. The ASPS guidelines indicate that large volume liposuction should not be combined with other surgical procedures but that limited liposuction can be done safely. Dr. A interpreted this to mean less than 1000cc's and limited to one area. The Committee accepted the evidence of Dr. A in this regard as the accepted standard of practice in Ontario.

Dr. Yazdanfar disagreed, and was of the view that the breast surgery was not as involved as she was just replacing old implants.

The Committee did not agree with Dr. Yazdanfar and, as well, notes the length of time under general anesthesia. Notwithstanding the volume is not large volume liposuction, the Committee regards this as major surgery and accepts the evidence of Dr. A that the performance of liposuction on this patient falls below standard.

The Committee finds that Dr. Yazdanfar failed to maintain the standard of practice in performing a full liposuction and breast augmentation in combination on this patient.

Ms EV

The Committee accepts the following as fact:

This 42 year old patient (67.9kg, 5ft.7in.) had large volume liposuction performed of the abdomen, love handles, lower back, inner thighs and outer thighs by Dr. Yazdanfar on March 28, 2007. Total aspirate removed was 6900cc's, of which 5000cc's was fat. She was discharged the same day, after three hours in recovery.

The medical record supports that the usual informed consent process was followed. Ms EV gave evidence that she could not remember discussing medical risks and was not told she could die.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds that Dr. Yazdanfar failed to maintain the standard of practice in her performance of liposuction on this patient.

Ms ST (Combined Procedure)

The Committee accepts the following as fact:

This 58 year old patient (104kg, 5ft.5in.) had a combination of liposuction from the love handles and lower back, and abdominoplasty. Dr. Yazdanfar did the liposuction part of the surgery and removed 3950cc's total aspirate, including 2900cc's of fat. She was discharged the same day after four hours and twenty minutes in recovery. Ms ST had a BMI>40 and was on a number of medications. She had an ASA classification of 3 given by the anesthesiologist.

Dr. A noted that liposuction and tummy tuck in combination carry the highest rate of complications. The ASPS guidelines confirm this and advise avoidance. Dr. K testified that her procedure should have been done in hospital.

Dr. Yazdanfar testified that she informed the patient of the added risk of combined procedures. She felt, generally, that liposuction volumes should be on the lower side and patients chosen carefully.

Ms ST gave evidence that she did not have her personal medical risks discussed, or the risk of death, nonetheless she recognized there was a chance of death with any surgery. The Committee noted the consent forms were signed and initialed as customary.

The Committee had regard for the opinion of Dr. A and ASPS guidelines, which clearly raise caution about this combination of procedures and the personal medical factors which increased this patient's risk of complications.

The Committee finds that the allegation of failing to maintain the standard of practice in Dr. Yazdanfar's performance of liposuction on this patient is proved.

Ms AJ

The Committee accepts the following as fact:

This 27 year old patient (73.5kg, 5ft.7in.) had large volume liposuction done of the abdomen, love handles, lower back and bra-line using Smartlipo on September 4, 2007, by Dr. Yazdanfar. A total aspirate of 5400cc's was removed, of which 2600cc's was fat. She was discharged after three hours and thirty minutes. Based on the medical record, the usual consent process was followed.

The Committee has determined that Dr. Yazdanfar failed to maintain the standard of practice of the profession in her treatment of this patient, in that she exceeded the accepted aspirate volume limit.

Ms EF

The Committee accepts the following as fact:

This 24 year old patient (77.3kg, 5ft.9in.) had large volume liposuction done of the abdomen, love handles, and lower back using Smartlipo on September 17, 2007, by Dr. Yazdanfar. A total aspirate of 7400cc's was removed, of which 4175cc's was fat. She was discharged the same day after two hours and fifty minutes of recovery. Based on the medical record, the usual consent process was followed.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Ms KO

The Committee accepts the following as fact:

This 47 year old patient (81.3kg, 168cm) had large volume liposuction done of the abdomen, love handles, lower back and bra-line using Smartlipo on September 22, 2007, by Dr. Yazdanfar. A total aspirate of 8850cc's was removed, of which 5100cc's was fat. She was discharged after two hours and forty minutes. The usual consent process was followed according to the medical record.

The Committee notes in this case that Dr. Yazdanfar exceeded the total fat guidelines of the AACS, which she professed to follow. She testified that she considers co-morbidity and considers she has leeway because of her canister liner, and that sometimes it is safer and better to finish than to have the patient return. The Committee did not accept the rationale offered justified the magnitude of the total aspirate removed.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Ms XO (Liposuction and Breast Augmentation on Different Dates)

The Committee accepts the following as fact:

This 24 year old patient (64kg, 5ft.5in.) had large volume liposuction of the abdomen, love handles, lower back and upper inner and outer thighs done by Dr. Yazdanfar on October 25, 2006. At that time, 5600cc's of total aspirate was removed, including 2800cc's of fat. She was discharged the same day after one hour and fifteen minutes of recovery.

She had a subglandular augmentation mammoplasty done May 18, 2007. The usual consent procedure was followed.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

This Committee has determined that the tumescent technique used by Dr. Yazdanfar in breast augmentation surgery is not sufficiently different from the accepted surgical technique to be considered a failure to maintain the standard of practice [p.214-224]. The Committee finds the allegation of failing to maintain the standard of practice in performance of breast augmentation on this patient is not proved.

Ms JR

The Committee accepts the following as fact:

This 28 year old patient (83.1kg, 5ft.7in.) had large volume liposuction done of the abdomen, love handles, and lower back using Smartlipo by Dr. Yazdanfar on September 28, 2007. At that time, 8825cc's of total aspirate was removed, of which 5675cc's was fat. She was discharged the same day after three hours and fifteen minutes of recovery. The usual consent procedure was followed according to the medical record.

In this case, Dr. Yazdanfar has exceeded even the volume normally viewed by the AACS as maximum (5000cc's fat). Dr. Yazdanfar gave evidence that this was a large patient and it was in her best interest to finish the surgery. The Committee did not accept this as a reasonable justification for the amount of fat or aspirate removed.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee

finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Ms PR

The Committee accepts the following as fact:

This 61 year old patient (70kg, 5ft.3in.) had large volume liposuction of the abdomen, love handles, lower back and upper back using Smartlipo by Dr. Yazdanfar on August 8, 2007. At that time, 8250cc's of total aspirate was removed, including 4600cc's of fat. She was discharged the same day after four hours of recovery. The usual consent procedure was followed according to the medical record.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Ms UK (Combined Procedure)

The Committee accepts the following as fact:

This 42 year old patient (59kg, 5ft.5in.) had liposuction from the abdomen, love handles, lower back and anterior axillary fat, as well as a breast augmentation done at the same time by Dr. Yazdanfar on September 26, 2007. She had a total aspirate of 4550cc's removed, including 2425cc's of fat. Dr. Yazdanfar was the sole surgeon and the patient was under general anesthesia for almost four hours. She was discharged the same day and remained in recovery for two hours and thirty-five minutes. The usual consent processes were followed, according to the chart.

The Committee accepted the opinion of Dr. A on this case, noting that risks are increased with combined procedures and that, even though the amount removed was not over 5000cc's, it was nonetheless considerable given the size of the patient and the number of sites treated. The Committee accepted Dr. A's evidence that, in combined procedures, only limited liposuction should be done (less than 1000cc's, one site). Dr. A raised concerns also about the use of Marcaine in the tumescent fluid for breasts, which was Dr. Yazdanfar's practice at that time. The Committee, however, had no evidence of how widespread the use of Marcaine was at that time and notes that Dr. Yazdanfar testified that she has stopped using it.

Dr. Yazdanfar believed, in respect to liposuction volume, that this was not a large number. The Committee did not agree given its review of the details specified above. There was ample evidence of the major nature of the patient's surgery.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Mr. TC

The Committee accepts the following as fact:

This 27 year old patient (118.8kg, 5ft.9in.) had large volume liposuction done from the breasts, abdomen, love handles and lower back using Smartlipo by Dr. Yazdanfar on July 11, 2007. At that time, 9350cc's of total aspirate was removed, including 5875cc's of fat. He was discharged the same day after four hours and forty minutes of recovery. The usual consent process was followed.

The Committee concluded that Dr. Yazdanfar failed to meet the standard of practice in her care of this patient. The Committee notes in particular the significant magnitude of

the operation, which exceeds the ASPS guidelines of 5,000cc's total aspirate, Dr. A's opinion that the surgery grossly exceeded guidelines, and the patient's BMI of >40 which is a significant co-morbidity.

Dr. Yazdanfar was of the view that this was a large patient and that trauma is less on a large patient when fewer areas are treated. Dr. K said that he thought this was acceptable for this patient's size over having him come back for an additional anesthetic, but admitted that it should probably be done in hospital. The Committee did not accept this as a justification.

Based on the volume of total aspirate removed and the number of sites treated, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Ms EK

The Committee accepts the following as fact:

This 20 year old patient (77kg, 5ft.4in.) had large volume liposuction done from the abdomen and love handles by Dr. Yazdanfar on May 28, 2006. At that time, 5650cc's of total aspirate, including 3200cc's of fat, was removed. She remained in recovery for just over two hours and was discharged the same day. It is clear from the medical record that the usual informed consent applied.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Ms LV

The Committee accepts the following as fact:

This 37 year old patient (74.4kg, 5ft.8in.) had large volume liposuction performed from the abdomen, love handles and lower back using Smartlipo. At that time, 6700cc's of total aspirate was removed, of which 3675 was fat. She recovered for three hours and thirty minutes and was discharged the same day. Consent was documented in the usual fashion.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Mr. PK

The Committee accepts the following as fact:

This 45 year old patient (116.8kg, 6ft.) had large volume liposuction done from the abdomen using Smartlipo by Dr. Yazdanfar on September 10, 2007. At that time, a total aspirate of 7900cc's was removed, of which 5300cc's was fat. He recovered for four hours and five minutes and was discharged to a taxi to go to a local hotel.

He had a second liposuction done October 10, 2007, from the love handles, lower back, breasts and small areas on the side of the abdomen using Smartlipo. At this time, 6550cc's of total aspirate was removed, of which 4150cc's was fat. He recovered five hours and ten minutes and again was discharged to a taxi.

The usual consent procedure applied.

This patient case was of particular concern to the Committee as Mr. PK had repeated liposuction surgeries, both of which exceeded the acceptable volume guidelines.

Furthermore, the amount of fat removed at the initial procedure even exceeded the AACS recommendations, which Dr. Yazdanfar professed to follow. He was a high risk patient with comorbidity (BMI 35) having a high risk procedure, as noted by Dr. A. Discharge after large volume liposuction in this case to a taxi, both times, is clearly unacceptable.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Ms CX

The Committee accepts the following as fact:

This 49 year old patient (73.4kg, 5ft.6in.) had large volume liposuction done of the abdomen, love handles and lower back using Smartlipo. She was obese with a thirty year history of smoking, and was classified as ASA 3 in terms of the anesthetic risk. A total of 5825cc's of total aspirate was removed, which included 3050cc's of fat. After three hours and thirty minutes in recovery, she was discharged to a taxi with another patient who had liposuction that day.

Dr. A was of the opinion that to discharge a patient in such a manner was unsafe and that, given her ASA classification, her procedure should have been done in a hospital.

Dr. Yazdanfar said this was a special case. She and her friend, who also had liposuction that day, wanted to go to the hotel, though staying overnight at the TCC was offered. They felt well after surgery, were making jokes and wanted to go out for a smoke and had stayed a long time. The Committee was not persuaded by her explanation.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Mr. PC

The Committee accepts the following as fact:

This 25 year old patient (98.7kg, 5ft. 4in.) had large volume liposuction of the abdomen performed by Dr. Yazdanfar on September 22, 2007. At that time, 8100cc's of total aspirate was removed, of which 5450cc's was fat.

This patient had a past history of hypertension, asthma and was classified as an ASA 3. It was not appropriate for liposuction surgery to take place in a clinic such as the TCC, according to the evidence of Dr. A, which the Committee accepted. The patient's size alone was a significant co-morbidity. The medical record indicates the usual informed consent process was followed.

The amount of fat removed exceeded even the guidelines Dr. Yazdanfar professed to follow.

The patient was discharged the same day after three hours and thirty minutes in recovery.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Ms FT

The Committee accepts the following as fact:

This 26 year old patient (87kg. 5ft.9in.) had large volume liposuction performed of the abdomen, love handles and lower back using Smartlipo on August 28, 2007, by Dr. Yazdanfar. She had 7200cc's of total aspirate removed, of which 4650cc's was fat. She was classified as ASA 3 based on a history of smoking, hypertension and obesity.

She was discharged the same day after three hours and five minutes in the recovery room. The usual consent was obtained.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Mr. RZ

The Committee accepts the following as fact:

This 47 year old patient (118.5kg, 6ft.2in.) had large volume liposuction done of the abdomen, right upper and lower back, right love handle and chin on July 7, 2007, by Dr. Yazdanfar. At that time, 9525cc's of total aspirate was removed of which 6175cc's was fat. He returned for a second procedure August 22, 2007, at which time he had liposuction of the left upper and lower back, left love handle and revision of the chin and abdomen.

After the first surgery, he was discharged to a taxi as his friend did not show after three hours and fifty-five minutes in recovery. The usual consent process was followed, according to the chart.

The Committee considered the excessive volume of aspirate removed constituted a gross violation of the standard. The Committee agreed with the opinion of Dr. A that to discharge to a taxi in such circumstances was unsafe.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Mr. BY

The Committee accepts the following as fact:

This 35 year old patient (128.3kg, 6ft.3in.) had large volume liposuction done of the abdomen and breast using Smartlipo on August 31, 2007, by Dr. Yazdanfar. At that time, 6900cc's of total aspirate was removed, of which 4650cc's was fat. Love handles/lower back were not done. The operative note states there were no complications and there was minimal bleeding for most of the procedure. There was increased bleeding close to the end, at which point the procedure was stopped. He was in recovery for four hours and fifty minutes. He was discharged to his wife to go home.

Based on the volume of total aspirate removed, which exceeds the volume of total aspirate accepted as the standard of practice for liposuction in Ontario, the Committee finds the allegation of failing to maintain the standard of practice in the performance of liposuction on this patient is proved.

Breast Augmentation Cases

This Committee has determined that the tumescent technique used by Dr. Yazdanfar in breast augmentation surgery is not sufficiently different from the accepted surgical technique to be considered a failure to maintain the standard of practice [p.214-224].

The College asks for findings in the augmentation cases relating to patients in her cosmetic practice from 2005 to 2007, based upon Dr. Yazdanfar's use of the tumescent technique. For the above reason, the Committee finds that the allegation of failing to maintain the standard based on her use of the tumescent technique is not proved (Ms DS, Ms XB, Ms ZA, Ms YM, Ms WR, Ms MG).

Summary

Having reviewed all the cases relevant to this allegation, the Committee finds the allegation of failing to maintain the standard of practice in Dr. Yazdanfar's performance of liposuction, including performance of liposuction in combination with other procedures, is proved. The Committee finds the allegation of failing to maintain the standard of practice in Dr. Yazdanfar's performance of breast augmentation is not proved.

b) In her engagement as a co-surgeon in the combination procedures of liposuction and abdominoplasty

This allegation relates to one case, that of Ms ST, and the following issues:

(i) obtaining informed consent;
(ii) the magnitude of the surgery, including the amount removed and number of sites treated at the same operative episode as abdominoplasty; and
(iii) the high risk nature of the patient

(i) Informed consent

In regard to obtaining informed consent from this patient, the Committee accepted that Dr. Yazdanfar followed her usual process. Her evidence was that she discusses the increased risk when two procedures are combined as exceeding the individual risks. Additionally, when, as in this case, another surgeon shares the operation, that surgeon independently interviews the patient to discuss risks and obtain informed consent. Dr. IA

was the other surgeon in her case. He did not testify. That this was the procedure was affirmed by the testimony of Dr. E and Dr. F, two other surgeons at her clinic.

The Committee accepts that, as a general practice, Dr. Yazdanfar discusses the risk of the combined surgery.

(ii) Magnitude of surgery

The Committee finds that, in cosmetic surgery, it is not uncommon to perform combined procedures. The issue in this case was whether the magnitude of the liposuction (including both the amount removed and the number of sites treated) was acceptable in the circumstances of this patient.

Dr. A's evidence was that the volume removed was well in excess of that considered to be safe. He cited amounts of 500-1000cc's to be appropriate in combined procedures. Dr. A refers to the cautious approach advocated by the ASPS and the recommendation to avoid such combinations.

(iii) High risk nature of patient

This patient was at high risk as a result of a significantly elevated BMI of >40 and history of smoking, such that her ASA classification was 3, as noted by the anesthesiologist. Normally, such patients have surgery done in hospital.

Dr. A was of the view that her risk of post-operative complications was significant and included pneumonia, DVT and others.

This is a high risk procedure to start with, as noted in the guidelines produced by the ASPS. Dr. K agreed that risk was increased in this patient because of her ASA level, as well as the combination of procedures.

It was Dr. Yazdanfar's evidence that she acknowledges the need to select patients carefully for combination procedures, but that no particular screening is required other than thinking of what you are doing, and keeping to a lower volume outside of the area of the tummy tuck.

The Committee does not believe that to do combination surgery known to be associated with serious complications in this high risk patient was within the standard of practice, based on the above.

The Committee therefore finds the allegation of failing to maintain the standard of practice in Dr. Yazdanfar's engagement as a co-surgeon in the combination procedures of liposuction and abdominoplasty is proved.

c) In her pre-operative evaluations

The basis of this allegation is that it is generally accepted that patients at high risk should not have procedures done at a facility such as the TCC where their needs may not fully be met.

Only under exceptional circumstances, as noted by Dr. K, would elective surgery on patients identified by the anesthetist as ASA 3 be done outside of hospital. The Committee accepts that this is the standard of practice for the profession.

The following patients were classified as ASA 3:

- Mr. PC (hypertension, asthma);
- Ms FT (smoking, hypertension, obesity);
- Ms CX(smoker x 30yrs, COPD, obesity); and
- Ms ST (hypothyroidism, hypertension, obesity, on multiple medications).

Dr. Yazdanfar suggests that surgeons in the ordinary course of every day practice do not know the ASA ratings of their patients. While this may be true, the ASA level is only a measure of pre-operative morbidity. On the basis of her own pre-operative assessment, Dr. Yazdanfar should have been aware of the substantially increased risk of the above patients.

It was clear to the Committee that, while Dr. Yazdanfar's procedures give her ample opportunity to decide on the suitability of patients for her clinic, she does not exercise that opportunity to tell patients that, in the interests of their safety, they are better treated in hospital.

The Committee finds the allegation that Dr. Yazdanfar failed to maintain the standard of practice in her pre-operative evaluations is proved.

d) Failing to obtain informed consent

The Committee has determined that Dr. Yazdanfar, in the course of her usual consent process, does disclose the serious risks. The issues are set out in section II (i) [p.193-198].

In support of this determination, in respect to the patients from 2005 to 2007, the medical records of two patients (Mr. PC p.101, Ms FT p.81) reference a discussion of risks, including the risk of death, in Dr. Yazdanfar's own hand.

In the face of a contemporaneous note to the contrary, the fact that Ms FT testified that no serious risks were discussed illustrates the lack of reliability of patient's memories for such details.

The Committee notes that while the usual consent process covers the serious risks, there are patients identified by the s.75 investigation who had significant personal risks. These personal risks were either not identified or ignored in the following cases:

i) patients who were classified as ASA 3 by the anesthesiologist – Mr. PC, Ms FT, Ms CX, Ms ST
ii) patients who had significant co-morbidities – Mr. TC, Mr. PK

For these patients to make an informed decision required a full discussion of their personal medical risks and the options which were available to them. The Committee was satisfied that these personal risks were either not acknowledged as relevant or dismissed as being unimportant.

The Committee finds the allegation of failing to maintain the standard of practice in failing to obtain informed consent is proved.

e) Booking procedures and payment requirements

The Committee has set out its determination on this issue in section II (iv) [p.224-228]. This applies to the cases at issue here.

The Committee finds the allegation of failing to maintain the standard of practice in her clinic's booking procedures and payment requirements is not proved.

f) Post-operative care and treatment

In respect of the s.75 cases, the issues relate to the following:

i) Discharge without escort

Notwithstanding the TCC policy, which requires patients to have a person to look after them for 24 hours after surgery, this was regularly not enforced.

The following patients were discharged unaccompanied to a taxi: Mr. RZ; Mr. PK (twice); and, Ms MG.

The evidence of Dr. A and Dr. K is that patients must be discharged with an escort. Dr. Yazdanfar recognizes the importance by having a policy in her clinic, which requires patients have an escort.

Various reasons were cited in explaining the circumstances and limitations facing staff when patients insist upon leaving. It is nonetheless the responsibility of the clinic to ensure safe practice and make certain that, if patients leave against medical advice, this is specifically recorded.

While patients bear an element of personal responsibility, what needs to be made clear by the physician is that discharging the patient without an escort is against medical advice, not a decision within the discretion of the patient.

The situation of Ms CX and Ms DW, where it was preplanned to discharge them into each other's care, is inexcusable. It was unsafe and unacceptable and a failure to maintain the standard of practice of the profession.

ii) Overnight monitoring

Patients having large volume liposuction require overnight monitoring in keeping with the ASPS guidelines.

Patients identified by the s.75 investigation who had large volume liposuction clearly show a pattern of same day discharge.

This Committee has determined that the standard of practice in Ontario, as stated in the ASPS guidelines, is to monitor patients overnight in a professional health care setting. This was not done.

The Committee finds the allegation that Dr. Yazdanfar failed to meet the standard of practice in her post-operative care and treatment is proved.

Disgraceful, Dishonourable or Unprofessional Conduct

a) By permitting, supporting or directing her staff's communication with patient Ms GR

The Committee accepted the following as fact:

Ms GR is a 21 year old patient who came to the TCC with droopy asymmetric breasts on May 13, 2008.

Ms GR, accompanied by her mother, Mrs. HP, attended for the pre-operative assessment with Dr. Yazdanfar, at which time breast augmentation, with a later lift if needed, was discussed, as recorded in the medical record (May 28, 2008).

A subglandular augmentation mammoplasty was done on May 31, 2008, in the usual fashion using 550cc high profile Silicone gel implants.

Ms D called the next day and no major concerns were noted on the medical record.

On June 2, 2008, the patient's condition deteriorated with the left breast swollen and painful.

Dr. Yazdanfar was contacted around 9 p.m.

During the night, the patient's condition worsened, and both the TCC and the hospital were called.

Arrangements were made by the TCC to see her at 9:00 a.m. on June 3, 2008, with a provisional plan to drain the presumptive hematoma.

When the patient fainted, her mother called an ambulance and she was taken to hospital.

The TCC called a number of times when the patient did not show. Mrs. HP returned the call and spoke to Ms D. The dispute in this case concerns the nature and content of the conversations between Mrs. HP and Ms D, and Dr. Yazdanfar's responsibility.

Disputed areas:

The evidence of Mrs. HP was that Ms D said that, if her daughter stayed in hospital, she would lose the right to come to the clinic and be checked afterwards. There was some discussion as to whether this was a threat and if it was in the contract. At this time, Mrs. HP told Ms D that Dr. Yazdanfar was not a plastic surgeon and that her daughter was staying in hospital.

It was clear from this and a later call that the conversation was becoming hostile, as Mrs. HP refused to identify the doctor taking care of her daughter and took offense when Ms D attempted to reassure. A follow-up call the next day ended rudely with Ms D denying what Mrs. HP had perceived as a threat.

Ms D was not called by the defence to refute the version given by Mrs. HP and the College requested that the Committee accept this as having an adverse inference on the member's case. However, the Committee had Ms D's contemporaneous notes on the chart and gave these notes more weight than any adverse inference.

The medical records of both the TCC and the hospital to which Ms GR was admitted were in evidence and reference to the various conversations is noted. In the hospital record, an episode of hypotension is noted (9:10 a.m.), which required a bolus infusion of normal saline, and analgesics were administered.

The note by Dr. KL on June 2, 2008, states "the patient was told not to go to ER despite N/V and LOC (taken to mean nausea, vomiting and loss of consciousness). It is also

stated that she was “told by the clinic if seen by MD, she will lose the right to return to the clinic”.

Notes made on the TCC record by Ms D are:

June 1, 2008 - no major concerns. Reviewed post operative instructions

June 3, 2008 - spoke to man at Ms GR’s home (7:50am) who said she had gone to the hospital. Dr. Yazdanfar notified. Ms D was informed that the patient was going to be seen at TCC at 9:00 am.

June 3, 2008 - spoke to Mrs. HP (9:00am) and was informed that Ms GR was now resting comfortably with IV. Ms D told Mrs. HP that Dr. Yazdanfar was waiting for Ms GR and ready to take her back into surgery. It appears no hostility is evident at this point. When she did not show, Ms D notes calling both Ms GR’s and Mrs. HP’s cell phone (11:00am) but they were both turned off.

June 3, 2008 - spoke to Mrs. HP (12:30pm) and told her Dr. Yazdanfar wants her to come here so we can treat her right away. She also records that, if another doctor operates on her breasts, Dr. Yazdanfar cannot be responsible if another complication arises.

June 3, 2008 - called at 7:30 p.m., mother answered and asked to call back. The phone was off when she did so.

June 4, 2008 - called mother at 9:00 a.m. to check on Ms GR. Mother said doing well, that a hematoma had been removed and that Ms GR would not be coming back for follow-ups. She spoke “very rude” and hung up abruptly.

The Committee agreed that Mrs. HP was faced with a very difficult situation. She was unprepared for the symptoms her daughter was experiencing. She was already unhappy with her daughter’s decision to proceed with the surgery, given what she had found out

about a patient of Dr. Yazdanfar's who had died. This heightened her concern, especially in the face of her daughter fainting. The decision to call EMS and proceed to hospital was reasonable.

It appears that Dr. Yazdanfar may have had to call in a surgeon to do the procedure at the TCC, but there was no evidence from Dr. Yazdanfar on this point. Ms GR testified that Dr. Yazdanfar told her another surgeon would do the hematoma operation.

In respect to what transpired in the conversation between Ms D and Mrs. HP, the Committee finds that there was discussion about what might result if Ms GR was operated on by another physician. Whether this was a threat or a warning about what would happen if further complications developed, it was not helpful for Ms D to discuss this at this time, given Mrs. HP's daughter was in the emergency room. It certainly had sufficient effect on Mrs. HP and Ms GR that they informed Dr. KL.

The heightened anxiety regarding her daughter and Ms D's attempt to reassure just increased the developing antagonism to the point of rudeness, as admitted by Mrs. HP in her final remarks to Ms D.

The Committee recognizes that Dr. Yazdanfar has responsibility for what her staff tell patients. However, this has some reasonable limits and, in the context of a heated interchange as was developing here, and where it was difficult to assess what exactly was said, the Committee did not believe there was sufficient evidence to make a finding of professional misconduct.

The Committee finds the allegation that Dr. Yazdanfar engaged in disgraceful, dishonourable and unprofessional conduct by permitting, supporting or directing her staff's communication with patient Ms GR, is not proved.

b) Knowingly breaching the acceptable standard of practice in the performance of liposuction

The Committee has found that Dr. Yazdanfar failed to maintain the standard of practice in her performance of liposuction in removing excessive volumes of total aspirate from patients in her cosmetic surgery practice from 2005 to 2007 (the s.75 patients) as noted in Failing to Maintain the Standard of Practice, paragraph a), above [p.293-309]. This finding included patients on whom combined procedures were performed. The Committee also found Dr. Yazdanfar inappropriately performed large volume liposuction on patients at high risk of complications. The Committee further found Dr. Yazdanfar failed to maintain the standard of practice in her discharge arrangements and, in some cases, her discharge practices were unsafe.

The Committee also finds this conduct to be disgraceful, dishonourable or unprofessional both with respect to the excessive volumes extracted and the conduct as a whole.

The Committee notes in particular that Dr. Yazdanfar exceeded even the volume limits of the AACS which she said she applied in her own practice. The uncontested evidence supported by the medical record in the cases of Mr. TC, Mr. PK and Mr. PC demonstrate removal of more than 5000cc’s of fat in patients with co-morbidities. The case of Mr. RZ is particularly disturbing and the Committee accepted that this procedure was frankly dangerous.

Dr. Yazdanfar sought to justify her volume violations on the basis of the AACS guidelines which, as in previous cases, the Committee did not accept. She also sought to justify her volume violations on the basis that the liners she uses in her canisters tend to an overestimate of what she actually takes out. She attempted to demonstrate this for the Committee and a small difference was demonstrated using coloured water under conditions, which may or may not be similar to the mixture of fat and fluid in the aspirate.

It was clear to the Committee that attempting to estimate the amount of fat during, or just at the end of, the procedure is difficult or impossible (example given by Dr. Yazdanfar is that it is like oil and vinegar when it comes out). Measurements are made some time after surgery to allow for complete separation. The decision to stop the operation cannot be accurately based on the total fat, and whether Dr. Yazdanfar's canister may be off by a few cc's due to the liner is irrelevant.

The Committee concluded that Dr. Yazdanfar was aware of the existence of the ASPS guidelines used by plastic surgeons doing cosmetic surgery in Ontario (p.246).

Based on the above considerations, the Committee finds the allegation that Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct, by knowingly breaching the acceptable standard of practice in her performance of liposuction, is proved.

c) Booking procedures and payment requirements

The Committee finds this allegation is not proved for the reasons cited in the standards section II (iv) [p.224-228].

IV. Allegations related to advertising

The Committee heard a motion brought by the defence challenging the constitutionality of s.6(2)(b) of Ontario Regulation 114/94, which prohibits the use of any and all testimonials and any and all superlative statements by physicians and surgeons in advertising. The Committee delivered its finding and reasons on this motion separately, dismissing the constitutional challenge.

The issues to be addressed are as follows:

1. Did Dr. Yazdanfar contravene Ontario Regulation 114/94 made under the *Medicine Act, 1991* through posting advertising on the Toronto Cosmetic Clinic website, which is misleading or deceptive and which contains testimonials and/or superlative statements about her cosmetic practice?

The following facts were set out in an Agreed Statement of Facts that was filed (Exhibit #45):

Schedule "A"

1. On or about October 10, 2007, the Toronto Cosmetic Clinic's Website contained, among other pages, the pages attached at Schedule "A" [to the Agreed Statement of Facts].

2. Among the pages attached at Schedule "A" are 4 pages which, as of October 10, 2007, were found under the link entitled "Testimonials".

Schedule "B"

3. On or about October 31, 2008, the Toronto Cosmetic Clinic's Website contained, among other pages, the page attached at Schedule "B" [to the Agreed Statement of Facts].

4. As of October 31, 2008, the page attached at Schedule "B" was found under the link entitled "Patient Stories".

5. As of October 31, 2008, a video of a woman named "Ms BW" could be played on the Toronto Cosmetic Clinic's website by clicking on the box "Ms BW", which is found at the page attached as Schedule "B".

Schedule "C"

6. On or about June 24, 2009, the Toronto Cosmetic Clinic's Website contained, among other pages, the pages attached at Schedule "C" [to the Agreed Statement of Facts].

7. As of June 24, 2009, the pages attached at Schedule "C" were found on the Toronto Cosmetic Clinic's website as follows:

> Page 1 – the "Home Page" of the Toronto Cosmetic Clinic's website could be found by logging on to the website www.tcclinic.com;
>
> Page 2 – from the Home Page, the page entitled "Breast Lift Procedure Toronto" could be found by clicking on the link "Breast lift";
>
> Page 3 – from the page entitled "Breast Lift Procedure Toronto", the page entitled "Toronto Physician Performing Cosmetic Procedures" could be found by clicking on the link "physician", under the heading "The Procedure";
>
> Page 4 – from the page entitled "Breast Lift Procedure Toronto", the page entitled "Breast Lift Toronto" could be found by clicking on the link "Breast Lift Toronto";
>
> Page 5 – from the page entitled "Breast Lift Toronto", the page entitled "Breast Lift and Mastopexy FAQ" could be found by clicking on the link "Breast Lift FAQ"; and
>
> Page 6 – from the page "Breast Lift and Mastopexy FAQ" the page entitled "Toronto Physician Performing Cosmetic Procedures" could be found by clicking on the link "physician" under the heading "Tell me about recovery".

The Committee accepted the following as fact in addition to the agreed statement of facts containing excerpts from the website:

- Dr. Yazdanfar advertises her cosmetic surgery practice through the Toronto Cosmetic Clinic website;
- This website contains testimonials and superlative statements as filed in the proceedings;
- A number of patients gave evidence that they found Dr. Yazdanfar through her website and were influenced by the testimonials it contained (Mr. AZ, Mr. BY, Ms FT);
- Websites of other physicians and surgeons use testimonials and superlative statements;
- The applicable legislation clearly prohibits misleading or deceptive information and the use of testimonials and superlative statements.

Position of the Parties:

The College takes the position that the breach of the regulation is clear. The College also asserts that aspects of the website contain false, misleading and deceptive information.

The member relies upon the defence of detrimental reliance. The member also takes the position that her website is not misleading to the public.

In respect of the doctrine of detrimental reliance, Dr. Yazdanfar's position is that the College has examined her advertising practices a number of times in response to complaints and has not found her in violation of any regulations.

The Committee had evidence of four proceedings allegedly relevant to this issue:

(i) A Complaints Committee decision dated September 2006, in response to a complainant who wrote to the College questioning Dr. Yazdanfar's qualifications to

perform cosmetic surgical procedures. His concern was her lack of approved surgical training and that her website left the impression that she was actually a surgeon. The Committee concluded, after reviewing the matter, that no further action against Dr. Yazdanfar was warranted. In doing so, they noted that there is no requirement that a physician complete a surgical residency in order to perform the cosmetic procedures she does. Based on the information the Complaints Committee had, they believed she had received adequate training for the procedures she was doing.

(ii) A Health Professions Appeal and Review Board decision of March 23, 2009, pursuant to an appeal of the above decision. The subject of deceptive advertising in regard to the member's qualifications was reviewed, and the investigation was considered adequate and the decision reasonable. In making its decision, the Board notes the public's right to know a physician's qualifications to perform a medical procedure in an area in which the physician professes competency. It further encouraged the College to consider additional measures enhancing transparency and clarity related to physician credentials and qualifications.

(iii) An Inquiries, Complaints and Reports Committee decision dated June 2009 subsequent to a complaint of October 9, 2007. This complaint related to an advertisement in *Elevate Magazine* Autumn 2006 and related to cosmetic procedures which the complainant believed the member was not trained to perform. The decision of the Committee was to take no further action, noting no contravention of the Advertising Regulations.

(iv) An Inquiries, Complaints and Reports Committee decision dated June 2009, subsequent to a further complaint. This complaint related to an Anti-Aging Show and the possibility that Dr. Yazdanfar would use this forum to "tout her skills" in a variety of cosmetic procedures. The decision of the Committee was to take no further action. In so doing, they noted that there was nothing to suggest that Dr. Yazdanfar attended or was associated with the Anti-Aging Show.

In applying the law in the matter of detrimental reliance, the Committee held that, to be considered applicable, the representation to the member would have to be clear and unambiguous. In other words, it would need to clearly state that Dr. Yazdanfar's website advertising, including the testimonials it contained, had been the subject of review and that the College found it acceptable.

In this matter, in none of the four decisions was the issue of testimonials and or superlatives raised. The subject material of the first two decisions was physician qualifications and whether they were appropriate and the remaining decisions dealt with advertising, or potential advertising, in venues other than the Toronto Cosmetic Clinic website.

The Committee, therefore, rejects that the argument of detrimental reliance applies as put forth by the defence.

Dr. Yazdanfar asserts that the information on the website is neither false nor misleading. The Committee disagrees. After a review of the website information in evidence, the Committee finds the following as examples of misleading information in the context of testimonials:

- Testimonial of Ms QA (March 27, 2007). Reference is made to labioplasty. The only reference to a physician is Dr. Yazdanfar, which conveys the impression that she was the one who did the surgery. This was not the case as she does not do labioplasties; and,

- Testimonial of a patient, Ms BW, appearing as a video after October 31, 2008, who had a tummy tuck and liposuction. Dr. Yazdanfar is the only physician cited and Ms BW states she would "not want anyone else to touch her". Dr. Yazdanfar does not do tummy tucks as implied.

Dr. Yazdanfar testified that she was aware that her website contained testimonials and, further, that she was aware of the advertising regulation which prohibited their use.

The fact that others doing cosmetic surgery have contravened the regulation is a matter to be dealt with elsewhere. It does not establish that the use of testimonials or superlative statements is acceptable practice.

Based on consideration of the above, the agreed facts, oral evidence and documents filed, the Committee finds this allegation is proved, i.e., that Dr. Yazdanfar contravened Ontario Regulation 114/94 by posting advertising on the Toronto Cosmetic Clinic website, which is misleading or deceptive and which contains testimonials and/or superlative statements about her cosmetic practice.

2. Did Dr. Yazdanfar engage in disgraceful, dishonourable or unprofessional conduct through posting advertising on the Toronto Cosmetic Clinic website, which is misleading or deceptive and which contains testimonials and/or superlative statements about her cosmetic practice?

The Committee accepts that the following demonstrates that Dr. Yazdanfar has posted misleading information on her website and has engaged in conduct considered disgraceful, dishonourable and unprofessional.

- Testimonial of Ms QA (March 27, 2007). Reference is made to labioplasty. The only reference to a physician is Dr. Yazdanfar, which conveys the impression that she was the one who did the surgery. This was not the case as she does not do labioplasties;

- Testimonial of a patient, Ms BW, appearing as a video after October 31, 2008 who had a tummy tuck and liposuction. Dr. Yazdanfar is the only physician cited and Ms BW states she would “not want anyone else to touch her”. Dr. Yazdanfar does not do tummy tucks as implied;

- The promotion of Smartlipo in her practice as the least invasive method of liposuction is misleading and/or deceptive. Many of the patients whose records were in evidence had been persuaded to have Smartlipo and paid an additional $1000.00 for this technique. The evidence of Ms LV was that she believed Smartlipo was used throughout and on all areas. Dr. Yazdanfar testified that she uses it a little all over in her procedures to soften the fat. Dr. GH testified and described the technique, its applications and use. He explained that this laser assisted liposuction is intended to liquefy fat before removal. It is appropriately used for small areas because it requires a lot of time to get the benefit. Small single zones usually less than 1000cc's of total aspirate are amenable to Smartlipo. He testified that, if you do not spend the time to do it properly, indicating that you do Smartlipo is just a marketing tool. Dr. GH testified that Smartlipo is not designed for multi-zone body contouring as it would take eight to ten hours to apply enough energy to make a meaningful difference. In light of the manner in which Smartlipo is employed by Dr. Yazdanfar, the Committee finds her website promotion of it to be misleading and deceptive; and,

- Dr. Yazdanfar indicated that she was aware of the ban applying to testimonials and superlatives in advertising. She had the opportunity to comply with the regulation by removing these from her website and chose not to do so.

The Committee finds the allegation that Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct through posting advertising on the Toronto Cosmetic Clinic website, which is misleading or deceptive and which contains testimonials and/or superlative statements about her cosmetic practice, is proved.

3. Does the case of Ms QR merit a separate finding of disgraceful, dishonourable or unprofessional conduct in respect of the allegation of misleading advertising?

The Committee had the evidence of Mr. UV and Ms QR, that they were both under the impression from her website that Dr. Yazdanfar performed breast lifts. They did not find

out that she did not perform breast lifts until a later date when a complaint was made to the College.

They had also contacted the TCC by email and had received information about the combination of a lift and augment, and this reinforced their belief that these procedures were done at the TCC by Dr. Yazdanfar.

In the profile of Dr. Yazdanfar, it is stated that “She frequently performs breast augmentation and liposuction, as well as several other aesthetic procedures”. That Ms QR and Mr. UV could have made the assumption they did is understandable.

Even though the Committee was of the view that the description of the techniques she does could be clearer, the website description is not incorrect. The fact that the lift option was not discussed in sufficient detail as found by this Committee was one reason Ms QR’s and Mr. UV’s misunderstanding persisted.

After review of all the evidence, the Committee concluded there was insufficient evidence to support a separate finding of professional misconduct as alleged. Therefore, the Committee finds that this allegation is not proved.

V. Incompetence

The Committee considered the allegation of incompetence, which requires a determination of the following issues:

i) Did Dr. Yazdanfar demonstrate a lack of knowledge, skill or judgment in her care of individual patients?

ii) If so, is the lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that Dr. Yazdanfar is unfit to continue to practise or that her practice should be restricted?

iii) Have there been changes undertaken by Dr. Yazdanfar to demonstrate that she has gained insight and she addressed her deficiencies such that she would be able to practise safely?

a) Did Dr. Yazdanfar demonstrate a lack of knowledge, skill or judgment in her care of individual patients?

The cases of liposuction and breast surgery are considered separately and followed by general comments.

Liposuction cases

Krista Stryland

In regards to the care and treatment provided to Krista Stryland, the Committee is satisfied that Dr. Yazdanfar has displayed a lack of knowledge, skill and judgment as follows:

- Dr. Yazdanfar failed to recognize the serious life threatening complications which occurred in this patient on whom she had just performed large volume liposuction. When her patient required reintubation and was in shock, she should have immediately called 911.

- Dr. Yazdanfar failed to be alert to post-operative problems in this patient whose liposuction volume was large in respect to the size of the patient, exceeded the volume of aspirate that should have been extracted and where the infranatant fluid was dark. She was unaware of, ignored or did not believe the abnormal low BP readings on the RR record and the monitor, which displays this information clearly, and did not defer the next case. She did not actively inquire as to whether the situation was improving and did not attend to Ms Stryland until sometime after the crisis had occurred, despite the fact that Dr. C and the circulating nurse

were going back and forth between the OR and RR. She could and should have stopped the surgery she was performing at any time but she did not;

- Dr. Yazdanfar made no acceptable assessment or differential diagnosis. A cursory examination without taking down the garment was insufficient given the circumstances. When she did attend to Ms Stryland, she spent only thirty seconds evaluating the patient and gave little thought to a differential diagnosis. She relied upon her anesthesiologist to manage post-operative problems and lacked the knowledge and experience to know whether he was competently managing this post-operative crisis. Even though she had been certified in ACLS, she did not actively participate in any way in the resuscitative efforts on her patient, other than assisting the nurse to put on a second binder and calling 911;

- Dr. Yazdanfar took no responsibility for the consequences of the surgery she had just performed, rather, deflected responsibility to the anesthesiologist and RR nurse, even though she took pains to ensure that she was the doctor who had the relationship with the patient. She also had a responsibility for the patient which she failed to fulfill.

Francine Mendelson

The Committee is satisfied that in the professional care she gave Francine Mendelson, Dr. Yazdanfar demonstrated a lack of knowledge, skill and judgment as follows:

- Dr. Yazdanfar failed to give proper weight to this patient's age and did a large volume procedure that increased her risk of serious complications. In failing to discuss the risks related to age and volume, she demonstrated a dismissive approach towards the incidence and seriousness of complications and left her patient believing they were not real.

- In performing large volume liposuction on this 66 yr old woman, she exceeded the acceptable limits for total aspirate;

- Though she had the capacity to keep this patient overnight, she was discharged to the care of an elderly husband in an unacceptable state, when she should have been monitored in a medical setting;

- In managing follow-up complications, Dr. Yazdanfar failed to give the patient appropriate advice upon receipt of a significantly abnormal ECG. Ms Mendelson should have been directed to go to the ER as soon as her ECG report was seen by Dr. Yazdanfar.

Patients in Cosmetic Practice from 2005 to 2007 (Section 75 Cases)

Dr. Yazdanfar demonstrated a lack of knowledge, skill or judgment in the following cases:

Ms ST

She carried out liposuction in combination with tummy tuck surgery (Dr. IA) on this patient who was morbidly obese (BMI>40) and on numerous medications. Dr. Yazdanfar agreed the BMI would increase risk "anecdotally" and proceeded, illustrating her cavalier approach to consequences. The patient was ASA 3, which is above what is normally accepted in an ambulatory facility. Dr. Yazdanfar offered that Dr. C did not discuss the ASA 3 with her. The Committee did not agree that this fact relieved her of responsibility. She should have known from her pre-operative assessment that this patient was unsuitable for large volume liposuction in her clinic;

Mr. RZ

Dr. Yazdanfar erred in judgment in a particularly egregious manner when:

- She performed a very large liposuction procedure on this patient contrary to the standard of practice in Ontario. In removing an amount of total aspirate of 9525cc's (6175cc's of fat), she placed this patient at risk of serious complications. This procedure was frankly dangerous;

- She did not monitor him overnight and discharged him to a taxi; and,

- In performing the procedure she did, Dr. Yazdanfar ignored even the AACS guidelines which she professed to follow and specifically warn against such large procedures outside of a hospital without appropriate safeguards

The Committee is of the view that this showed a flagrant disregard for the patient and is totally unacceptable practice.

Mr. TC

The Committee finds that Dr. Yazdanfar exhibited a lack of judgment in her liposuction treatment of this patient:

- She did a large procedure from a number of sites (breasts, love handles, abdomen and lower back). He had 9400cc's of total aspirate and 5875cc's of fat removed, which exceeds the volume guidelines that this Committee accepts apply in Ontario, and even the more liberal AACS guidelines which Dr. Yazdanfar professed to follow;

- She decided to do this procedure at her facility knowing he was morbidly obese and that he was at increased risk of many complications;

- In this case, her lack of judgment spanned the pre-operative, operative and post-operative care she provided. Not only was he a poor candidate for an ambulatory facility, the amount of aspirate removed was excessive and he was discharged the same day.

Mr. PK

The Committee finds that Dr. Yazdanfar demonstrated a lack of judgment in the care she provided to this patient:

- She performed two large volume liposuction procedures both exceeding acceptable volume guidelines. One of the procedures exceeded even the AACS guidelines that she professed to follow;

- She ignored the co-morbidity of this patient, his BMI of 35, and failed to adjust the volume removed downwards; and,

- Mr. PK was discharged both times by taxi. Even though he was kept for over five hours in recovery and Dr. Yazdanfar said they wanted him to stay, she had an obligation to ensure the patient understood this was against medical advice and to document this, and she did not.

Ms CX and Ms DW

In regard to these two patients, the Committee finds Dr. Yazdanfar to have displayed a lack of knowledge, skill or judgment:

- Ms CX exhibited co-morbidities and nonetheless was subject to large volume liposuction in excess of accepted standards; and

- These patients were discharged to the care of one another by taxi. This was unsafe practice. Dr. Yazdanfar felt this was a special case and she was a phone call away. The manner of discharge was preplanned and accepted by Dr. Yazdanfar. In the opinion of the Committee, this was an inexcusable lack of judgment which impacted the safety of both patients.

Mr. PC

The Committee finds that Dr. Yazdanfar demonstrated a significant lack of judgment in her care and treatment of this patient:

- She performed large volume liposuction and removed 8100cc's of total aspirate (5500cc's fat) in this patient who had a history of labile hypertension and asthma (ASA 3);

- In performing this large volume liposuction, Dr. Yazdanfar breached the standard of practice in Ontario, demonstrated disregard for the patient and exceeded the AACS guidelines which she professed to follow;

- This was unsafe to do at her facility and she did not monitor him overnight.

The errors in judgment spanned this patient's pre-operative, operative and post-operative care, as he was an unsuitable candidate, had an excessively large procedure and was discharged inappropriately.

Ms FT

The Committee finds that Dr. Yazdanfar demonstrated a lack of knowledge, skill or judgment in her treatment of this patient:

- She performed liposuction removing 7200cc's of total aspirate (4650cc's of fat), which exceeded acceptable volume guidelines. She failed to modify the volume removed based on this patient's co-morbidities, which included obesity, hypertension and a smoker with an ASA 3;

- She failed to monitor the patient overnight after doing surgery of this magnitude in the TCC setting and discharged her patient the same day.

The following additional cases illustrate the pervasive nature of the excessive amounts of fluid removed during liposuction by Dr. Yazdanfar and her failure to monitor overnight: Ms MP; Ms ZX; Ms AJ; Ms EF; Ms KO; Ms SJ; Ms JR; Ms PR; Ms LV; and Ms EK.

In regard to her practice of liposuction generally including all of the above patients:

Dr. Yazdanfar‘s most consistent errors were those of judgment.

She failed to adhere to the standard of practice regarding aspirate volume limit in liposuction in Ontario. She exceeded the volume of total aspirate limit, which the Committee found to be the standard of practice in Ontario.

Dr. Yazdanfar did not consider the limits of her knowledge and training and did not take this into account when deciding to perform large volume liposuction, which is a major surgery, in high risk patients. It was clear that she knew this was a point of vulnerability, and that liposuction was potentially dangerous, yet she still did not limit the magnitude of the procedures she performed. Dr. Yazdanfar demonstrated a lack of knowledge, skill and judgment in managing a critically ill patient in the post-operative period.

The Committee has no doubt that Dr. Yazdanfar acquired technical skill in liposuction. However, she has failed to exercise that skill in a reasonable manner.

Breast Augmentation Cases

Ms QR

The Committee finds that Dr. Yazdanfar displayed a lack of knowledge, skill or judgment in her care and treatment of Ms QR:

- In failing to discuss the options for surgery which were appropriate (mastopexy, mastopexy and augmentation and augmentation alone);

- In failing to inform the patient that she did not perform mastopexy;

- In failing to discuss the risks associated with selecting a large and heavy implant size;

- In failing to inform the patient that capsulotomy was an option when capsular contracture developed;

- By suggesting smaller implants in the same pocket which was not an acceptable standard of care in the circumstances.

Ms WX

The Committee finds that Dr. Yazdanfar displayed a lack of knowledge, skill or judgment in her care and treatment of Ms WX:

- In failing to recognize that this was a complicated case exhibiting a serious deformity which was beyond her ability to deal with;

- In failing to explain that there were many treatment options and that some of her deformity could not be corrected;

- In selecting and using large implants which increased the risk of future complications and failing to advise that implant migration was a potential problem, among others.

The Committee concluded that, in performing surgery on this patient, Dr. Yazdanfar far exceeded her limitations. This placed her patient at risk of future complications and is unacceptable care. The lack of judgment displayed is fundamental and speaks to overconfidence and a failure to appreciate her professional responsibility.

Breast augmentation cases in general

The Committee was satisfied that Dr. Yazdanfar had acquired skill in performing breast augmentation. However, this technical skill is limited. Dr. Yazdanfar lacks knowledge and judgment in the diagnosis, management options and treatment of post-operative problems facing complex breast patients, as demonstrated by the cases of Ms QR and Ms WX.

b) Is the lack of knowledge, skill or judgment of such a nature or to an extent that Dr. Yazdanfar should not be permitted to practise or that her practice should be restricted?

Seriousness of the misconduct

The performance of liposuction can endanger patients' lives when accepted standards are exceeded. To expose patients to unacceptable risks for an elective procedure is inconsistent with acceptable practice.

Dr. Yazdanfar exceeded volume standards on patients and, in some cases, in a reckless and unrestrained manner, as with the Mr. RZ case.

Dr. Yazdanfar sought to justify her actions in removing the amounts she did. Her testimony demonstrated to the Committee that she either does not understand or accept reasonable limits, or the standard of practice.

Dr. Yazdanfar performed large volume liposuction in patients unsuitable for this procedure and exceeded reasonable volume limits in patients with co-morbidity. This reflects a serious lack of judgment and a serious disregard for patient safety.

Dr. Yazdanfar did not adhere to standards applicable in Ontario. Rather, she exhibited a fixed view on the liberal guidelines of the AACS, which do not reflect the standard in Ontario. Despite her professed adherence to these guidelines, she exceeded their volume guidelines in a number of cases.

There was no thought given to the serious consequences of the surgery she was carrying out and the need to have meaningful emergency guidelines in place. The Committee was dismayed to learn that the emergency manual in place at the time of the Stryland death was inappropriate, in that it contained irrelevant material adopted from another jurisdiction that did not meet the needs of her practice or her clinic.

In all of these respects, Dr. Yazdanfar engaged in dangerous practice. By doing so, she placed the lives of her patients in jeopardy. This is an abrogation of her professional responsibility and inconsistent with the principles of the profession.

Pattern of Care

When Dr. Yazdanfar commenced her liposuction practice in 2003, she was doing small volumes, limited sites and using local anesthesia. Over time, she extended the magnitude of the operations she was performing to the point that she was doing large volume liposuction on a frequent basis.

Dr. Yazdanfar was of the view that more is better and pushed the limits. This was not just a single occurrence. The Committee's findings of a lack of knowledge and judgment apply in a number of cases. She repeatedly did large volume liposuction in patients with co-morbidities. She did this not only on a number of different patients, but repeated procedures on the same patient.

Standing by and failing to call 911 when appropriate in the Krista Stryland case demonstrated that she was not up to the task of caring for this critically ill patient. Her testimony at the hearing demonstrated that she lacked insight into her deficiencies. The nature and the extent of the lack of knowledge and judgment was such that the Committee concluded that she is unfit to practise or that her practice should be restricted.

c) Has Dr. Yazdanfar demonstrated that she has gained insight and addressed the deficiencies noted?

The Committee is aware that to make a finding of incompetence, the lack of knowledge, skill or judgment displayed by the member must be current, that is to say that if the deficiencies have been corrected to the satisfaction of the Committee, a finding of incompetence should not be made. The Committee must take into account what has happened but must also take into account post event insight and correction of deficiencies to determine whether the member is incompetent.

The Committee notes the following changes which Dr. Yazdanfar had undertaken in her practice up to the time of the s.37 order:

- Following September 2007, there was modification of the consent forms with the addition of embolic phenomena, and unforeseen events, which could lead to hospitalization, even ICU admission;

- Serious risks, such as cardiac events, are specifically noted, as is the risk of death following liposuction;

- In regard to overnight stays, the following was added “If you wish, for remaining overnight or for us to provide overnight care, please notify us in advance, and we can arrange this. A fee will be charged for this service”;

- It is required that pre and post-operative instruction sheets are signed, confirming they have been received;

- Faced with an abnormal ECG, as in the Mendelson case, Dr. Yazdanfar has indicated she would send such a patient directly to hospital;

- After the death of Krista Stryland, the anesthesiologist must record the first vital signs in the RR and forms have been modified to correspond;

- There has been a change in the Emergency Procedures Book. This was examined 25-9-2008 and approved by inspectors from the College; and,

- Marcaine has been removed from use in breast augmentation cases.

Has Dr. Yazdanfar demonstrated that she has gained insight?

Dr. Yazdanfar failed to consider that she was performing inappropriate surgery when, even after the death of Ms Stryland, she continued to do large volume procedures (Ms KO September 22, 2007; Mr. PC September 22, 2007).

Dr. Yazdanfar denied any responsibility for the death of Ms Stryland, who succumbed from the complications of liposuction surgery and failed resuscitation. This denial persisted throughout these proceedings to the extent that she claimed that her contribution was nothing more than the fact she accepted her as a patient in the first place.

Dr. Yazdanfar testified that her skills in management in regard to liposuction are the equivalent of a six year surgical resident, which is unsupportable. Dr. Yazdanfar demonstrates an unjustifiable overconfidence with respect to her care of patients. She believes she has been unfairly attacked because she is not a plastic surgeon. The focus of the evidence has been on her deficiencies in knowledge and judgment as a physician and not because she is not qualified as a plastic surgeon.

Dr. Yazdanfar maintains her belief that removal of 5000cc's of fat is safe. She testified that, if the College directed her to, she would do smaller volumes and repeat procedures, not because of patient safety but because she believes she is vulnerable to attack if a complication occurs, as she is not a certified plastic surgeon. She refused to consider her training to be insufficient in the management of complications.

Dr. Yazdanfar had no hesitation in accepting breast cases which were complicated, and in offering an incomplete range of options. She offered approaches to management of difficult post-operative complications exceeding her limited expertise.

She still does not believe that patients having large volume liposuction need overnight monitoring in a professional setting after surgery. Her current forms offer this as an option of convenience for patients.

The Committee considered the above factors and has determined that Dr. Yazdanfar has developed little insight into her deficiencies.

Responsibility

The Committee determined that Dr. Yazdanfar shared responsibility for the care of Krista Stryland with her anesthesiologist in her practice setting. The surgeon and the anesthesiologist needed to work as a team and did not. Simply put, Dr. Yazdanfar did not know what to do because she had insufficient training or expertise in managing such crises.

Dr. Yazdanfar appeared to have learned little and still maintains the validity of her views with respect to large volume liposuction guidelines and that 5000cc of fat is safe for her to remove. This Committee has concluded that she removed unsafe volumes from patients and continued to do so even after the death of her patient from complications of liposuction surgery. She holds a fixed view that the AACS guidelines are the only ones that are relevant to her practice, yet she has exceeded these guidelines repeatedly in removing larger volumes than even they support. She failed to see beyond the AACS, determined that she was right, and refused to seek or respect the volume limits accepted as the standard of practice in Ontario.

By the nature and extent of her lack of knowledge, skill and judgment, engaging in dangerous practices which jeopardized the health of patients and demonstrating a lack of insight and responsibility as noted above, this Committee finds the allegation of incompetence is proved.

CONCLUSIONS

A summary of the findings made is as follows.

PROFESSIONAL MISCONDUCT

In respect of the patient Krista Stryland

The Committee finds that Dr. Yazdanfar failed to maintain the standard of practice:

- in her performance of liposuction;
- in her post-operative care and treatment; and,
- in her record keeping.

The Committee finds that Dr. Yazdanfar engaged in unprofessional conduct:

- in commencing liposuction on another patient while Ms Stryland was unstable and/or failing to abort the liposuction on the other patient after learning of Ms Stryland's unstable and/or deteriorating condition; and,
- in knowingly breaching the acceptable standards of practice with respect to her performance of liposuction

[Notice of Hearing, Schedule A, paras. 3(b) and (c) and 4(a) and (c)]

In respect of the patient Francine Mendelson

The Committee finds that Dr. Yazdanfar failed to maintain the standard of practice:

- in her failure to obtain informed consent;
- in her performance of liposuction; and,
- in her post-operative care and treatment including her discharge arrangements.

The Committee finds that Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct:

- in knowingly breaching the acceptable standards of practice with respect to her performance of liposuction.

[Notice of Hearing, Schedule A, paras. 6(b), (d) and (e) and 7(a)]

In respect of the patient Ms MP

The Committee finds that Dr. Yazdanfar failed to maintain the standard of practice:

- in performance of liposuction; and,
- in post-operative care and treatment.

The Committee finds that Dr. Yazdanfar engaged in unprofessional conduct:

- in knowingly breaching the acceptable standards of practice with respect to her performance of liposuction.

[Notice of Hearing, Schedule A, paras. 9(b) and (d) and 10(a)]

In respect of the patient Ms QR

The Committee finds that Dr. Yazdanfar failed to maintain the standard of practice and engaged in unprofessional conduct:

- in failing to obtain informed consent
- in failing to provide the patient with a proper choice of procedures;
- in failing to advise the patient that she did not perform one of the requested procedures;
- in failing to adequately advise the patient of increased complications with increased implant size;

- in failing to select, assist the patient in selecting and failing to take responsibility for selection of appropriate implant size; and,
- in offering an inappropriate manner of correcting the first operation (using smaller implants in the same pocket).

[Notice of Hearing, Schedule C, paras. 3(a), (b), (c), (e), (f), (i)]

In respect of the patient Ms WX

The Committee finds that Dr. Yazdanfar failed to maintain the standard of practice and engaged in unprofessional conduct:

- in failing to obtain informed consent;
- in failing to formulate an appropriate treatment plan, in that she failed to adequately advise about and explore all possible options for dealing with the patient's presenting complaint;
- in failing to advise the patient of increased complications with increased implant size;
- in failing to select, assist the patient in selecting, and failing to take responsibility for selection of the appropriate implant size;
- in failing to make appropriate treatment decisions and recommendations; and,
- in failing to recognize and appropriately manage complications.

[Notice of Hearing, Schedule C, paras. 6(a), (b), (c), (d), (g), (h)]

In respect of patients in her cosmetic surgery practice from 2005-2007 (s.75 cases)

The Committee finds that Dr. Yazdanfar failed to maintain the standard of practice:

- in the performance liposuction, including performance of liposuction in combination with other procedures;

- in her engagement as a co-surgeon in the combination of liposuction and abdominoplasty;
- in her pre-operative evaluations;
- in failing to obtain informed consent in the patients with co-morbidities;
- in her post-operative care and treatment.

The Committee finds that Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct:

- in knowingly breaching acceptable standards in her performance of liposuction.

[Notice of Hearing, Schedule B, paras. 2(a), (b), (c), (d), (f) and 3(b)]

ADVERTISING

The Committee finds that Dr. Yazdanfar contravened Ontario Regulation 114/94 made under *the Medicine Act, 1991* through posting advertising on the Toronto Cosmetic Clinic website, which is misleading or deceptive and which contains testimonials and/or superlative statements about her cosmetic practice.

The Committee finds Dr. Yazdanfar engaged in disgraceful, dishonourable or unprofessional conduct through posting advertising on the Toronto Cosmetic Clinic website, which is misleading or deceptive and which contains testimonials and/or superlative statements about her cosmetic practice.

[Notice of Hearing, allegation 2, Schedule B, para. 4]

INCOMPETENCE

The Committee finds the allegation of incompetence is proved.

The Committee directs that the Hearings Office make arrangements for a penalty hearing.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Behnaz Yazdanfar, this is notice that the Discipline Committee ordered that there shall be a ban on the publication of the name or identity or any information that could disclose the identity of the patients whose names were disclosed at the hearing, or in the documents filed at the hearing, except for the names of Ms Krista Stryland or Ms Francine Mendelson, pursuant to 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: Yazdanfar, B. (Re)

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

IN THE MATTER OF a Hearing directed by the Complaints Committee, the Executive Committee and the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Sections 26(2), 36(1), and 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***, S.O. 1991, c.18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. BEHNAZ YAZDANFAR

PANEL MEMBERS:

DR. M. DAVIE (Chair)
S. DAVIS
DR. P. CHART
S. BERI
DR. P. TADROS

Hearing Dates:	August 29 and 30, 2011
Decision Date:	December 21, 2011
Release of Written Reasons:	December 21, 2011

PUBLICATION BAN

PENALTY AND REASONS FOR PENALTY

The Discipline Committee of the College of Physicians and Surgeons (the "Committee") heard this matter over sixty-eight days at Toronto on: July 13 to 17, 22 to 24, September 14 to 16, 18, 21, 22, 30, October 1, 2, November 2 to 6, 9 to 12, 18, 23, 24, 26, 27, 30 and December 1, 2, 9 to 11, 2009; January 11, 12, 20 to 22, February 8, 17, 18, 22, 23, March 1 to 4, 22, 23, 25, 30, 31, April 12 to 16, 20, June 7 to 10 and July 21 and 22, 2010. At the conclusion of the hearing, the Committee reserved its decision on finding.

On May 4, 2011, the Committee delivered its written decision and reasons which sets out its finding that Dr. Behnaz Yazdanfar has committed an act of professional misconduct, in that she failed to maintain the standard of practice of the profession; she contravened the advertising regulation; and she engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Discipline Committee also found that Dr. Yazdanfar is incompetent.

The Committee heard evidence and submissions on penalty and costs on August 29 and 30, 2011, and reserved its decision.

EVIDENCE AND SUBMISSIONS ON PENALTY

A. Evidence

The Committee received victim impact statements from Krista Stryland's family, Mr. AB, Dr. AC, Ms QR, Ms WX and Ms MP. In addition, the Committee received a report on compliance monitoring of Dr. Yazdanfar's practice done by the College, dated August 18, 2010.

The Committee also heard testimony from three witnesses which is summarized as follows:

Mr. LW

Mr. LW testified that he was born in the Middle East and moved to Canada around 1998. He owns a real estate brokerage company which serves the Middle Eastern community. Dr. Yazdanfar was his family's doctor until she changed her practice to cosmetic surgery. They were among the last patients in her family practice. He testified that Dr. Yazdanfar was truly caring and was the best family doctor that the family ever had.

Under cross examination, Mr. LW agreed that he had not read the findings made by the Committee in respect of Dr. Yazdanfar's conduct. Counsel for the College questioned Mr. LW regarding his expectations of a family doctor for patient safety, respect for limitations in expertise and the exercise of good judgment. While he agreed that a physician not practising with regard for such matters would not meet his expectations, this description did not equate to the Dr. Yazdanfar he knew.

It was clear to the Committee that this witness held Dr. Yazdanfar in high regard as a family physician. His evidence was credible but was of limited assistance to the Committee as his relationship with Dr. Yazdanfar was dated and his knowledge of the current matter was limited.

Ms TX

Ms TX testified that she is a Ph.D student. Her field of interest is eye movement in children. In this capacity she works with physicians. Ms TX first met Dr. Yazdanfar in 2003 through friends. On one occasion, she called Dr. Yazdanfar seeking advice regarding her son. She testified that Dr. Yazdanfar saw him and described her as calming, attentive, compassionate and able to establish instant rapport.

Ms TX testified that she did not expect doctors to be able to know everything but to be receptive to new information. On cross examination, she agreed that she would expect physicians to know the limits of their expertise, to value patient safety above all and to take responsibility for their actions.

Ms TX has been a close friend of Dr. Yazdanfar since 2007 and is aware of the current proceedings. Her opinion of Dr. Yazdanfar is that she exhibits humility and not a know-it-all attitude. She has not read the details of this case.

The Committee accepts the evidence of this witness as truthful. Her description of Dr. Yazdanfar attests to their friendship and Dr. Yazdanfar's character.

Ms PQ

Ms PQ testified that she was born in the Middle East and came to Canada in the late 1980's. She met Dr. Yazdanfar ten years ago. She described the current relationship as close, like family. The two families share children's activities, social activities and community events.

Ms PQ described Dr. Yazdanfar as caring, compassionate and attentive, with the ability to communicate well with others of all ages. She was aware back in 2001 of the change in Dr. Yazdanfar's practice from family practice to cosmetic surgery; Dr. Yazdanfar was absent at times because of studying. Dr. Yazdanfar appeared excited and focused when applying for a change in scope. In 2007, after the death of Krista Stryland, she described Dr. Yazdanfar as being devastated. She became withdrawn and upset but she has coped with the help of friends. She had no one-on-one conversation about the Stryland death with Dr. Yazdanfar and found it hard to fathom.

Ms PQ agreed in cross examination that she had no knowledge of Dr. Yazdanfar's medical practice. Ms PQ has not read the decision but is aware of the findings that were made by the Committee, though not the specifics.

The Committee accepted the evidence of this witness as credible. Her evidence reflects the close family-like relationship they had and the loyalty which appeared sincerely felt. While this evidence relates to character, it has limited relevance to the medical practice setting and the findings made by this Committee.

B. Submissions

The College submits that revocation of Dr. Yazdanfar's certificate of registration is the appropriate penalty in this matter, given the very serious nature of the findings. The College asks also for a reprimand and costs.

The College cites the findings of the Committee of serious disregard of patient safety, failure to uphold the core values of the profession, inappropriate use of her technical skill, lack of knowledge and a failure to apply the knowledge she had, lack of managerial leadership, lack of responsibility and accountability, lack of insight and a fundamental lack in judgment. The College notes the undermining of public confidence in the profession and the effect on the honour and reputation of the profession, which is a consequence of such conduct. It is the position of the College that revocation is the only way that public protection can be achieved.

Dr. Yazdanfar's counsel contends that revocation is out of keeping with the circumstances of this case and the case law. She submitted that this is not the most serious of cases. Defence counsel submits that the appropriate penalty is a continuation of the interim order of May 26, 2010, which permits Dr. Yazdanfar to practice as a surgical assistant and to perform some preoperative and post operative care under specified conditions.

Counsel for Dr. Yazdanfar maintains this matter relates only to the performance of cosmetic surgery. This is the first time Dr. Yazdanfar had a finding made against her by the Discipline Committee, and she has otherwise a clean professional record in the almost fifteen years she has been in practice. Counsel for Dr. Yazdanfar asserted that the member has a right to make a full and fair defence and her denial of the allegations should not be used to increase the harshness of the penalty. The defence cites the lack of requirements in 2002 for those performing cosmetic surgery and notes that Dr. Yazdanfar sought and was approved by the College for a change in scope for her breast augmentation procedure. The defence submitted that Dr. Yazdanfar has cooperated with

the College and has been compliant with the interim order. Witnesses for the defence have characterized Dr. Yazdanfar as caring and compassionate.

It was submitted on behalf of Dr. Yazdanfar that the previous restrictions under the s. 37 interim order, as amended by the Committee on March 4, 2010, address any issue of patient safety.

DECISION AND REASONS ON PENALTY

A. The Law and General Principles of Penalty Decisions

Section 51 (2) of the Health Professions Procedural Code ("the Code") states:

> If a panel finds a member has committed an act of professional misconduct, it may make an order doing any one or more of the following:
>
> 1. Directing the Registrar to revoke the member's certificate of registration
>
> 2. Directing the Registrar to suspend the member's certificate of registration for a specified period of time
>
> 3. Directing the Registrar to impose specified terms, conditions or limitations on the member's certificate for a specified or indefinite period of time
>
> 4. Requiring the member to appear before the panel to be reprimanded
>
> 5. Requiring the member to pay a fine of not more than $35,000.00 to the Minister of Finance

Section 52 (2) of the Code states:

> If a panel finds a member is incompetent, it may make an order doing any one or more of the following:

1. Directing the Registrar to revoke the member's certificate of registration
2. Directing the Registrar to suspend the member's certificate of registration
3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified period of time or indefinite period of time

It is clear to the Committee that the penalty must be proportionate to the findings made. In addition, there are a number of established general principles which the Committee must follow when determining the appropriate penalty. These principles include protection of the public, maintenance of the integrity of the profession and the College's ability to govern the profession, denunciation of the conduct, specific and general deterrence, maintenance of the public trust and rehabilitation. These principles often overlap and apply in whole or in part, with appropriate weight determined by the individual circumstances of each case.

In this matter the paramount consideration is protection of the public. In this respect, the parties are in agreement, though their respective positions vary.

The Committee is of the view that protection of the public requires maintenance of the public trust and preserving the integrity of the profession. Inherent to maintaining the public trust is denunciation of serious misconduct and a clear direction that such conduct will not be tolerated.

The Committee had regard for *Bolton v. Law Society,* [1994] 2 All E.R. 46(C.A.) at page 492 para. *f*, where the following comments are made in addressing the purpose of the penalty, which equally apply to the medical profession:

> *The second purpose is the most fundamental of all: to maintain the reputation of the solicitor's profession as one in which every member, of whatever standing, may be trusted to the ends of the earth.*

And para. *g*:

> *All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness.*

The Committee also notes the words of the Divisional Court in the case of *Moore v. The College of Physicians and Surgeons of Ontario*, [2003] O.J. No. 5200 at para 7, also quoted in *Sazant v. College of Physicians and Surgeons of Ontario*, [2011] O.J. No. 192:

> *In our view, the sentencing process involves a balancing of various factors with the protection of the public being the guiding principle. These factors include general and specific deterrence, proportionality, as well as the need for the College of Physicians and Surgeons to maintain its credibility in the community and with its members as a self-governing body.*

Furthermore, the Committee had regard for the words of the Discipline Committee in the 2010 reinstatement application hearing of *Gillen (Re)*, [2010] O.C.P.S.D. No 14, addressing the expectations of a self-regulating body at page 37 para. 237:

> *That responsibility includes not only maintaining public safety but also the confidence of the public in the medical profession. The two go hand-in-hand. If the public does not have confidence and trust that the College is maintaining standards of professionalism, integrity, and quality, then public safety is also compromised.*

B. Factors Considered by the Discipline Committee

In this matter, achieving a just and fair penalty determination requires consideration of the findings, the evidence admitted in both phases of the hearing, and the submissions of counsel on the facts and the law. The seriousness of the misconduct and the impact of the misconduct are both relevant issues. The Committee further examined the issue of revocation and the types of conduct that would support such a penalty. The Committee

had regard for the circumstances in which the conduct arose. Finally, the Committee looked to the issue of public trust.

The Committee sets out its decision and reasons in this matter as follows:

(a) Nature of the Misconduct/Incompetence

The seriousness of the conduct in this matter is set out in detail by the Committee in its findings and reasons. In addition, the Committee makes the following comments:

Professional Responsibility

Dr. Yazdanfar did not exhibit an understanding of the limits of her training or how this should have influenced the care she provided. She did not accept that her training was limited. She proceeded to do major surgery when she had neither the knowledge nor experience to recognize or properly treat complications. The Committee was shocked to hear her equating her experience with a six year residency program. She ventured down another pathway, believing either that she would not run into serious complications or that she was capable of handling them. Her lack of knowledge/and or ability and her faulty judgment ended in tragic consequences with the death of Krista Stryland. In failing to observe appropriate limits, she violated her professional responsibility by treating not just one but many patients in an unsafe manner.

The Committee was particularly troubled by Dr. Yazdanfar's failure to take responsibility for her actions. Dr. Yazdanfar shifted blame in the Stryland matter to Dr. C and her recovery room nurse while ignoring her personal responsibility. Dr. Yazdanfar made her patients responsible for the implant size in the cases where she could have but did not give them appropriate advice. Her fixed view that the AACS guidelines are the ones appropriate for her practice, with no regard for what is done or the standard in Ontario, shows a fundamental disregard of her obligations.

Standard of Practice

Dr. Yazdanfar's failure to limit her practice appropriately led to her failure to maintain the standard of practice. By exceeding safe volume limits in her liposuction procedures, Dr. Yazdanfar put the lives of her patients at risk. She removed volumes of aspirate in the performance of liposuction far beyond what surgeons acting properly would do in a comparable setting. From the evidence, it was clear that large excessive procedures were frequently done, and in some cases repeatedly on the same patient. This pattern of disregard of basic patient safety is troubling for the Committee, as Dr. Yazdanfar could have restrained herself and she did not.

Dr. Yazdanfar's failure was not limited to volumes alone. She failed to safely discharge patients in a number of ways, which not only breached the standard of practice but was inexcusable. She performed procedures on some patients who were unsuitable candidates. While she had acquired technical skill in performing breast augmentation, she failed to maintain the standard of practice in diagnosis and treatment when she failed to recognize the complexity of the case of Ms WX and supported the use of implants that were too large, and when she did not provide Ms QR with sufficient information to make an informed choice. These cases are but examples but they illustrate errors, both of omission and commission. Dr. Yazdanfar had the opportunity to act in the patient's interest and she did not.

Dr. Yazdanfar exhibited credulousness and overconfidence. No doubt she was influenced by the views of individuals in the USA where she sought training. She appeared to be swept up by unwarranted enthusiasm and honestly held the erroneous belief that she had the requisite ability. This does not, however, relieve her from the responsibility of knowing and practising within the limits adhered to by those doing liposuction in Ontario.

By her serious and repeated failure to maintain the standard of practice, Dr. Yazdanfar did not observe her paramount responsibility as a physician to respect patient safety.

Incompetence

The seriousness of Dr. Yazdanfar's conduct is illustrated by her lack of knowledge and judgment. Her limited knowledge and her proposed treatment of complex breast problems in the cases of Ms QR and Ms WX demonstrate why years of residency learning are required to make appropriate judgments in complex situations. Dr. Yazdanfar's lack of knowledge and judgment are most obvious in the care she provided to Krista Stryland. In performing too large a procedure, in failing to act when she should have, in doing a token examination and in giving no thought to a differential diagnosis, Dr. Yazdanfar failed this patient in the most fundamental way.

Dr. Yazdanfar's lack of judgment was clear in the evidence before the Committee throughout the hearing. She operated on patients who should have had their procedures done in hospital. She did larger operations than she should have done. She discharged patients inappropriately. These errors in judgment spanned her practice and were not isolated events.

Dr.Yazdanfar failed to reflect appropriately on what she was doing following the death of Ms Stryland, as demonstrated by her performing excessive liposuction procedures on other patients several days later. Her statement that she believes that it is safe for her to remove 5 litres of fat, and her failure to acknowledge any responsibility, speaks to a lack of insight. This lack of insight and understanding is essential in making a finding of incompetence. In this matter, there was no demonstration that Dr. Yazdanfar had acquired insight to any significant degree.

The Committee respected Dr. Yazdanfar's right to deny the allegations made against her and this fact has no bearing on its penalty decision.

The pattern of behaviour and its extent as reflected in the finding of incompetence speaks to the need for significant sanction.

Role as Manager/Administrative Role

Dr. Yazdanfar's lack of professional responsibility was clear when she ignored the law when advertising her clinic. Her misleading advertising of Smartlipo and the way she performed it was found by the Committee as having the purpose of achieving competitive commercial advantage or personal gain, without putting the interest of the patient foremost.

Her use of an emergency manual which was not appropriate for her clinic was unsupportable.

The Committee carefully considered all of the above and concluded that to achieve proportionality in this matter requires a serious penalty sanction. To adequately address the findings made, the Committee concluded that only revocation or a lengthy suspension together with strict terms, conditions and limitations would suffice to meet the proportionality test.

(b) Impact

The Committee acknowledges that the conduct described above can and did have profound and tragic results.

The description of the impact of Krista Stryland's untimely death on her family and her young son is particularly moving. The struggle to maintain their family unit was challenged by colliding emotions.

In the family's words:

> *The horrific events that occurred on the day of Krista's death haunt us to this day.*

And,

> *That we have survived as a family unit is surprising. It is a testimony to the immensity of the loss we share, our fervent determination to hold together, and*

> *the deep-seated knowledge that this is what Krista would have expected from us.*

In the words of Mr. AB:

> *To lose ones friend and mother of my child, has been incredibly difficult for me; but not nearly as difficult as sitting down and looking my son in the eye and telling him his mother is dead. To try to explain to my son, that it isn't his fault that mommy is gone, and to try to explain why she died is something I hope no other parent would have to do.*
>
> *There isn't a day that goes by that I don't think about what happened to Krista. I constantly cycle through feelings of anger, sadness and frustration.*

The impact of Francine Mendelson's experience following liposuction on her daughter was significant.

Dr. AC stated:

> *I am still haunted by the first night post-op I spent with my mom after my dad called me, hysterical about the volume of bodily fluids that were coming from her incisions. I stayed up the entire night, rebandaging her incisions every hour with absorbent maxi pads to keep up with the fluid losses. As a veterinarian, I couldn't imagine how a human doctor could possibly discharge a patient in this state.*

The undermining of trust in the profession is illustrated by the following statements made by,

Ms QR:

> *Since my experience with Dr. Yazdanfar I have a marked loss of faith in the medical field as a whole. I live in fear of myself and my loved ones having to access a specialist for any reason. My scepticism about physician's qualifications leads to countless hours of research which does little to alleviate my anxiety.*

I will suffer an illness and research my symptoms on the internet rather than access the expertise I know is out there, because I'm uncertain who I can trust to have the credentials they claim to have.

Ms WX:

In 2003 I was catastrophically injured in an MVA. 2yrs and 2 dozen surgeries later I was in the best shape of my life. My faith in the medical community and its health care practitioners was strong.

After my experiences with Dr. Yazdanfar I struggle to trust my Dr.s and their advice.

Ms MP:

I no longer "trust" doctors in the innocent sense of the word. I will never go to any doctor for any mild treatment and instead endure pain and make personal attempts at natural home remedies.

c) Revocation

The Committee was mindful of the comments of the Divisional Court in *The College of Physicians and Surgeons of Ontario v. Boodoosingh* (1990), in the words of Justice Montgomery:

that the penalty of revocation should be reserved for repeat offenders and the most serious cases.

The Committee notes as well the description by Steinecke, in *A Complete Guide to the Regulated Health Professions Act, October 2010,* at page 6-120, that:

While no exhaustive list of cases warranting revocation can be drawn up, the order will usually only be made in cases involving premeditation, exploitation of a vulnerable person, dishonesty or lack of integrity or where the member is otherwise not suitable to remain a member of the profession.

The Committee accepts that revocation is an appropriate sanction in situations where conduct is found to be of a most serious nature. This is usually the case in certain types of serious sexual abuse and fraud, but revocation may also be appropriate for serious clinical misconduct, in cases with no redeeming features, or general incompetence. The Committee was of the opinion that revocation, though the harshest sanction, is not "a death sentence" in a professional sense. There remains the possibility of application for reinstatement after one year.

In making the determination of an appropriate penalty in the matter before us, the Committee looked carefully at the case law cited by the parties and makes the following comments.

Serious sexual abuse, fraud, dishonesty and exploitation are undisputedly reasons for revocation of a member's certificate of registration.

The cases of *Wai Ping (Re),* [2004] O.C.P.S.D. No.33 and *Bacon (Re*) [2000] O.C.P.S.D. No. 16 relate to clinical activity which satisfied the most serious criterion and deserve particular attention.

In the *Wai Ping* matter, the Committee was faced with a specialist in obstetrics and gynaecology with enormous deficiencies in care affecting many patients. There was repeated serious disregard of fundamental principles of medicine across his practice, including lack of adherence to accepted guidelines. His range of deficiencies was wide and included surgical skill and judgment. His pattern of care is described by the discipline Committee in its reasons at para. 109 as follows:

> *The Committee was of the opinion based on all the findings that Dr. Wai Ping exhibited a pattern of care where serious errors in judgment occurred repeatedly, surgical procedures were done which were not indicated, medical management was not used when it was appropriate, there was a rush to a surgical solution with serious complications and results for patients that goes far beyond errors in judgment.*

In *Bacon*, the situation was of a family doctor who advertised as a general practitioner, restricting his practice to patients with ADD, ADHD, Epilepsy, Hyperactivity, Learning Problems and Sleep Disorders. The Committee found a failure to maintain proper documentation, to diagnose correctly, to use drugs appropriately and to follow the advice of specialists. In addition, he did inappropriate investigations and took inappropriate action on test results. Failure to diagnose and treat properly extended to general medical treatment as well.

In both *Wai Ping* and *Bacon*, revocation was ordered.

It was the view of the Committee that the misconduct in these cases reflected a general incompetence and was more egregious than the findings made in Dr. Yazdanfar's practice. This fact does not in any way diminish or understate the seriousness of the nature of the misconduct in the findings made against Dr. Yazdanfar, which were outlined earlier.

The Committee also had regard for the opinion of the Divisional Court in *Wilson v. College of Physicians and Surgeons of Ontario* [2003], 178 O.A.C. 268 (Div. Ct.). Dr. Wilson was a neurologist as well as a director of an EEG clinic. The Committee concluded that Dr. Wilson's lack of judgment and insight applied to all areas of his practice, and revoked his certificate of registration. The Court disagreed and reduced the penalty to a lengthy suspension and banned him for life from acting in the capacity of a medical director. Evidence had been produced during the hearing from respected peers in support of Dr. Wilson's fitness to practice as a neurologist.

None of the above cases are specifically comparable to Dr. Yazdanfar. However, they provide some context and assisted the Committee in making its determination.

The Appropriate Order

The circumstances in regard to the findings in this matter are unique. The seriousness of the misconduct and its impact on patients, the profession and the public is indisputable. The penalty imposed must be commensurate.

In view of the very serious nature of the findings and the widespread impact, the Committee has concluded the appropriate penalty to ensure protection of the public is a two year suspension and restrictive terms that prevent Dr. Yazdanfar from practicing as a cosmetic surgeon on a going forward basis.

On the evidence, the Committee concluded that a long term suspension together with strict terms, conditions and limitations on Dr. Yazdanfar's certificate of registration is more appropriate than revocation, which was seriously considered. The following factors were considered relevant to the conclusion reached:

- This is the first time Dr. Yazdanfar has been before the Discipline Committee. The Committee recognizes that Dr. Yazdanfar is at a relatively early stage in her career, and though she has made truly serious errors, there is a reasonable potential of rehabilitation;

- There was no evidence to suggest that she was not technically proficient in performing some surgical procedures. The Committee accepted that she has acquired limited technical skill;

- Dr. Yazdanfar was qualified in family medicine and formerly was a member of the College of Family Practice. While Dr. Yazdanfar chose to limit her practice to cosmetic surgery and there was no evidence that Dr. Yazdanfar intends returning to family medicine, the Committee is of the view that her qualifications should not be dismissed;

- Dr. Yazdanfar sought a change in scope for her breast augmentation practice, which suggested to the Committee a degree of compliance with College Policy; and

- Dr. Yazdanfar committed time and resources to furthering her education. This speaks to a commitment to and an interest in learning.

While the Committee heard some evidence that Dr. Yazdanfar was viewed as compassionate and caring by friends and a former patient, this was given little weight as the witnesses testifying were unaware of the findings of the Committee.

The Committee was also aware that at the relevant time there was a vacuum with respect to required qualifications for physicians to do liposuction surgery. Notwithstanding the circumstances of the time, Dr. Yazdanfar had the obligation to deliver safe patient care and this she failed to do.

(d) Terms, Conditions and Limitations

Surgical Assistant

The defence has asked that Dr. Yazdanfar be permitted to practise as a surgical assistant in a hospital based setting or free standing cosmetic facility provided that a member of the College of Physicians and Surgeons of Ontario who is approved by the College is performing the surgery and is in attendance.

The Committee agrees that the public is protected if Dr. Yazdanfar is permitted to surgically assist in a hospital based setting where there is appropriate oversight. In this context, she would have the opportunity to engage with a number of surgeons which would open the opportunity for her to re-establish with the core values of the profession. The Committee also had the evidence of Dr. K, who was of the opinion that Dr. Yazdanfar would be a good surgical assistant. The Committee is aware that Dr. Yazdanfar may find that acquiring such a position is not easy due to this case.

However, the Committee does not believe the public is adequately protected by permitting Dr. Yazdanfar to fulfil the surgical assistant role at private or freestanding cosmetic facilities. Regardless of the proposed oversight, this could provide opportunity for Dr. Yazdanfar to become emboldened with time and to move into a more dominant

role. This would be of particular concern if surgery were contemplated at a facility where she had a financial interest. In addition, the Committee notes, as stated in the *Wai Ping* matter, that there are no guidelines as to the extent of the role of a surgical assistant. This is usually decided by the most responsible qualified physician and is based often on the perceived expertise of the individual surgical assistant.

Pre-operative Care

Counsel for Dr. Yazdanfar requested that Dr. Yazdanfar be permitted to conduct pre-operative assessments of surgical patients, provided that the patients are under the care of and referred by surgeons approved by the College of Physicians and Surgeons of Ontario. Such pre-operative assessments are limited to taking a history and physical and ordering appropriate investigations.

The Committee disagrees. This Committee has found that Dr. Yazdanfar failed to maintain the standard of practice in her preoperative assessments in a number of cases (Ms ST, Mr. PC, Ms FT, Ms CX). The Committee was of the view that, as a result, Dr. Yazdanfar should not be in a position where her pre-operative assessment could or would be relied upon. Accepting such a condition would expose the public to risk when making the decision about whether a cosmetic procedure should be done in a freestanding/private facility or a hospital.

Post-Operative Care

Counsel for Dr. Yazdanfar requested that Dr. Yazdanfar be permitted to conduct post-operative assessments of surgical patients commencing two weeks post-operatively.

The Committee disagrees. This Committee has found that Dr. Yazdanfar has failed to maintain the standard of practice in her immediate post operative care (Stryland), short term care (Mendelson), and long term care (Ms WX, Ms QR). Dr. Yazdanfar lacks the knowledge required to recognize, diagnose and treat long term complications of cosmetic surgery appropriately. To permit her to do so exposes the public to unnecessary risk and is not supportable.

(e) Trust in the Medical Profession

Much has been said of trust that the public must have in the medical profession. This flows from the fundamental need of patients to trust the doctor they consult to inform them of the options and to treat them appropriately. This applies to those seeking cosmetic surgery just as it does to those who are ill.

The public should be assured that those holding a certificate of registration to practice medicine will act with honesty, integrity and within their area of expertise. A failure to do so is a fundamental breach of professional responsibility.

The impact of such behaviour on the trusting relationship of the public with the profession collectively, the regulatory body and individual hard working physicians cannot be underestimated. In the Committee's view, Dr. Yazdanfar's failure to practise within the limits of her expertise is simply intolerable.

(f) Reprimand

A reprimand in this matter is appropriate for the Committee to express directly to Dr. Yazdanfar its abhorrance of her conduct.

The Committee believes that the imposition of the terms in the Order below will satisfy the need for protection of the public. Dr. Yazdanfar is prohibited from performing any independent surgery. A number of regulatory changes have been made in the years subsequent to the death of Krista Stryland. The family and the public may take some comfort in knowing that there have been regulatory changes and that such circumstances should not arise again in the future.

ORDER

Therefore, the Discipline Committee orders and directs that:

1. The Registrar suspend Dr. Yazdanfar's certificate of registration for a period of two (2) years commencing on the date of this Order.

2. Dr. Yazdanfar appear before the Committee to be reprimanded, on a date to be fixed by the Committee which shall be no later than three (3) months from the date that this Order becomes final.

3. The following terms, conditions and limitations be imposed on Dr. Yazdanfar's certificate of registration for an indefinite period:

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

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

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

(d) Dr. Yazdanfar shall publish the terms, conditions and limitation imposed on her certificate of registration in any advertisement of her clinic where she is referred to, including on her website, and shall post signage of these restrictions in a form acceptable to the College in the Toronto Cosmetic Clinic or any other clinic owned by her.

ORDER AND REASONS ON COSTS

The Committee heard submissions on costs from both parties.

Section 53.1 of the Code provides:

> In an appropriate case, a panel may make an order requiring a member who the panel finds has committed an act of professional misconduct or finds to be incompetent to pay all or part of the following costs and expenses:
>
> 1. The College's legal costs and expenses
> 2. The College's costs and expenses incurred in investigating the matter
> 3. The College's costs and expenses incurred in conducting the hearing

Rule 14 of the Rules of Procedure of the Discipline provides:

> Rule 14.04 (1)
>
> A party requesting an order for costs or expenses shall, where practicable, deliver a detailed written explanation of the basis upon which the costs or expenses requested are calculated.
>
> Rule 14.04 (3)
>
> Where the request for costs or expenses includes the cost or expense to the College of conducting a day of hearing, no evidence of the cost or expense of a day of hearing is needed if the request is equal to or less than the amount set out in Tariff A.

Submissions

The College asks for $219,000.00 in costs. The College bases this request upon 60 hearing days at a per diem rate of $3650.00 (Tariff). The College does not ask for the full number of days (70), recognizing that not all of the allegations were proved.

The member does not dispute that this is a suitable case for costs, but submits that a lesser amount would be fair. Counsel for Dr. Yazdanfar submits that based on a 60% success rate for the College, that an amount equal to 39 hearing days at the tariff rate would strike the appropriate balance, of $142,350.00. Counsel for Dr. Yazdanfar submitted that days cancelled due to illness or half days should not be counted, and that the full number of hearing days is 65. Furthermore, counsel for Dr. Yazdanfar contends that she should not be punished for defending herself.

Decision

The Committee has determined that this matter is an appropriate case for costs. The Committee bases its conclusion on the following.

The nature of the misconduct and finding of incompetence was serious, involving patient safety and ignoring the tenets of the medical profession. The misconduct was repeat in nature and standards of practice were breached with many patients. The hearing was lengthy and prolonged.

The Committee reviewed the case law on costs which was helpful in guiding its decision. The comments of the Divisional Court in *Freedman v. Royal College of Dental Surgeons*, [2001] O.J. No.1726 (Div.Ct.) indicate that the conduct of the hearing and the facts of the case are relevant considerations. In addition, the Divisional Court in *Sazant v. College of Physicians and Surgeons of Ontario*, [2011] O.J. No. 192 (Div.Ct) notes that the repeat nature of the misconduct and the number of victims are factors to be considered (at para. 283).

In assessing quantum, the Committee is aware that the per diem tariff does not cover the actual costs of the College of a hearing day before the Discipline Committee. Furthermore, the costs requested did not include investigative costs, the costs of experts or the cost of legal preparation and attendance, all of which may be included in a costs order.

Costs awarded are inherently arbitrary but must be fair and reasonable, as noted in the Divisional Court ruling in *Chuang v. Royal College of Dental Surgeons of Ontario,* [2006] O.J. No. 2300 (Div. Ct.). The Court further notes:

> *The members of the Royal College of Dental Surgeons should not be liable for the costs of guilty members. However, members should not be liable for the whole costs of defending themselves, particularly when their right to practise is at stake.*

The use of a tariff in this case is sensible given the complexity and number of costs involved. The analysis is qualitative, not quantitative. The College is not seeking the full amount that could be ordered under the Code. The Committee agrees that 60 days at the tariff rate, or $219,000.00, is a reasonable proportion of the costs, given the extent and seriousness of the findings made. The hearing was long and protracted with extra experts, some adding little value, called by the defence. Additionally, a motion in mid hearing caused delay and could have been argued at the outset.

The Committee is of the opinion that the College was substantially successful in proving the serious allegations related to safe patient care. As there were some areas where the College did not succeed, a reduction of 5 days is reasonable, using 65 days as the total length of the hearing.

The Committee did not penalize Dr. Yazdanfar for defending herself. And the award of costs is not itself punitive or outside the ability of Dr. Yazdanfar to pay on the evidence before the Committee.

The Committee is of the view that an award of $219,000.00 achieves the appropriate balance in this matter.

ORDER

The Committee orders and directs that Dr. Yazdanfar pay to the College $219,000.00 in respect to costs, such costs to be paid within 12 months of the date of this Order.