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• END OF LIFE DECISION-MAKING: *RASOULI v. SUNNYBROOK HEALTH SCIENCES* •

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Introduction

On June 29, 2011, the Ontario Court of Appeal released a noteworthy decision about end-of-life decision-making in *Rasouli v. Sunnybrook Health Sciences*. The respondent, Mr. Rasouli, was hospitalized for bacterial meningitis after benign brain tumour surgery, and his condition caused him severe brain damage. He was placed on a mechanical ventilator without which, Mr. Rasouli's death would be inevitable. Physicians concluded that Mr. Rasouli was in a "permanent vegetative state",[1] would "never again regain consciousness",[2] and his life-sustaining measures were medically ineffective. The physicians proposed to withdraw life support and provide end-of-life palliative care, as they felt this would be in Mr. Rasouli's best interest. Mr. Rasouli's wife, acting as his substitute decision-maker, wished to keep her husband alive on life support; and therefore, she did not consent to the physicians' proposal to withdraw life support.

Under s. 10(1) of the *Health Care Consent Act*,[3] a health practitioner must obtain consent prior to administering a treatment. The dispute arose as to whether withdrawing the medically ineffective life support was considered "treatment" under the *HCCA* and whether it could be done unilaterally by physicians, without the substitute decision-maker's consent.

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Superior Court of Justice Decision

Rasouli v. Sunnybrook Health Sciences Centre and Cuthbertson, [2011] O.J. No. 1100

The family filed a suit at the Ontario Superior Court of Justice, and the decision was rendered on March 9, 2011. The trial judge addressed the matter by examining whether withdrawing life support was statutorily considered "treatment" under the *HCCA*.

Justice Himel, writing for the Court, acknowledged that life support was a form of treatment. She ascertained that life support satisfied the "therapeutic"[4] and "preventive"[5] criteria in the definition of "treatment" under s. 2(1) of the *HCCA*. To determine whether the withdrawal of life support was a form of treatment, Himel J. noted that "treatment" under s. 2(1) of the *HCCA* included "plan of treatment",[6] which itself encompassed the "withholding or withdrawal of treatment".[7] As a result, the withdrawal of life support would have fallen under "plan of treatment"[8] and then "treatment",[9] which necessitated consent. Justice Himel concluded that the withdrawal of life support was a form of "treatment" under the *HCCA*, and therefore physicians must obtain consent before withdrawing life support. She also noted that when this type of conflict involving consent exists between physicians and the substitute decision-maker, then the matter should be referred to the Consent and Capacity Board.

Ontario Court of Appeal Decision

Rasouli v. Sunnybrook Health Sciences Centre, [2011] O.J. No. 2984

The physicians appealed this lower court decision to the Ontario Court of Appeal. The appellants were concerned that this requirement for obtaining consent to withhold and withdraw ineffective treatment would have negative conse-

quences for the medical profession. Their appeal did not address any issues about costs and saving medical resources. The appellants disagreed with Himel J.'s interpretation of "treatment" under the *HCCA*, as they claimed that "treatment"[10] did not include withholding or withdrawing treatment that was futile. The appellants declared that Rasouli's life support was ineffective, there was no prospect of recovery; and therefore, his life support was not a form of "preventive" and "therapeutic" "treatment" under s. 2(1) of the *HCCA*. On the other hand, Rasouli's wife disagreed with the appellants and believed the life support was not valueless as it was keeping her husband alive. The appeal court judges did not conclude whether Rasouli's life support was futile or valuable in his case.

Writing for the Court of Appeal judgment, Justices Moldaver and Simmons stated that it was unnecessary to address whether the appellants were correct in their interpretation of "treatment" under the *HCCA*. However, the judges noted that the legislation did not specify that consent was required for the withholding and withdrawing of ineffective life support; and had the legislature wanted to include futile treatment in the provision, this condition would have been clearly stated in the legislation. Additionally, they noted that the *HCCA* did not require physicians to obtain consent prior to withholding or withdrawing ineffective treatments in general.

The Court of Appeal's judgment focused primarily on whether consent was required for Rasouli's physicians' proposal to remove the mechanical ventilator and begin end-of-life palliative care. It examined the definition of palliative care and determined that "treatment" under s. 2(1) of the *HCCA* included palliative care. Furthermore, palliative care included end-of-life palliative care, which is the type of care provided to patients awaiting death following the withdrawal of life support. For that reason, physicians must obtain consent to administer end-of-life palliative care subsequent to the removal of a ventilator. The question remained as to whether the specific removal of a ventilator was also a form of "treatment" under the *HCCA*.

The judges determined that when a physician removes a ventilator, the patient's death will be imminent, so this removal will trigger a need for end-of-life palliative care to assist the patient with the dying process. As a result, withdrawal of life support and end-of-life palliative care are linked to one another and are to be viewed as a "treatment package".[11] They illustrated that this situation is different from circumstances where death is not imminent, such as terminating ineffective chemotherapy treatment. In these cases, death is not immediate, and it is unknown how long the patient will survive after terminating chemotherapy; and therefore, ending chemotherapy will not simultaneously trigger end-of-life palliative care. The judges clarified that where death is not imminent and is not triggering immediate end-of-life palliative care, as in the example above, physicians do not require consent to end futile treatment.

To summarize, the Court of Appeal declared that end-of-life palliative care includes the withdrawal of life support and therefore, physicians must obtain the substitute decision-maker's consent for this treatment option (removal of life support followed by end-of-life palliative care). If consent is refused, and it is questionable as to whether this refusal is in the patient's best interest, then the physician may elect to pursue the matter further, and must refer the proposition to the Consent and Capacity Board. Justices Moldaver and Simmons noted that there are

drawbacks to this Board process. For instance, as outlined in s. 21(1) of the *HCCA*, if the substitute decision-maker refuses treatment and corroborates that this refusal is congruent with the patient's wishes, when he or she was in a former capable state, then the Board may not review the matter.[12] However, overall, the Court of Appeal minimized this concern and agreed that there were numerous benefits to this Board process.

On June 29, 2011, the Ontario Court of Appeal upheld the Superior Court of Justice's decision and concluded that the appellants were not permitted to remove the ventilator unilaterally. Ultimately, a physician cannot withdraw life support without the substitute decision-maker's consent, and if consent is not provided, then the decision must be placed before the Ontario Consent and Capacity Board.

We are advised that the physicians have sought leave to appeal from the Supreme Court of Canada and an update will be provided on the outcome.

Conclusion

The Court of Appeal's ruling has a fundamental impact on Ontario residents awaiting death in hospitals, their families, the medical profession and the Consent and Capacity Board. Given the scarcity of case law available to guide those involved in end-of-life decision-making conflicts, the *Rasouli* case is significant in Ontario and may influence other jurisdictions.

[*Editors' note*: Dianne Hajdasz is a second-year law student at the University of Ottawa and spent the month of June 2011 with Dykeman Dewhirst O'Brien LLP in Toronto as part of the University's internship program.]

1 *Rasouli v. Sunnybrook Health Sciences Centre*, [2011] O.J. No. 2984, 2011 ONCA 482 at para. 4.
2 *Ibid.*
3 *Health Care Consent Act*, S.O. 1996, c. 2, Schedule A [*HCCA*].
4 *Ibid.* s. 2(1).
5 *Ibid.*
6 *Ibid.*
7 *Ibid.*
8 *Ibid.*
9 *Ibid.*
10 *Ibid.*
11 *Rasouli v. Sunnybrook Health Sciences Centre*, [2011] O.J. No. 2984, 2011 ONCA 482 at para. 52.
12 *Ibid.* at para. 59.

• CCB TRANSFER HEARINGS: THE FIRST YEAR IN REVIEW •

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Introduction

On May 18, 2010, amendments were made to Ontario's *Mental Health Act*, R.S.O. 1990, c. M.7 [the *Act*]. Among these amendments were provisions allowing involuntary patients detained in psychiatric facilities to apply to the Consent and Capacity Board ("the Board" or "CCB") for a transfer to another psychiatric facility (s. 39.2 of the *Act*). The new provisions represented a departure from the traditional collaborative approach to patient transfers and require a significant investment of resources on the part of psychiatric facilities.

This article canvasses major themes and issues that have emerged from a psychiatric facility perspective in the first year. They will be of par-

ticular interest to psychiatric facilities in Ontario, and more generally to those across Canada who face similar issues in dealing with patients' requests for transfer.

Who can bring an application and when?

In addition to those brought by involuntary patients, applications may also be brought by any person on behalf of an involuntary patient or the Officer in Charge of the psychiatric facility where the patient is detained.

An application can be made after the fourth renewal of a certificate of involuntary status and every fourth renewal thereafter. An applicant may also bring a new application, with leave, 12 months after the final disposition of an application by the Board. Leave may be granted where there has been a material change in the patient's circumstances. As a result of an amendment to the *Health Care Consent Act*, S.O. 1996, c. 2, Schedule A, a transfer hearing must be held within 30 days after an application is made, unlike the usual seven days for Board hearings.

Who are the parties?

The parties to an application are the Officers in Charge of both the patient's current psychiatric facility and the proposed receiving psychiatric facility and the patient or any person who has applied on his or her behalf. The Minister of Health and Long Term Care ("the Minister") is entitled to notice of the application and to be heard at the hearing. The Minister may also apply to be a party to the hearing. As with hearings to review involuntary status, the Board panel in a transfer hearing is made up of three or five members. The panel must consist of at least one lawyer, at least one psychiatrist and at least one member of the public who is neither a psychiatrist nor a lawyer.

What are the criteria the Board will consider?

If the patient does not object, the Board *may* order the patient transferred to the psychiatric facility named in the application. In considering whether to order a transfer, the Board must consider the following criteria:

1. Whether the psychiatric facility named in the application is able to provide for the patient's care and treatment;
2. Whether the psychiatric facility named in the application is able to safely manage any risk the patient poses to the patient or another person;
3. Whether the transfer is in the patient's best interests;
4. Whether the transfer is likely to improve the patient's condition or well being;
5. Whether the transfer is likely to foster the patient's reintegration into the community; and
6. Whether an attempt has been made to transfer the patient under s. 29 of the *Act*, which allows psychiatric facilities to arrange a transfer between them.

If the Board orders a transfer, the Board may specify a period of time within which the transfer must be made.

Why are these provisions important from a psychiatric facility perspective?

The provisions raise a number of issues for psychiatric facilities, including the following:

1. The power to order a transfer is a departure from a "collaborative approach" towards a more litigious approach. Prior to these amendments, facilities have employed a collaborative approach to patient transfers,

working together to meet the needs and act in the best interests of the patient. The transfer application process gives the Board powers to intervene in what is arguably a matter of clinical judgment and decision-making.

2. Hospitals can bring an application for transfer of a patient to another facility, but only where the patient does not object. Section 29 of the *Act* allows facilities to arrange a transfer between them, regardless of whether the patient consents. Given the complexity and resources involved in bringing an application before the Board, a hospital would likely only bring an application under the new transfer provisions where the receiving facility is unwilling to collaboratively arrange a transfer under s. 29 and the patient does not object. As no applications have been brought by a hospital to date, it is unclear how this will play out in the future.

3. It is not yet clear to what extent the Board will consider the logistical realities of the receiving facility, such as bed availability. The provisions allow the Board to transfer a patient without consent of the receiving facility. In early decisions, the question of beds has been deferred until after the Board has determined the patient should be transferred. At this point in the proceedings, the question is no longer whether the patient will be transferred, but when. Since the Board has yet to order the transfer of a patient, it is unclear how this analysis will play out.

4. The new provisions confer powers on the Board that are more akin to those exercised by the Ontario Review Board with respect to forensic patients. In transfer hearings, the Board must consider and weigh the criteria, not all of which must be clearly met before a transfer may be ordered. This kind of analysis is arguably more akin to the balancing which is done by a court or the Ontario Review Board of the four factors under s. 672.54(c) of the *Criminal Code*, R.S.C. 1985, c. C-46, to arrive at the least onerous and least restrictive disposition and order a forensic patient detained at a particular hospital, even over the objection of the receiving hospital.

5. Transfer hearings are complex and generally require legal counsel. It can therefore be expected that they will require a significant investment of time and resources. The *Act* allows for an application to be made at every fourth renewal of a certificate of involuntary detention. Since each renewal lasts three months, an involuntary patient can bring an application for transfer approximately once every 12 months. Evidence should be called by the hospital that speaks to the criteria the Board must weigh in deciding whether to grant the transfer. All facilities, particularly larger ones that will see a greater number of applications, are to be prepared for the additional resources required to handle these applications.

Recent Decisions: Procedural and Substantive Issues

Since May 2010, the Board has only heard six applications for transfer.[1] Four of these involved the Centre for Addiction and Mental Health. All six applications were brought by patients and none were successful. These early hearings focused on issues such as the onus of proof and fleshing out the content of the criteria to be considered.

Reasons for the applications

In four hearings, the patient was seeking a transfer back to a facility where he or she had been admitted in the past. For the most part, the patients wanted a transfer so they could be closer to family and friends and have greater access to activities and resources.

Procedure and Onus

In the first hearing under the new provisions, *G.J.*, it was decided at the outset that the patient should present evidence first. This would allow the hospital named in the application to know the reasons for the request before it had to reply. The Board stated that this would also lead to a narrowing of the issues on which evidence would have to be lead.

The clearest statement of the onus and standard of proof in transfer hearings is found in *A.H.*:

> *The Board ultimately determined that the onus rested with the person requesting the transfer. The standard of proof before the Board is proof on a balance of probabilities. The Board must be satisfied on the basis of clear, cogent and compelling evidence that the onus has been discharged. The Board must consider all evidence properly before it. Hearsay evidence may be accepted and considered, but it must be carefully weighed.*

The Board in *B.M.* arrived at the same conclusion.

Transfer hearings are unlike most other hearings before the Board. In a transfer hearing, the patient is seeking to assert a positive right to be moved to another facility; she or he is not asserting "freedom from" the impact of a decision made by a health care practitioner. In cases of involuntary status and treatment capacity, for example, it is appropriate for the health care practitioner to bear the onus. In transfer hearings, it is not. While it is arguably possible for no one party to bear the onus, this approach would likely be unworkable for parties, who need to know the evidentiary burden they must meet. Similarly, the Board should be persuaded on the standard of probabilities based on clear, cogent and compelling evidence that the criteria are met before exercising its discretion to order a transfer.

Criteria the Board will consider

The Board took a relatively consistent approach to the six criteria across the six decisions. While the full content of these criteria remains uncertain, certain guiding principles have been elucidated:

Whether the receiving facility is able to provide for the applicant's care and treatment.

The wording of this criterion does not make it clear whether the question is one of the type of care and treatment provided, one of availability of a bed for the patient, or both; however, in *G.H.*, the Board stated that the matter of bed availability can be addressed by the Board in its decision on the timing of the transfer, if ordered. In *S.W.* the Board characterized the patient's care and treatment as requiring, at minimum, medication and detention with supervision, and found that since it was a psychiatric facility in the province of Ontario, the proposed facility could provide this care and treatment. The Board did not accept the proposed facility's submissions that, as an acute care facility with only one long-term patient, it could not provide appropriate programming and recreational activities. The ability to provide more than basic psychiatric care was considered under the "best interests" criterion instead.

Whether the receiving facility is able to safely manage any risk posed by the patient to him or herself or another person.

In each case, the Board looked at the risks posed by the particular patient and whether the receiving facility was equipped to manage these risks. The Board does not appear to have looked at which facility can better care for the patient or manage the risks, just whether the receiving facility can do so. Both of the first two criteria relied entirely on evidence from the two hospitals, who are better positioned to adduce evidence on these issues. So although the overall onus has been described as resting with the party who brings the application, the hospital

should adduce evidence with respect to matters within its particular knowledge.

Whether the transfer is in the patient's best interests.

Rather then focusing solely on the receiving facility, as with the first two criteria, the approach to the "best interests" question involves a comparative approach between the two facilities. In each case, the Board considered the patient's evidence about his or her reasons for wanting a transfer in light of the hospital's evidence regarding the likelihood of those goals being realized. In doing so, the Board appears to have compared the patient's situation at their current facility with the likely conditions at the receiving facility. Where, for example, the patient would be in more restrictive circumstances at their intended destination, the Board has found the goals of more access to family and activities would not be realized and the transfer would not be in the patient's best interests.

In *S.R.*, the Board accepted the submission that significant weight must be given to family relationships. However, while the Board has acknowledged that proximity to family, socialization, and personal relationships are beneficial, it appears actual evidence that a transfer will make these conditions more likely is required before a transfer will be ordered. Where the patient's desire for a transfer was based on delusional beliefs caused by mental illness, the Board has held that supporting these beliefs by ordering a transfer would not be in the patient's best interests.

Whether the transfer is likely to improve the patient's condition or well-being, and whether the transfer is likely to foster the patient's reintegration into the community.

Given the comparative approach taken to the "best interests" question, the Board has described these criteria as largely overlapping with the previous one. As with the "best interests" criterion, actual evidence of likely improvement in the patient's condition and a likelihood of reintegration into the community is necessary.

Whether an attempt had been made to transfer the patient under s. 29 of the Act.

It is not yet clear whether this is a prerequisite condition or merely one factor to be considered. Arguably, failure to attempt a transfer is highly relevant, as it is indicative of the current facility's belief that a transfer is not required. In one decision, however, the facilities attempted and failed to arrange a transfer after the transfer application was made. The Board stated that this attempt had no bearing on its decision to refuse the application.

Moving forward

Though there are still a number of outstanding procedural and substantive questions relating to transfer hearings, two principles have emerged from the six decisions thus far:

First, the onus is on the applicant to adduce clear, cogent and compelling evidence to convince the Board on a balance of probabilities. This has been played out in the decisions. The panel at three of the six transfer hearings has accepted that this is the onus. The Board has not accepted general evidence that certain things would be beneficial. Instead, it required that sufficient specific evidence be adduced to show that the benefits are likely to materialize. In particular, all of the decisions found that insufficient evidence had been led to show that a transfer would improve the applicant's condition or foster his or her reintegration into the community.

Second, it appears so far that no one criterion is determinative. Rather, the patient's particular circumstances may influence the weight given to each criterion. In *S.W.*, for example, the Board

acknowledged that the legislation provides no guidance as to how the various criteria should be weighed. Since the treatment plan was to discharge the patient as soon as appropriate arrangements could be made, the Board analyzed each criterion in light of this goal, paying particular attention to whether a transfer would foster reintegration. In contrast, the Board in the other decisions looked at the evidence as a whole and balanced the criteria in light of the patient's reasons for wanting a transfer. More decisions will be required to assess whether treatment goals, the patient's desires, or a combination of both affect how the criteria are assessed.

What does the future hold?
Post *Conway* Charter Applications

Among the procedural and substantive issues that remain to be decided, constitutional questions are likely to present challenges for mental health facilities at transfer applications in the future.

The recent decision of the Supreme Court of Canada in *R. v. Conway*, [2010] S.C.J. No. 22, addressed whether administrative tribunals are "courts of competent jurisdiction" for the purpose of awarding remedies under s. 24(1) of the *Canadian Charter of Rights and Freedoms* [*Charter*] where such power is not removed by the enacting legislation. While s. 70.1 of the *Health Care Consent Act* prohibits the Board from considering the constitutional validity of a provision of an *Act* or regulation under s. 52 of the *Charter*, in light of the *Conway* decision, the Board may revisit its jurisdiction to consider s. 24(1) *Charter* violations in the future.

Before *Conway*, the Board was required to make decisions consistent with *Charter* values. After *Conway*, the Board must continue to do so; however, it remains an open question whether the Board is a court of competent jurisdiction for s. 24(1) purposes. Given the nature of proceedings before the CCB, it also remains to be seen whether the CCB will engage in *Charter* review, or use its existing framework to give effect to *Charter* values.

In *G.J.*, a *Charter* issue was raised related to the timing of the hearing, which began more than 30 days after the application was first made. In its reasons, the Board notes that it had two options: (1) to further adjourn the hearing for parties to make submissions relating to the *Charter* application, or (2) to consider whether a *Charter* argument was necessary, given that a separate application need not necessarily be heard in order for the Board to remedy a situation in a *Charter*-compliant way. The Board chose the latter. Importantly, the remedy being sought for the alleged *Charter* violation was a transfer to the patient's choice of facility, which was the same remedy sought in the transfer application. There was therefore no reason to delay the proceedings to hear a separate *Charter* application.

It remains to be seen whether *Conway* will significantly impact transfer applications and the issues brought before the Board in that context. Involuntary admissions and detentions engage liberty interests in a fundamental way and are one of the few areas where the Board has limited discretion to rescind a certificate of involuntary status, even where the criteria for confirming the certificate have been met. Transfer hearings arguably confer more discretion and therefore may be suited to *Charter* analysis. Further, while incapacity and involuntary status hearings must be heard within seven days of an application for review, transfer hearings must be heard within 30 days of an application. Given the notice requirements for *Charter* applications, the longer time periods associated with

transfer hearings may result in *Charter* applications. Future decisions will show whether the Board will entertain *Charter* applications, or will endeavor to decide the matter in a *Charter*-compliant way using the existing framework.

Conclusion

The new transfer hearing provisions introduce processes, parties and analyses which differ from the Board's "bread and butter" work. While it has been decided that the onus in these hearings is on the applicant, the exact content of the criteria, and the weight accorded to each, remains to be seen. The extent to which *Conway* opens the door to *Charter* applications and analysis in these hearings is also uncertain. As more applications are heard, we will more fully understand the impact of transfer hearings. For psychiatric facilities, the key question is whether the Board's new jurisdiction to order transfers will result in a problematic fettering of clinical decision-making. In the meantime, facilities should be prepared for the investment of resources that will be required to handle these lengthy and complex matters.

[*Editors' note*: Nyranne Martin is Senior Legal Counsel to the Centre for Addiction and Mental Health. Kendra Naidoo is an Associate with the Health Law Group of Borden Ladner Gervais LLP. An earlier version of this article was published by *Health Law Matters* and was presented at health law conferences for the Ontario and Canadian Bar Associations.]

[1] *G.J. (Re)*, PE-10-1018 (CCB, August 2, 2010); *A.H. (Re),* TO-10-1044 & TO-10-1050 (CCB, August 28, 2010); *C.D. (Re),* PE-10-1637 (CCB, September 7, 2010); *B.M. (Re),* KI-10-2096 (CCB, September 26, 2010); *S.W. (Re)*, NB-10-2649 (CCB, December 29, 2010); and *S.R. (Re)*, PE-10-4252 *(CCB, May 11, 2011)*.

• PHYSICIAN QUALIFICATIONS FOR INVASIVE COSMETIC PROCEDURES PERFORMED IN PRIVATE ONTARIO CLINICS •

Vivene Salmon, Toronto

Introduction

In the United States, the National Organization for Women Foundation reported that in 2001, over 8.5 million people had undergone cosmetic procedures; of those people, over 88 per cent were women.[1] In Canada, close to 25,000 liposuction procedures and 17,000 breast augmentation procedures are performed annually.[2] As in the United States, women are overwhelmingly the consumers of cosmetic surgery procedures in Canada. In fact, cosmetic surgery has increasingly become a widely accepted mainstream practice in many parts of the world. In 2003, the total cosmetic procedure market in Canada was worth more than half a billion dollars.[3]

Over the past several years, physicians who are not certified plastic surgeons have increasingly moved into this lucrative practice area, with sometimes devastating outcomes for patients.

On September 20, 2007, 32-year-old Krista Stryland died after undergoing liposuction surgery performed by Dr. Behnaz Yazdanfar and Dr. Bruce Liberman at the Toronto Cosmetic Clinic ("TCC"), an unlicensed private clinic owned and operated by Dr. Yazdanfar. Dr. Yazdanfar was a general practitioner qualified in family medicine, who had decided to enter the cosmetic surgery industry in 2003 and focus her practice on liposuction and breast augmentation.[4] Dr. Yazdanfar has never been accredited as a

plastic surgeon and holds no surgical designation or hospital privileges, but had taken courses on breast augmentation and liposuction.[5]

On May 4, 2011, a professional disciplinary committee of the Ontario College of Physicians and Surgeons found Dr. Yazdanfar incompetent and guilty of professional misconduct for "failing to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 under the *Medicine Act,* 1991"; contravening the *Regulated Health Professionals Act,* 1991; and engaging in conduct that would "reasonably be regarded by members as disgraceful, dishonourable or unprofessional."[6]

The patient's best friend, testified before a discipline committee of the Ontario College of Physicians and Surgeons that she and Stryland had "googled liposuction/Toronto and compared the site of Dr. VS and the TCC. Ms. Stryland felt that TCC were the experts, [and] liked the before and after shots and testimonials. They [TCC] were going to use a new technique that was safer and would go right down to muscle, which made her excited."[7] Stryland's ex-husband had voiced concerns about her receiving liposuction, but after looking at the TCC website, he was left with the impression "that liposuction was safe, with minor side effects and that Stryland would be back to work in two days."[8] Other patients involved in similar legal proceedings against Dr. Yazdanfar describe being "excited" about the amount of liposuction that could be done at one time[9] and noted that "all the people there [in the clinic] looked beautiful."[10] Many of Dr. Yazdanfar's patients describe leaving the clinic feeling they were good candidates for the selected cosmetic procedure.

Sadly, for several patients of the TCC; including Krista Stryland, Francine Mendelson, and several other anonymous patients, their respective cosmetic surgeries resulted in serious medical issues and in Stryland's case, her death. It is evident, as concluded by the disciplinary committee of the College, that TTC catastrophically failed to sufficiently discuss the risks associated with the cosmetic procedures offered by the clinic and to adequately describe the qualifications of the medical doctors in the clinic performing the cosmetic procedures.

One health law writer has noted that Dr. Yazdanfar's patients, like many other patients receiving invasive[11] cosmetic procedures in unlicensed private medical clinics, "when faced with complex medical choices: choices such as whether or not a treatment's benefits outweigh its risks and about a physician's credentials and skills, lack the information and expertise needed to make informed judgments."[12]

In the decision of the disciplinary committee of the Ontario College of Physicians and Surgeons on May 4, 2011, the Committee stated, "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."[13]

Nonetheless, Stryland's tragic death brought into sharp focus the laws and regulations surrounding the private cosmetic surgery market in Ontario, particularly regarding the level of qualifications needed to perform cosmetic surgery in unlicensed private Ontario medical clinics.

Ontario medical doctors operating in unlicensed private medical clinics may legally perform high-risk cosmetic surgery, even if they are not

registered with the Royal College of Physicians and Surgeons of Canada ("RCPSC"). In May 2010, the College of Physicians and Surgeons of Ontario released its "Out-of-Hospital Premise Standards" which set out detailed inspection standards for private facilities. Among those standards are qualifications required of physicians who perform invasive procedures. Such physicians must hold valid RCPSC certification in the area, or must have completed all CPSO requirements for a change in scope of practice and have active privileges to do similar procedures at a local hospital."[14]

According to the CPSO website, Dr. Yazdanfar's licence to practice medicine is restricted, pending the outcome of the committee's deliberations; a penalty hearing date occurred in late August, 2011, and a decision is likely imminent.[15]

Colleen Flood, a professor at the University of Toronto Faculty of Law states, that "this would catch the general practitioner, with no surgical specialization, who has begun offering liposuction or breast augmentation procedures … it is not clear that the training required of physicians who request a change in the scope of their practice can provide an adequate substitute for the lengthy training undergone by RCPSC-credentialed surgeons."[16]

Moreover, while the College of Physicians and Surgeons of Ontario in 2009 enacted regulations forbidding the use by non-specialist of terms that suggest specialist training,[17] "'Dr. Jones, Cosmetic Surgeon' is not allowed, while 'Dr. Jones, General Practitioner, practicing in Cosmetic Medicine' is permitted."[18]

Given the increasing mainstream acceptance of cosmetic surgery and easy access by the public to these types of procedures, it is imperative that physicians practicing in unlicensed private clinics in Ontario be accredited/qualified as specialists in surgery or plastic surgery to perform invasive cosmetic procedures. Patients must be provided with accessible, current information about the skills and competency of physicians who propose to perform cosmetic procedures. To this end, stringent measures must be enacted to provide patients with adequate information about the training and skills of physicians performing cosmetic procedures in unlicensed private clinics and the risks and benefits associated with those procedures.

[*Editors' note*: Vivene Salmon, B.A., LL.B., is a Toronto lawyer.]

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1 National Organization for Women Foundation, "Women's Health Project: Fact Sheet" *National Organization for Women Foundation,* online: <http://www.nowfoundation.org/issues/health/whp/whp_fact1.html>.

2 Flood, M. Colleen, *et al.,* "Cosmetic Surgery Regulation and Regulation Enforcement in Ontario," (2010), 36 Queen's L.J. 31-70 at para. 63.

3 "Cosmetic Surgery: Balancing Risk" *CBC* (April 10, 2008), online: CBC <www.cbc.ca/news/background/health/cosmetic-surgery.html>.

4 *Yazdanfar* (Re), [2011] O.C.P.S.D. No. 6 at paras. 8 and 230.

5 *Ibid.* at para. 230.

6 *Ibid.* at para. 2.

7 *Ibid.* at paras. 62-63.

8 *Ibid.,* at para. 57.

9 *Ibid.* at para. 113.

10 *Ibid.* at para. 91.

11 Invasive cosmetic procedures include liposuction, breast augmentation and rhinoplasty.

12 *Supra* note 2, at para. 2.

13 *Supra* note 4, at para. 7.

14 *Supra* note 2, at para. 36.

15

16 *Ibid.*

17 Until recently, Ontario doctors could call themselves cosmetic surgeons, even if they were not certified to practice plastic surgery [O. Reg. 114/94, s.9(1)].

18 *Supra* note 2, at para. 31.