NOTICE OF PUBLICATION BAN

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

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

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Frank,
2018 ONCPSD 20

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. CATHY SHEILA FRANK

PANEL MEMBERS: **DR. C. CLAPPERTON (CHAIR)**
MAJOR A.H. KHALIFA
DR. E. SAMSON
MR. P. PIELSTICKER
DR. P. GARFINKEL

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS S. O'BRIEN
MS M. KELLYTHORNE

COUNSEL FOR DR. FRANK:

MS C. BRANDOW

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS J. McALEER

Hearing Date: February 26, 2018
Decision Date: February 26, 2018
Release of Written Reasons: April 30, 2018

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on February 26, 2018. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and is incompetent. The Order also set out the Committee's penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Cathy Sheila Frank committed an act of professional misconduct:

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

2. under paragraph 1(1)33 of Ontario Regulation 856/93 in that she has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Frank 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*.

RESPONSE TO THE ALLEGATIONS

Dr. Frank admitted to allegation 1 in the Notice of Hearing, that she has failed to maintain the standard of practice of the profession and to the allegation of incompetence. Counsel for the College withdrew the allegation of disgraceful, dishonourable or unprofessional conduct.

THE FACTS

The following facts were set out in the Agreed Statement of Facts and Admission, which was filed as an exhibit and presented to the Committee:

1. Dr. Cathy Frank is a 60 year-old obstetrician and gynecologist who received her certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College) in June 2002. At the relevant time, she practised in St. Thomas and/or London.

2. Between 2009 and 2012, more than 30 patients filed complaints with the College regarding their treatment by Dr. Frank. Investigations into the patient complaints revealed that, as detailed further below, Dr. Frank had failed to maintain the standard of practice of the profession in the care and treatment of patients and demonstrated a lack of knowledge amounting to incompetence in the following respects:

   - failing to adequately investigate causes of patients' symptoms prior to deciding on surgical management;
   - failing to obtain informed consent before performing surgeries or procedures;
   - failing to adequately document informed consent discussions and the manner in which she conducted gynecological surgeries;
   - performing surgeries and procedures in a manner inconsistent with the standards of practice of the profession; and
   - failing to adequately monitor and assess post-operative patients, including those exhibiting symptoms of complications.

Patient A

3. Patient A was referred to Dr. Frank for menorrhagia (heavy menstrual bleeding) and seen in 2003. Dr. Frank offered Patient A an ablation or a laparoscopically assisted vaginal hysterectomy ("LAVH"). Patient A initially chose an ablation but changed her mind to an LAVH at a subsequent appointment. The LAVH was performed.

4. Prior to proceeding with an LAVH, and in breach of the standard of practice, Dr. Frank failed to complete necessary investigations to diagnose dysfunctional uterine bleeding, such as ordering an ultrasound and blood work. Dr. Frank failed to record any discussion of any options other than ablation and LAVH or any discussion of specific risks of the surgical options in Patient A's medical record, contrary to the standards of practice. Patient A does not recall any such discussion.

5. Following the surgery, Dr. Frank failed to adequately address Patient A's follow-up care needs, in breach of the standards of practice. She allowed Patient A to be discharged without an examination, despite a hemoglobin reading that had dropped significantly, and a description by the nurse of Patient A as being pale, bruised and diaphoretic. While documenting that this was due to the Patient's desire to leave, she did not document that this was against medical advice. Dr. Frank also failed to adequately document the assessments of Patient A upon her re-attendance twice to the hospital. Patient A was readmitted by her family physician on her third attendance and seen by a different gynecologist. Patient A ultimately was found to have internal bleeding with a large pelvic hematoma, bruising of her lower abdomen, and vault cellulitis, which were caused by the LAVH.

Patient B

6. Patient B saw Dr. Frank in 2007 on referral for cystocele and vaginal vault prolapses from a urologist. Dr. Frank offered a posterior repair and possible Nichol's sling. Dr. Frank's record failed to reflect any discussion of alternative options or of any specific risks for the patient in undergoing the procedures, in breach of the standards of practice.

7. Dr. Frank attempted the surgical procedures but was not able to complete all of the intended repairs so she discontinued the procedure. Patient B's prolapse returned and Dr. Frank then referred her to a urogynecologist for ongoing management. The College does not allege that Dr. Frank's performance of the surgery or referral to a urogynecologist after the surgery failed to meet the standard of practice of the profession.

Patient C

8. Patient C was referred to Dr. Frank for dysmenorrhea. Dr. Frank obtained an ultrasound, which was unremarkable. Patient C was then booked for an LAVH, which was performed. Dr. Frank failed to adequately investigate the possible causes of menorrhagia and dysmenorrhea before booking Patient C for an LAVH. She did not record eliciting a history of pelvic pain, did not check TSH (though Patient C had known hypothyroidism on replacement), did not perform an endometrial biopsy or a pap test, and did not evaluate uterine size and mobility.

9. Patient C's tolerance for surgical risk from the LAVH was very low because her child was scheduled for surgery four days after her own surgery. Dr. Frank failed to record having discussed with Patient C any specific risks of the LAVH. It was Patient C's recollection that Dr. Frank advised her that she would be well enough to accompany her child to surgery in four days and that the LAVH was a simple operation.

10. Following the LAVH, Patient C experienced low blood pressure, requiring a fluid bolus, and a significant drop in hemoglobin. There is no evidence in the record that Patient C was assessed by a physician, but she was nonetheless discharged from hospital. Patient C returned to another hospital some days later and was ultimately diagnosed with a hematoma and underwent subsequent surgery. Dr. Frank's failure to monitor for, identify and treat Patient C's complication represents a failure to adequately follow up on her patient post-operatively in breach of the standard of practice.

Patient D

11. Dr. Frank managed Patient D's pregnancy following 32 weeks' gestation. According to Patient D, when she saw Dr. Frank at 34 weeks' gestation, she reported decreased fetal movement. Dr. Frank recorded that there was fetal movement; however, there is no documentation in Dr. Frank's record about kick counting (to measure fetal movement) nor of advising the patient to go to hospital triage to have the baby assessed if there was decreased fetal movement. This lack of documentation breached the standard of practice.

12. At 35 weeks, Patient D presented to the emergency department and found the fetus was deceased. Patient D was then booked for an induction of labour. Dr. Frank ordered 800 mcg of Misoprostol every four hours, which was an inappropriately high dose for induction of a term 35 week pregnancy and in breach of the standard of practice. Dr. Frank also failed to obtain Patient D's informed consent to her off-label use of Misoprostol in breach of the standard of practice.

Patient E

13. Patient E saw Dr. Frank in 2005 for pain associated with ovarian cysts and a family history of ovarian cancer. Dr. Frank conducted a laparoscopic right salpingo-oophorectomy and left ovarian resection.

14. When Patient E was later reassessed by Dr. Frank post-operatively, Patient E was complaining of pain. An ultrasound was done and revealed a 9cm left adnexal mass. Dr. Frank recommended to Patient E that this mass be removed in its entirety by way of laparotomy. Dr. Frank failed to document any other options for treatment or management offered to the patient and failed to document the specific risks of the laparotomy, in breach of the standards of practice.

Patient F

15. Patient F was referred to Dr. Frank by her family physician for irregular periods and consideration of an endometrial ablation. Dr. Frank saw Patient F in April 2009 and scheduled her for an endometrial ablation. The endometrial ablation was performed in May. Dr. Frank failed to perform the required investigations (for example, blood work and ultrasound) to determine the cause of the irregular periods before proceeding with an endometrial ablation.

Patient G

16. Patient G saw Dr. Frank in September, 2006 for severe abdominal pain. The pain was somewhat, although not completely, cyclical, and thus should have been investigated as potentially chronic pelvic pain via a multidisciplinary approach. An ultrasound was done and was normal. Dr. Frank offered the patient an LAVH. Dr. Frank failed to investigate and propose a cause of Patient G's pain before proceeding with an LAVH, in breach of the standard of practice. Dr. Frank's record failed to reflect having offered Patient G any non-surgical treatments. The LAVH was performed in November, 2006, but did not resolve Patient G's pain.

Patient H

17. Dr. Frank attended to Patient H when Patient H was admitted to hospital in labour in 2008. Dr. Frank was the on-call physician. During the second stage of labour, while pushing, a fetal bradycardia occurred. As a result, Dr. Frank performed a forceps delivery with midline episiotomy. However, Dr. Frank failed to document obtaining consent for either procedure and the patient states that no informed consent discussion took place.

18. When Dr. Frank repaired the midline episiotomy, she failed to note a fourth degree laceration. Patient H was required to return and undergo a primary repair of the fourth degree laceration procedure seven days later. Dr. Frank fell below the standard of practice by failing to identify the fourth degree tear at the time of her repair of the episiotomy immediately after delivery.

Patient I

19. Patient I saw Dr. Frank in 2009 for problems regarding menorrhagia and a prior laparotomy for a ruptured ovarian cyst that had become infected.

20. Dr. Frank failed to complete necessary steps to identify the cause of Patient I’s symptoms before scheduling Patient I for an LAVH.

21. The LAVH took place. Dr. Frank documented in the operative report that Patient I's right ovary looked abnormal and that she removed it. This was Patient I's only ovary (as her other ovary had been previously removed in another surgery). The removal of Patient I's ovary was not discussed with Patient I before the surgery, nor with any family member during the surgery. Dr. Frank's failure to discuss the removal of the ovary with Patient I meant that Patient I had no opportunity to consent to a procedure that rendered her prematurely menopausal.

22. Patient I only became aware that her ovary had been removed when she reviewed her medical records several years later. Dr. Frank failed to meet the standard of practice by failing to obtain informed consent for the removal of Patient I's ovary.

Patient J

23. Patient J saw Dr. Frank in April, 2005 regarding an ultrasound that revealed a fibroid in her uterus. She was asymptomatic at that time and did not want any treatment. She saw Dr. Frank again in January, 2006 on referral from her family physician again as her fibroid was increasing in size.

24. In her reporting letter to the referring physician, Dr. Frank documented having discussed with Patient J the possibility of complications of an increasing fibroid including the remote possibility of cancer. She only documented discussing two options for treatment of the fibroid: embolization and an LAVH. Dr. Frank failed to document discussion of other non-invasive treatment options. Patient J proceeded with an LAVH due to her misunderstanding of the degree to which cancer was a risk and her lack of understanding of other treatment options.

Patient K

25. Patient K initially saw Dr. Frank in October, 2003 for pain associated with fibroids. Dr. Frank performed a diagnostic laparoscopy in January, 2004. Patient K was subsequently

re-referred and seen by Dr. Frank in January, 2007 for heavy menses and a large uterine fibroid. Dr. Frank's record reflects only having offered Patient K an LAVH to address the fibroid. Dr. Frank's medical record fails to reflect any discussion of non-surgical options or of any specific risks of an LAVH for Patient K, even though she had increased risk due to the fibroid and two previous caesarean sections, contrary to the standards of practice.

26. Dr. Frank also failed to perform an investigative step necessary to rule out cancer, namely an endometrial biopsy in advance of the LAVH.

27. Dr. Frank performed the LAVH in April, 2007. She failed to adequately document the procedure in her operative note, as it did not clearly describe how the procedure was performed.

Patient L

28. Patient L was seen by Dr. Frank in March, 2006, after having been referred for heavy, irregular bleeding. Dr. Frank failed to conduct required steps, which would have provided more information about Patient L's treatment options, specifically, an endometrial biopsy, before proceeding with an LAVH. Patient L was booked on the first visit for an LAVH. Dr. Frank performed the LAVH. Dr. Frank failed to adequately document the procedure in the operative note, as it does not clearly set out how the procedure was performed, in breach of the standard of practice.

Patient M

29. Patient M was seen by Dr. Frank in May, 2006, for menorrhagia. Dr. Frank failed to take the appropriate investigative step of obtaining an endometrial biopsy before proceeding with an LAVH.

30. Dr. Frank discussed some other options with Patient M, but booked Patient M for an LAVH on the first visit. Dr. Frank failed to document discussion of risks specific to Patient M. Patient M does not recall having been advised of the risks associated with the

procedure. Patient M faced a specific risk of damage to her bladder because of her previous history.

31. Dr. Frank performed the LAVH. Dr. Frank failed to adequately document the procedure in the operative note, as it does not clearly set out how the procedure was performed, in breach of the standard of practice.

Patient O

32. Patient O was referred to Dr. Frank for prenatal care and delivery of her fourth child. Following the delivery of her fourth child, Patient O saw Dr. Frank and discussed surgical sterilization. Dr. Frank offered her a tubal ligation, which was then performed. Dr. Frank's record does not reflect any discussion of alternative options or of any specific risks of the procedure, in breach of the standard of practice.

Patient P

33. Dr. Frank managed Patient P's pregnancy and attended for her delivery. Patient P was admitted for a post-dates induction in May, 2006. After Patient P pushed for approximately one hour, Dr. Frank delivered the baby using forceps. Patient P experienced a third-degree tear of the perineum. Dr. Frank failed to record any discussion with Patient P of the indication for forceps, the risks and benefits of forceps, or the alternatives to forceps use, and Patient P does not recall any such discussion.

Patient Q

34. Patient Q saw Dr. Frank in October, 2005 for heavy, painful periods. Dr. Frank ordered an ultrasound, which was found to be normal. Patient Q was next seen in follow-up, at which time Patient Q was booked for an LAVH. Dr. Frank failed to take the required step of obtaining an endometrial biopsy preoperatively.

35. Dr. Frank failed to document discussion of risks specific to Patient Q, in particular the increased risk of bladder injury as a result of Patient Q's prior caesarean sections. Dr. Frank failed to document which medical management options were discussed and the advice given to Patient Q as to each of those options given Patient Q's specific circumstances. It was Patient Q's understanding that Dr. Frank was recommending a hysterectomy for her.

36. Dr. Frank failed to adequately document the procedure in her operative note, as it did not clearly describe how the procedure was performed.

Patient R

37. Patient R was a patient in her first pregnancy seen by Dr. Frank for prenatal care. She was admitted to hospital in August, 2005 for induction of labour. Patient R had a prolonged second stage of labour followed by a failed forceps delivery by Dr. Frank. Dr. Frank then planned for the patient to go for a caesarean section, which she carried out approximately three hours later when an OR became available. In view of Patient D's prolonged labour and the failed forceps delivery, Dr. Frank should have, but did not, order prophylactic antibiotics prior to the caesarean section.

38. Following surgery, Patient R presented with an abnormal ECG and developed a fever, which continued for five days. Dr. Frank failed to appropriately document and coordinate Patient R's post-operative care and failed to ensure appropriate assessment of the patient. Patient R was found to have an intra-abdominal abscess which was drained by another physician seven days after the caesarian section.

Patient S

39. Patient S was seen by Dr. Frank in 2008 for heavy menstrual cycles. She was found to have multiple fibroids. She wished to avoid surgery and was given a prescription for an Evra patch. However, Patient S attended at hospital with abdominal pain, heavy flow and a palpable suprapubic mass. On the same day, she also saw Dr. Frank who noted pain and

bleeding. Dr. Frank ordered an ultrasound which found a large uterus with multiple fibroids. Dr. Frank booked Patient S for an LAVH. Dr. Frank failed to document the details of alternative treatment options that were discussed or the specific risks for Patient S, contrary to the standards of practice.

40. The surgery was completed in December, 2008. Dr. Frank's operative note indicated that, following the introduction of the laparoscope, a small bowel puncture due to the trocar placement was identified. Dr. Frank obtained an intra-operative general surgery consultation and, on advice, proceeded to a laparotomy (abdominal approach).

41. Given the size of the uterus and the presence of multiple fibroids, Dr. Frank should have proceeded with an abdominal rather than a laparoscopic approach. The manner in which Dr. Frank conducted the surgery therefore breached the standard of practice.

Patient T

42. Dr. Frank performed an LAVH on Patient T in 2007. During the surgery, Dr. Frank used a laparoscopic LigaSure device for a vaginal approach for cauterization of the uterosacral and cardinal ligaments. The shaft length of the instrument may have increased the risk of injury to the patient which could have been avoided with a different approach or method, such that it amounted to a breach of the standard of practice. Patient T presented to the emergency department a few days following surgery with urinary incontinence, and also presented to Dr. Frank's office. Dr. Frank ultimately facilitated Patient T being seen by further specialists and she was diagnosed with a ureterovaginal fistula, subsequently undergoing reparative surgery.

Patient U

43. Dr. Frank performed an LAVH on Patient U in 2010. During the surgery, Dr. Frank used a laparoscopic LigaSure device for a vaginal approach to divide the tissues up the broad ligament. The shaft length of the instrument may have increased the risk of injury to the patient which could have been avoided with a different approach or method, such that it

amounted to a breach of the standard of practice. Patient U experienced a ureteric vaginal fistula following surgery.

Patient V

44. Dr. Frank performed an LAVH on Patient V in 2009. During the surgery, Dr. Frank used a laparoscopic LigaSure device for a vaginal approach. The uterosacral and cardinal ligaments were cauterized and cut using the laparoscopic LigaSure device. The shaft length of the instrument may have increased the risk of injury to the patient which could have been avoided with a different approach or method, such that it amounted to a breach of the standard of practice.

45. Following the surgery, Dr. Frank failed to address in a timely way Patient V's post-operative complications, specifically what was eventually identified as a bowel perforation sustained during the surgery. Dr. Frank should have arranged for a general surgical consultation and a restricted diet earlier in light of Patient V's symptoms of bloody bowel movements, abdominal distension, severe pain, and a suspicion of bowel perforation.

Patient W

46. Dr. Frank assumed the prenatal care of Patient W in April, 2005. Patient W attended at hospital and was seen by others on October 6, 10 and 11, 2005. On October 12, 2005, Dr. Frank was notified of Patient W's re-attendance at hospital, assessed Patient W and admitted Patient W to hospital with a spontaneous rupture of membranes. An ultrasound showed a fetal heart rate of 133 and decreased amniotic fluid. Dr. Frank prescribed a 50 mcg dose of Misoprostol to augment labour.

47. There was a non-reassuring difficulty in registering a fetal heart rate. Dr. Frank then performed an emergency caesarean section. The infant was delivered and could not be resuscitated.

48. The use of Misoprostol for the induction of labour was not appropriate in this case and breached the standard of practice. Misoprostol can cause tetanic uterine contractions. Dr. Frank failed to obtain Patient W's informed consent for an off-label use of Misoprostol.

49. Immediately after the delivery, Dr. Frank performed a tubal ligation. Patient W did not consent to the tubal ligation. Dr. Frank failed to document any discussion with Patient W about a tubal ligation in her office records nor to document performance of the tubal ligation in her operative note in a timely manner, which breached the standard of practice.

Patient X

50. Patient X was seen by Dr. Frank in 2005 on referral for menorraghia. Patient X was booked for an LAVH on her first visit. Dr. Frank's medical records do not reflect any discussion of specific alternative options for Patient X, nor of any specific risks of the surgery, in breach of the standards of practice.

51. Dr. Frank failed to conduct or document necessary investigative steps to ascertain the cause of the menorraghia prior to booking Patient X for an LAVH, specifically, Dr. Frank's record does not document any physical examination prior to recommending an LAVH, nor does Patient X recall Dr. Frank having conducted one.

Patient BB

52. Patient BB saw Dr. Frank in 2003 for menorrhagia, pelvic pain, and stress incontinence. Dr. Frank obtained an ultrasound, which was found to be normal. At a subsequent appointment, Dr. Frank scheduled Patient BB for an LAVH and a tension free transvaginal tape procedure. These procedures were conducted. Dr. Frank failed to document in Patient BB's medical record any discussion of non-surgical options or of any specific risks related to the procedures.

Patient DD

53. Patient DD was seen by Dr. Frank in 2003 for menometrorrhagia. An ultrasound showed an ovarian cyst which was noted to be not simple. Dr. Frank booked Patient DD for an endometrial ablation and a diagnostic laparoscopy with possible ovarian cystectomy. Dr. Frank failed to document in Patient DD's medical record any discussion of specific alternative options, or of specific risks related to these procedures. During the surgery, Patient DD's uterus was perforated. The College does not allege that Dr. Frank's performance of the surgery failed to meet the standard of practice of the profession.

Patient EE

54. Patient EE was referred to Dr. Frank for post-menopausal bleeding, hot flashes, and atrophic vaginitis. Dr. Frank first assessed Patient EE in 2009. Dr. Frank ordered an ultrasound and subsequently performed an endometrial biopsy. Dr. Frank then carried out an LAVH with bilateral salpingo-oopherectomy (BSO) in 2010. Dr. Frank failed to document having discussed the specific risks of the LAVH and BSO along with the risks of not having surgery, such as the risk of progression, spread, and mortality.

55. The pathology from the LAVH and BSO showed that Patient EE had two types of cancer: a well differentiated endometrioid adenocarcinoma and an adult granulosa cell tumour. Follow-up for these cancers should have included a pelvic exam every three to four months for the first two years and every six months for up to five years. Dr. Frank failed to advise Patient EE of the pathology findings and of the appropriate frequency of follow up required, in breach of the standard of practice, rather advising her to attend for follow up in one year's time.

Patient AAA

56. Dr. Frank was the physician on-call at the hospital who managed Patient AAA when she was admitted to hospital in labour in 2006. After one hour of pushing, the fetal heart rate tracing showed variable decelerations. Dr. Frank decided to deliver the baby by forceps.

Dr. Frank failed to adequately assess and document the station and position of the fetal head before doing this. She then tried using forceps four times. She re-applied the forceps three times (including a change of forceps type). Each time, she noted that the forceps "slipped off." The trial of forceps lasted approximately half an hour. Dr. Frank failed to meet the standard of practice of the profession in her multiple uses of the forceps.

57. Dr. Frank failed to document in the record having received informed consent to proceed with a trial of forceps. Patient AAA does not recall having provided informed consent.

58. Dr. Frank moved to a caesarean section. However, and in breach of the standard of practice, Dr. Frank failed to appropriately arrange anaesthesia support before starting the trial of forceps, which then resulted in a delay of 48 minutes for anaesthesia to arrive.

59. Dr. Frank failed to adequately document how she performed the caesarean section. In particular, she failed to properly document the position of the baby at birth. She recorded the delivery as a "breech extraction" in her delivery summary, but did not make any reference to this in her operative note, stating there that it was in a vertex presentation.

60. Patient AAA and her baby both experienced significant complications following the birth. The baby required resuscitation and transfer to another hospital.

Admission

61. Dr. Frank admits the facts in paragraphs 1-60 above and admits:

(a) that she thereby failed to maintain the standard of practice of the profession in her care of all of the patients described above, under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*; and

(b) that in addition, she was incompetent as defined in subsection 52(1) of the Health Professions Procedural Code, in her professional care of Patient A, B, C, D, E, F, G, H, I, J, K, L, M, O, P, Q, R, S, T, U, V, W, X, and AAA.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Frank's admission and found that she committed an act of professional misconduct, in that she has failed to maintain the standard of practice of the profession. The Committee also found that Dr. Frank is incompetent.

AGREED STATEMENT OF FACTS FOR PENALTY

The following facts were set out in an Agreed Statement of Facts for Penalty, which was filed as an exhibit and presented to the Committee:

Prior Decisions

1. On March 4, 2009, the College's Complaints Committee issued a decision in which it required Dr. Frank to attend to be cautioned. The concerns of the Complaints Committee related to Dr. Frank's management of a twin pregnancy, including inadequate documentation and the failure to order appropriate bloodwork and glucose testing.

2. On September 13, 2016, the College's Inquiries, Complaints and Reports Committee ("ICRC") issued a decision in which it required Dr. Frank to attend to be cautioned. This decision was disposed of at the same time as some of the complaints in the current matter. The ICRC's concerns related to Dr. Frank's prenatal care of the patient in 2006 and, specifically, her failure to appropriately manage/investigate the patient's weight gain, hypertension and decreased fetal movement.

Undertakings

3. Dr. Frank has been the subject of a number of undertakings with the College as a result of prior complaints, reports and practice assessments. Currently, as further detailed below, Dr. Frank's practice is restricted as a result of undertakings entered into in 2011 and 2014, as well as an interim undertaking entered into in 2016 pending the current hearing, in lieu of an interim order.

4. On January 19, 2009, Dr. Frank provided an undertaking ("2009 Undertaking") agreeing to undergo a practice assessment and abide by recommendations of the assessor. She also agreed to complete the College's Medical Record-Keeping course as well as the Society of Obstetricians and Gynaecologists of Canada ("SOGC") ALARM course. A copy of the 2009 Undertaking is attached as Tab A [to the Agreed Statement of Facts for Penalty].

5. The 2009 Undertaking arose as a result of concerns regarding Dr. Frank's clinical care arising from two public complaints received in July and August of 2006. As a result of the two public complaints, the College initiated an investigation into Dr. Frank's practice under s. 75a of the *Health Professions Procedural Code,* Schedule 2 to the *Regulated Health Professions Act, 1991 (*the "*Code*"). The 2009 Undertaking was entered into in resolution of the s. 75a investigation.

6. On September 14, 2011, Dr. Frank agreed to an undertaking restricting her ability to practise obstetrical and gynecological surgery (the "2011 Undertaking"). Under the 2011 Undertaking, Dr. Frank was not permitted to practise gynecological or obstetrical surgery, unless as part of a remediation program. She also could not apply for gynecological or obstetrical privileges, and she was not permitted to practise as the most responsible physician in respect of any gynecological or obstetrical patients in any hospital. Nothing in the 2011 Undertaking nullified the 2009 Undertaking, which remained in effect. A copy of the 2011 Undertaking is attached as Tab B [to the Agreed Statement of Facts for Penalty].

7. The 2011 Undertaking arose after St. Thomas-Elgin General Hospital announced that it would be conducting an external review into Dr. Frank's practice at the hospital. Dr. Frank subsequently voluntarily resigned her staff appointment at the hospital and this was reported to the College.

8. On December 7, 2012, Dr. Frank signed an undertaking (the "2012 Undertaking"). Under this undertaking, the 2011 Undertaking remained in effect, meaning that the restrictions on Dr. Frank's ability to practise obstetrical and gynecological surgery continued. In addition, under the 2012 Undertaking, Dr. Frank agreed to a two-year period of clinical supervision. She also agreed not to perform ultrasound procedures without further

training if the College deemed that her training and certification were not appropriate. She further agreed to complete a program in medical ethics. A copy of the 2012 Undertaking is attached as Tab C [to the Agreed Statement of Facts for Penalty].

9. The 2012 Undertaking arose as a result of recommendations made by assessors pursuant to the 2009 Undertaking.

10. On October 21, 2014, Dr. Frank executed another undertaking (the "2014 Undertaking"), which replaced the 2009 and 2012 Undertakings. The 2011 Undertaking restricting Dr. Frank's scope of practice to exclude obstetrical and gynecological surgery remained in effect. In addition, pursuant to the 2014 Undertaking, Dr. Frank could not conduct ultrasound testing, interpret ultrasound images, or perform ultrasound-guided procedures unless she completed remediation and reassessment. Dr. Frank also agreed to ongoing clinical supervision. A copy of the 2014 Undertaking is attached as Appendix D. The undertaking includes an Individualized Education Plan to be completed by Dr. Frank.

11. The 2014 Undertaking arose as a result of the recommendations from a clinical supervisor retained pursuant to the terms of the 2012 Undertaking.

12. On April 27, 2016, Dr. Frank provided an undertaking in lieu of an order under s. 37 of the *Code* pending the disposition of the current matter (the "2016 Undertaking"). Pursuant to this undertaking, Dr. Frank agreed to practise under a clinical supervisor who would submit reports to the College at least once per quarter. The restrictions on her scope of practice from the 2011 and 2014 Undertakings remained in effect. Attached as Tab E is a copy of the 2016 Undertaking. Attached as Tab F [to the Agreed Statement of Facts for Penalty] is Dr. Frank's Individualized Education Plan from the 2014 Undertaking, revised and updated pursuant to the terms of the 2016 Undertaking.

Current Practice Restrictions

13. Dr. Frank has existing practice restrictions as a result of the undertakings described above which are as follows:

(a) As further detailed in Tab B [to the Agreed Statement of Facts for Penalty] (2011 Undertaking), pursuant to the terms of the 2011 Undertaking, which remains in effect, Dr. Frank is not permitted to:

(i) Practise in the area of gynecological or obstetrical surgery unless she is doing so as part of a Remediation Program pre-approved by the College and is supervised by a preceptor who is acting as most responsible physician ("MRP") for all patients;

(ii) Apply for gynecological or obstetrical surgery privileges at any hospital whatsoever; and

(iii) For further clarity, Dr. Frank is not permitted to engage in the practice of medicine as the MRP in respect of any obstetrical or gynecological patients, at any hospital whatsoever.

(b) As further detailed in Appendix F (revised and updated Individualized Education Plan), the terms of the 2014 Undertaking that have not been completed remain in effect. Specifically:

(i) While Dr. Frank may be the MRP performing ultrasounds on her own patients, she may only do so under the supervision of the clinical supervisor (who reviews her charts as described in paragraph b(iii) below).

(ii) While Dr. Frank may be the MRP performing ultrasound-guided procedures on her own patients, she may only do so under the supervision of the clinical supervisor, meaning that Dr. Frank's ultrasound-guided procedures may only be performed in the clinical supervisor's clinic and where a reproductive endocrinologist and infertility specialist is always available on the premises to intervene if required. Although Dr. Frank is permitted to perform ultrasound-guided procedures in these circumstances, Dr. Frank currently has ceased performing these procedures.

(iii) The clinical supervisor is required to select and review a minimum of fifteen charts per month related to imaging, ultrasound-guided procedures and pelvic and pregnancy ultrasounds and meet with Dr. Frank once every month. The clinical supervisor is also required to provide quarterly reports to the College.

(c) As further detailed in Tab E [to the Agreed Statement of Facts for Penalty] (2016 Undertaking), until final disposition of this Discipline Committee proceeding, Dr. Frank is required to practise under the guidance of a clinical supervisor with respect to all areas of her practice. The clinical supervisor is required to review at least fifteen of Dr. Frank's patient charts from all areas of her practice once every month and meet with Dr. Frank once every month. The clinical supervisor is also required to submit written reports to the College at least once every quarter.

(d) The 2014 Undertaking required reassessment of Dr. Frank's practice following the required remediation. In the process of agreeing to the 2016 Undertaking, Dr. Frank agreed to submit to a reassessment of her practice by an assessor or assessors selected by the College, to take place six months after she had returned to practise following the conclusion of the Discipline Committee proceeding.

14. Therefore, since 2011, Dr. Frank has been prohibited from performing any obstetrical or gynecological surgeries. Since 2012, Dr. Frank's ability to perform ultrasounds and ultrasound-guided procedures has been restricted. Dr. Frank's current practice consists of reproductive endocrinology and infertility, office gynecology and early obstetrical care.

Monitoring Reports

15. The College has received reports from Dr. Frank's clinical supervisors pursuant to the undertakings described above and, in particular, most recently, pursuant to the requirements of the 2014 Undertaking and the 2016 Undertaking. The recent reports received from Dr. Frank's clinical supervisor have been consistently positive. While Dr. Frank's current clinical supervisor under the 2014 and 2016 Undertakings, Dr. Clifford Librach has raised criticisms in individual cases, the number of criticisms has declined

over time. In addition, Dr. Librach has not raised any significant practice concerns. Attached as Tab G [to the Agreed Statement of Facts for Penalty] are the four most recent reports from Dr. Librach regarding Dr. Frank's performance of ultrasounds and ultrasound-guided procedures. Attached as Tab H [to the Agreed Statement of Facts for Penalty] are Dr. Librach's four most recent reports regarding Dr. Frank's remaining scope of practice.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Frank made a joint submission as to an appropriate penalty and costs order. The penalty proposed included a reprimand, a 24-month suspension and the imposition of terms, conditions and limitations on Dr. Frank's certificate of registration.

The proposed terms, conditions and limitations include that Dr. Frank's practice be restricted to the areas of reproductive endocrinology and infertility, office-based gynecology and early obstetrical care (i.e., before 20 weeks of pregnancy. Upon her return to practise, she will be able to perform ultrasound-guided procedures only in a clinic belonging to a clinical supervisor and where a reproductive endocrinologist and infertility specialist are always available. She will practise in a group setting acceptable to the College. The proposed terms, conditions and limitations also provide for chart reviews, patient contacts, unannounced inspections, contact with her Clinical Supervisors and a reassessment of her practice by a College-appointed assessor approximately six months after she resumes practice. The College will be permitted to communicate with OHIP regarding her submissions and fees.

In considering the jointly proposed order, the Committee was mindful that it should not depart from a joint submission on penalty, unless it would bring the administration of justice into disrepute, or is otherwise not in the public interest (*R. v. Anthony-Cook*, [2016] 2 SCR 204).

The Committee also took into account the principles of penalty in considering the proposed order. Paramount in this case is the protection of the public. Also important are: expressing the profession's abhorrence of the behaviour; maintaining public confidence in the profession and

the College's ability to regulate the profession in the public interest; specific deterrence of the member; general deterrence of other physicians; and, when possible, the penalty should provide for rehabilitation of the member. The penalty should also be proportionate to the misconduct.

The Committee also considered the aggravating and mitigating factors in this case and reviewed similar cases. The Committee concluded that the jointly proposed order was appropriate.

Aggravating Factors

Nature of the Misconduct

i) Deficiencies in Clinical Care

Dr. Frank has admitted that she failed to maintain the standard of practice in relation to various very serious deficiencies in her clinical care involving a large number of patients (27). In relation to her care of 24 of the patients, she also admitted that she is incompetent.

Dr. Frank's operating room work resulted in frequent complications and she was slow in identifying and treating these outcomes. Several of the patients had post-operative hematomas (Patients A and C, who were not examined prior to discharge in spite of falling haemoglobins).

Dr. Frank failed to note a fourth degree laceration in Patient H. Patient P experienced a third degree laceration following forceps use. Patient S experienced a small bowel puncture due to trocar placement which was related to laparoscopic, rather than an abdominal approach in surgery. Patient T and Patient U both developed ureterovaginal fistulas following a procedure which was related to Dr. Frank's selection of surgical method or instrument.

Dr. Frank did not adhere to conventional practice for dosages of medication. Patient D was given excessively high doses of Misoprostil for induction of labour. Dr. Frank also failed to use prophylactic antibiotics when indicated (Patient R).

There were many deficiencies in after-care for surgical patients. Patient R developed an intra-abdominal abscess which was drained by another surgeon seven days postop. Patient V developed a perforation which was not handled in a timely way. Patient EE did not receive appropriate follow-up care when two types of cancer were discovered. Patient AAA experienced significant complications when Dr. Frank did not arrange for appropriate anaesthesia support before starting a trial of a forceps delivery.

Dr. Frank failed to maintain the standard of practice of the profession when it came to investigating possible causes of her patients' symptoms. For example, Patient A, who experienced uterine bleeding, did not receive an ultrasound or blood work. Nor did others in her practice: Patient F who had irregular periods; Patients C and I with menorrhagia; Patient G for chronic pain. Patients K, L, M, and Q did not receive an endometrial biopsy when indicated.

Dr. Frank did not always describe the risks involved in proposed treatments (Patients B, M, and P). She did not present possible alternate therapies (Patients E, J, K, O, S, X, BB, and DD) and did not obtain informed consent from some of her patients. For example, Patient I had her one remaining ovary removed without prior discussion.

ii) Poor Medical Record-Keeping

Dr. Frank's problems do not reflect a single episode or even a few episodes over a brief period of time. Rather serious deficiencies occurred over seven years and began in 2003, shortly after she obtained her certificate of registration for independent practice. The on-going nature of the deficiencies indicates a serious lack of self-scrutiny or reflection about her clinical work and its effects on others.

iii) Deficiencies in Knowledge, Skill, and Judgment

Dr. Frank's deficiencies reflect a whole variety of problems in knowledge, skills, and judgement in many basic areas – covering almost the entire gamut of clinical care in obstetrics and gynaecology.

The number of patients impacted, the lengthy period of time over which the misconduct occurred, and Dr. Frank's failure to reflect on and correct the deficiencies in her practice or limit her practice to areas in which she was competent are all aggravating factors in this case.

Prior History with the College: Undertakings

Dr. Frank has had a long history of involvement with the College, including many undertakings:

- In response to complaints in 2006, Dr. Frank entered into an undertaking with the College in 2009, agreeing to a practice assessment and to abide by the assessor's recommendations, and to take courses in record-keeping and the OB/GYN ALARM course.

- When St. Thomas Elgin General Hospital reported that it would be conducting an external review into Dr. Frank's hospital practice, Dr. Frank entered into an undertaking in 2011. Pursuant to the 2011 Undertaking, Dr. Frank was not permitted to practise gynacologic or obstetric surgery, unless it was part of her remediation program. She could also not apply for privileges in obstetrics or gynecology elsewhere, and she was not permitted to practise as the MRP in any hospital for OB/GYN patients.

- A third undertaking in 2012 was initiated by assessors who were following the 2009 Undertaking. While the 2011 Undertaking continued, Dr. Frank also agreed to a two-year period of clinical supervision, and not to perform ultrasound procedures without further training. She also agreed to complete a program in medical ethics.

- Dr. Frank entered into a fourth Undertaking with the College in 2014 as a result of the report of a clinical supervisor appointed to supervise her practice in 2012. Prior to this, Dr. Frank's scope of practice continued to exclude obstetric and gynecologic surgery. Pursuant to the 2014 Undertaking, she was not able to conduct ultrasound testing or interpret ultrasound images, unless she completed her remediation and reassessment. She also agreed to on-going clinical supervision and an individualized education plan.

- Pursuant to the fifth undertaking from 2016, Dr. Frank was required to practise under the supervision of a clinical supervisor who would provide quarterly reports to the College. The restrictions on her certificate of registration and education requirement as documented in 2014 remained in effect.

Prior History with the College: ICRC Cautions

Dr. Frank had prior cautions from the ICRC:

- In 2009, Dr. Frank was cautioned by the ICRC regarding her management of a twin pregnancy. She had failed to order appropriate laboratory tests and there was inadequate documentation.
- In September 2016, Dr. Frank was cautioned by the ICRC for the second time. This caution is related to complaints in the current case.

Mitigating factors

The Committee noted the following mitigating factors.

Dr. Frank has admitted her professional misconduct and incompetence and has expressed responsibility for her behaviour. By agreeing to the statement of facts on liability and jointly proposed penalty, Dr. Frank has saved considerable time and cost and the significant emotional burden for the witnesses of having to testify in a contested hearing.

Dr. Frank has previously entered into undertakings with the College voluntarily and has pursued many of the requirements set out in these undertakings. This is her first appearance before the Discipline Committee.

Dr. Frank’s current supervisor is consistently positive regarding her skills and behaviour in the restricted areas of her current practice.

Case Law

While no two cases are exactly alike, it is useful to compare similar cases when determining the appropriateness of the penalty. The Committee reviewed the case of *CPSO v. Prevost* (2015). Dr. Prevost, an obstetrician and gynaecologist, was found deficiencies in his care of 28 patients. As in the case with Dr. Frank, there were significant difficulties in obtaining or documenting informed consent and appropriate pre-operative medical or anaesthesia consults. Follow-up did not occur in a timely manner, and there were problems in communication and charting. Dr. Prevost entered into an undertaking with the College in which he resigned his certificate of registration and agreed not to re-apply for registration to practise in Ontario. Dr. Prévost also agreed never to practise obstetrics or gynecology in any jurisdiction after his resignation. The Discipline Committee in this instance noted a blatant disregard by Dr. Prevost for the welfare of his patients and for patient safety. While similarities exist with the current case, it is noteworthy that Dr. Frank's behaviour has improved significantly since 2011 when her practice became limited in scope and there was strict oversight. She has since received very positive reports.

In *CPSO v. Austin* (2014), Dr. Austin admitted to engaging in professional misconduct, in that he failed to maintain the standard of practice in his care of four patients. He had practised obstetrics and gynecology since 1973. In 2007, he agreed to terms, conditions, and limitations on his certificate of registration that restricted his obstetrical practice to office prenatal care only. His surgical practice and elective caesarean sections were to be performed only in the presence of another obstetrician/gynecologist. The joint submission regarding penalty included a reprimand and costs, as Dr. Austin had previously resigned his membership with the College and agreed never to re-apply for registration to practise medicine in Ontario or in any other jurisdiction. It was noted that Dr. Austin's errors covered "not just one area of care, but the spectrum of care of the four individual patients."

The Committee also considered *CPSO v. Yazdanfar* (2011). Dr. Yazdanfar was a general practitioner practising cosmetic surgery. As in Dr. Frank's case, Dr. Yazdanfar was found to have committed an act of professional misconduct, in that she failed to maintain the standard of practice of the profession. The Discipline Committee also found her to be incompetent. She did

not observe appropriate limits and exceeded safe volume limits in conducting liposuction procedures. She removed volumes of aspirate far beyond what surgeons acting properly would do. She stood by and failed to call 911, while a patient was in significant distress and eventually died. She also failed to obtain informed consent and to safely discharge patients in a number of ways. She was also found to have contravened the regulations regarding advertising. The Committee found that she failed to take personal responsibility for her actions. This case demonstrates very serious clinical breaches, which resulted in a two-year suspension, followed by significant practice restrictions.

Conclusion

Having considered all of these factors, the Committee was satisfied that the proposed penalty in this case was appropriate. The public is protected by the two-year suspension of Dr. Frank's certificate of registration and by the imposition of significant terms, conditions and limitations on Dr. Frank's certificate of registration on her return to practice. She will be practising only in areas in which she has been evaluated to be competent. She will be closely monitored in a group setting by a supervisor approved by the College and will be supervised and reassessed.

The two-year suspension and practice restrictions serve as a strong deterrent to the profession as a whole and a specific deterrent to Dr. Frank. Rehabilitation has in part occurred by the various education programs she has taken and the close supervision in her restricted areas of practice.

The public can be reassured of the College's ability to regulate the profession in the public interest.

Costs

This is an appropriate case in which to order costs in the amount agreed upon by the parties.

ORDER

The Committee stated its finding in paragraphs 1 and 2 of its written order of February 26, 2018. In that Order, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Frank attend before the panel to be reprimanded.

4. the Registrar suspend Dr. Frank's certificate of registration for twenty-four (24) months, to commence at 12:01 a.m., February 27, 2018.

5. the Registrar impose the following terms, conditions and limitations on Dr. Frank's certificate of registration:

(i) Dr. Frank shall practise only in the areas of reproductive endocrinology and infertility, office-based gynecology and early obstetrical care (i.e. before 20 weeks of pregnancy);

(ii) Upon returning to practice following the suspension of her certificate of registration pursuant to paragraph 4 above, Dr. Frank shall comply with any College policy regarding re-entering practice in existence at the time of her resumption of practice. Without restricting the generality of the foregoing, any program pursuant to the College policy regarding re-entering practice shall, at a minimum, require that:

1) Dr. Frank initially perform ultrasound-guided procedures only in a clinic belonging to a clinical supervisor and where a reproductive endocrinologist and infertility specialist is/are always available on the premises to intervene if required; and,
2) Approximately six (6) months following Dr. Frank's return to practice, Dr. Frank undergo a reassessment of her practice (the "Reassessment") by a College-appointed assessor or assessors (the "Assessor(s)"). Dr. Frank shall cooperate fully with the Reassessment, which may include a review of Dr. Frank's patient charts, direct observation, interviews with staff and/or patients, and/or other tools deemed necessary by the College. The results of

the Reassessment shall be reported to the College, and, if requested to do so by the College, Dr. Frank shall abide by the recommendations of the Assessor(s). Any of those recommendations of the Assessor(s) which are limitations and/or restrictions on Dr. Frank's practice and/or which the Inquiries, Complaints and Reports Committee identifies as limitations and/or restrictions on her practice shall be included on the public register as terms, conditions, or limitations on her Certificate of Registration for the purposes of section 23 of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991,* S.O. 1991, c. 18, as amended;

(iii) Dr. Frank shall only practise in a group setting which has been approved by the College;

(iv) Dr. Frank shall consent to sharing of information among the Assessor(s), any of her Clinical Supervisor(s), and the College as any of them deem necessary or desirable in order to fulfill their respective obligations;

(v) Dr. Frank shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce her compliance with the terms of this Order;

(vi) Dr. Frank shall submit to, and not interfere with, unannounced inspections of her Practice Locations and patient charts by a College representative for the purposes of monitoring her compliance with the terms of this Order;

(vii) Dr. Frank shall give her irrevocable consent to the College and to her Assessor(s) to make enquiries of her patients regarding medical services provided by her in order to ensure that she is documenting all information relevant to her practice in an accurate way;

(viii) Dr. Frank shall consent to the College providing any Chief(s) of Staff or a colleague with similar responsibilities at any location where she practises with any information the College has that led to this Order and/or any information arising from the monitoring of her compliance with this Order; and,

(ix) Dr. Frank shall be responsible for any and all costs associated with implementing the terms of this Order.

6. Dr. Frank pay to the College costs in the amount of $10,180.00, within thirty (30) days of the date of this Order.

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

TEXT of PUBLIC REPRIMAND
Delivered February 26, 2018
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. CATHY SHEILA FRANK

As a self-regulating profession, physicians take Standards of Practice with utmost seriousness. Your failure to do so on so many levels, for so many years is shocking. We are taught in medical school of the importance of informed consent, investigation of causes, consideration of alternative treatments, the importance of documentation and the provision of adequate aftercare. You failed in all these areas, as well as with regard to medication prescribing. Your operating room care on a number of occasions fell below the acceptable standard of care, and caused great morbidity and suffering to patients to whom you had a fiduciary responsibility.

In our view, your numerous deficiencies with regard to your practice, suggests a lack of critical self-appraisal. Your serious errors undermine the public confidence, and by extension the good reputation of the profession as a whole. Hearing about your failings contributes to people feeling even more anxious about tests, surgery or even having a baby. Your incompetence and failing to maintain the Standard has harmed so many in myriad ways.

This is your first appearance before the Discipline Committee, and we're heartened by the positive reviews of your clinical supervisors. We hope you never appear before us again.

This is not an official transcript