Dr. Tiffany Wai Mei LEE

Council Decision

Date Charge(s) Laid:	April 10, 2018
Outcome Date:	June 16, 2018
Hearing:	June 16, 2018
Disposition:	Ethics Course, Reprimand, Costs

Dr. Lee admitted to unprofessional conduct for practicing medicine and providing medical services in a Saskatoon Hospital without being licensed by the College of Physicians and Surgeons of Saskatchewan.

The Council of the College of Physicians and Surgeons imposes the following penalty on Dr. Tiffany Wai Mei Lee pursuant to ***The Medical Profession Act, 1981****:*

1) Pursuant to Section 54(1)(b) of The Medical Profession Act, 1981, the Council hereby suspends Dr. Lee for a period of 1 month suspended pending the successful completion of an ethics course on ethics and professionalism to the satisfaction of the Registrar. Such course shall be completed within the next 12 months. The programs "Medical Ethics, Boundaries and Professionalism" by Case Western Reserve University, "Probe Program" by CPEP and "Medical Ethics and Professionalism" by Professional Boundaries Inc., are ethics programs acceptable to the Registrar.

2) Pursuant to Section 54(1)(e) of *The Medical Professional Act, 1981*, the Council hereby reprimands Dr. Lee. The format of that reprimand to be determined by the Council;

3) Pursuant to section 54(1)(i) of *The Medical Profession Act, 1981*, the Council directs Dr. Lee to pay the costs of and incidental to the investigation and hearing in the amount of $690. Such payment shall be made in full by July 1, 2018.

4) Pursuant to section 54(2) of *The Medical Profession Act, 1981*, if Dr. Lee should fail to pay the costs as required by paragraph 4, Dr. Lee's licence shall be suspended until the costs are paid in full.

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REGISTRAR
KAREN SHAW, M.D.

18 September, 2018

Dr. T. Lee
[redacted]

Dear Dr. Lee,

The Council has considered your matter and accepted your admission of professional misconduct with respect to your licensure. Despite our understanding that you are a fully qualified and well trained physician, the bylaws governing registration cannot be overlooked regardless of the best of intentions to provide care to those in need. The fact remains that you elected to practice medicine without having a license to do so. There are very few areas of professional misconduct which are considered as serious as practising medicine without a license.

It is unfortunate that the start of a potentially long and successful medical career stumbled with a moment of poor judgement. The start of any new chapter in a career brings new challenges, some of which may provoke anxiety, but all of which require careful consideration and a thoughtful approach. In circumstances where a physician finds themselves on the horns of a dilemma, seeking the help of colleagues is often essential even when it may be unpalatable. It was argued that as a new practitioner, you were unable to contact a member of your department to solicit aid in changing your roster. The Council rejects this argument, as there is always a colleague up to and including Area Chiefs of Staff (previously Senior Medical Officers) or their designates who are available on a 24/7 basis to manage urgent and emergent administrative issues. While it may have been embarrassing to enlist the aid of such persons, we are certain that you now agree it would have been preferable to be embarrassed, than to be disciplined for misconduct.

Continued……..

Misunderstanding of the rules of licensure are unfortunately common. For those who find registration bylaws complex, the College maintains a robust staff who are willing and able to help practitioners transition into practice within reasonable timelines. The registration bylaws of the College exist to ensure not only that the public is assured of medical care delivered by those who are fully qualified and licensed to deliver such care, but also to aid practitioners in identifying the necessary requirements to obtain regular licensure. Despite the necessary complexity of registration bylaws, infractions are treated with the upmost significance by the Councils of every medical regulatory authority across the country.

The Council recognises that your poor decision did not place patients in harm's way, and was undertaken in a somewhat misguided attempt to avoid administrative difficulties with your new departmental colleagues. We recognize the forthright manner in which you have admitted your mistake from the outset. While any discipline matter is a stain, it need not impede your future success. It is the sincere hope of the Council that you will now be able to move forward to great professional success and satisfaction in your practice as a duly licensed member of the College.

Sincerely,

The Council of the College of Physicians and Surgeons of Saskatchewan

IN THE MATTER OF SECTION 46 (O) OF **THE MEDICAL PROFESSIONAL ACT, 1981** AND DR. TIFFANY WAI MEI LEE OF THE CITY OF SASKATOON, SASKATCHEWAN

Ms. Michelle Ouellette QC, for Dr Lee

Mr. Bryan Salte QC, for the College of Physicians and Surgeons of Saskatchewan.

REASONS FOR DECISION

Introduction and Background

[1] Dr. Lee is a 29 year old physician who obtained her M.D., from McMaster University in Ontario in 2012. Dr. Lee subsequently obtained her FRCPC in Internal Medicine in 2016 and fellowship in Critical Care Medicine in 2017. She has been fully licensed in Ontario since August, 2016.

[2] Dr. Lee was previously licensed by the College of Physicians and Surgeons of Saskatchewan for one month in 2012 as an undergraduate medical student (JURSI). She was also subsequently licensed as a resident. Dr. Lee is currently licensed in both Saskatchewan and Ontario. Dr. Lee has privileges to practice critical care in Saskatoon on an itinerant basis, but her primary practice is in Ontario.

[3] The course of events put forward by the Registrar's Office and uncontested by Dr. Lee is available in CPSS document **Info 118_18**. On 15 August, 2017 Dr. Lee requested an expedited licence to accommodate her initial day of practice scheduled for 19 August, 2017. She was advised that this timeline was not possible. Further communications took place which did not result in expedited licensure being granted. Dr. Lee began practice in Saskatoon Health Region as an intensive care physician on 19 August, 2017 without having a license to do so. The Saskatoon Health Region contacted CPSS on August 31, 2018 to communicate concerns of Dr. Lee practicing without a licence. Subsequent investigation confirmed the facts as presented by the Registrar's Office to the Executive Committee. The Executive Committee proceeded to charge Dr. Lee with unprofessional conduct.

THE CHARGE

[4] The Executive Committee of Council laid the following charges against Dr. Lee.

> *You Dr. Tiffany Wai Mei Lee are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) of* ***The Medical Profession Act, 1981*** *s.s. 1980-81 c. M-10.1.*
>
> *The evidence that will be led in support of this charge will include one or more of the following:*
>
> *(a) You practiced medicine in Saskatchewan in the period of approximately August 20, 2017 to August 28, 2017 without being licensed by the College of Physicians and Surgeons of Saskatchewan;*
>
> *(b) You provided medical services in a Saskatoon Hospital without having been privileged to do so;*
>
> *(c) You were advised in communications with staff of the College of Physicians and Surgeons of Saskatchewan that you would not receive a license to practice medicine until after August 20, 2017 and that you should delay your planned starting date to practice medicine in Saskatchewan.*

[5] On Saturday 16 June, 2018 Council convened a penalty hearing pertaining to Dr. Tiffany Wai Mei Lee. Dr. Lee admitted the charges laid against her.

THE PENALTY

[6] At its meeting of 16 June 2018, submissions were made by Ms. Michelle Ouellette on behalf of Dr. Tiffany Lee and Mr. Bryan Salte on behalf of the Registrar's Office. Following deliberation Council imposed the following penalty:

a. *Pursuant to Section 54(1)(b) of The Medical Profession Act, 1981, the Council hereby suspends Dr. Lee for a period of 1 month suspended pending the successful completion of an ethics course on ethics and professionalism to the satisfaction of the Registrar. Such course shall be completed within the next 12 months. The programs "Medical Ethics, Boundaries and Professionalism" by Case Western Reserve University, "Probe Program" by CPEP and "Medical Ethics and Professionalism" by Professional Boundaries Inc., are ethics programs acceptable to the Registrar.*

b. *Pursuant to Section 54(1)(e) of The Medical Professional Act, 1981, the Council hereby reprimands Dr. Lee. The format of that reprimand to be determined by the Council;*

c. *Pursuant to section 54(1)(i) of The Medical Profession Act, 1981, the Council directs Dr. Lee to pay the costs of and incidental to the investigation and hearing in the amount of $690. Such payment shall be made in full by July 1, 2018.*

d. *Pursuant to section 54(2) of The Medical Profession Act, 1981, if Dr. Lee should fail to pay the costs as required by paragraph 4, Dr. Lee's license shall be suspended until the costs are paid in full.*

Factors in Establishing Penalty

[7] The factors which are frequently considered in imposing an appropriate penalty are outlined in **Camgoz v. College of Physicians and Surgeons**, 1993 CanLII 8952 (SK.Q.B.) https://www.canlii.org/en/sk/skqb/doc/1993/1993canlii8952/1993canlii8952.html?resultIndex=3

a) the nature and gravity of the proven allegations;

b) the age of the offending physician;

c) the age of the offended patient;

d) evidence of the frequency of the commission of the particular acts of misconduct within particularly, and without generally, the Province;

e) the presence or absence of mitigating circumstances, if any;

f) specific deterrence;

g) general deterrence;

h) previous record, if any, for the same or similar misconduct,

i) the length of time that has elapsed between the date of any previous misconduct and conviction thereon, and, the member's (properly considered) conduct since that time;

j) ensuring that the penalty imposed will, as mandated by s. 69.1 of the Act, protect the public and ensure the safe and proper practice of medicine;

k) the need to maintain the public's confidence in the integrity of the respondent's ability to properly supervise the professional conduct of its members;

l) ensuring that the penalty imposes is not disparate with penalties previously imposed in this jurisdiction in particular, and in other jurisdictions in general, for the same or similar act of misconduct.

The Position of the Registrar

[8] The Registrar's Office presented both written and verbal arguments for consideration. Based on these arguments the penalty sought may include:

a. A suspension
b. An order that Dr. Lee take and ethics course
c. A reprimand
d. An order that Dr. Lee pay the College's costs of $690

[9] The timecourse of the case was presented in document **Info 118_18** and are uncontested by Dr. Lee. The Registrar's Office put forward the argument that Dr. Lee was fully aware that she would be incapable of obtaining licensure by the date of her first scheduled shift in the ICU. There were no concerns regarding competency or quality of care delivered. The Registrar's Office does not accept that the administration of SHR would not have been able to coordinate alternate care had Dr. Lee demonstrated that she was not duly licensed. The question of CMPA coverage was raised in as much as it is not clear that Dr. Lee's Ontario license implies CMPA coverage in Saskatchewan had there been a misadventure in care resulting in a finding against Dr. Lee during the period of unlicensed practice. The Registrar's Office suggests that Dr. Lee was fully aware of her situation, and that she made a deliberate decision to proceed to practice regardless of the obvious absence of licensure.

[10] Relevant case law presented and rebutted included:

a. Merchant v. Law Society of Saskatchewan, 2014 SKCA 56
b. Peet v. Law Society of Saskatchewan, 2014 SKCA 109
c. Farbeh v. College of Pharmacists of British Columbia, 2015 BCSC 642
d. Dr. Abed, CPSS 2016
e. Dr. Syan, CPSO 2016
f. Dr. Ernst, CPSS 2017

[11] The case law presented focused on the challenges in determining penalty in situations where the penalty sought may be outside the range of comparable case law which may seem contrary to the accepted 'Camgoz factors.' Further case law focused on practicing in defiance of an undertaking, and the consequences of poor communication with the Registrar's Office or its proxy departments within the College.

The Position of Dr. Lee

[12] Council for Dr. Lee presented both written and verbal arguments for consideration. Based on these arguments the penalty sought should be limited to;

a. A reprimand
b. Costs incurred

[13] Council for Dr. Lee opines that the period in question was exceptionally busy for Dr. Lee in that she was completing serial locum positions while studying for a complex examination in critical care medicine. The result of these pressures was a failure on Dr. Lee's part to initiate the licensure application in sufficient time. There was a further 'understandable' inability to manage the complexities of licensure application given a misunderstanding on her part that past educational licensure was sufficiently similar to allow for expedited process to full licensure. There was no understanding that seemingly redundant components of the application process were required on subsequent applications.

[14] Council for Dr. Lee explained that Dr. Lee was unable to communicate her lack of licensure with her department head as he was unavailable in the time course in question. As a new practitioner with no local contacts, it was suggested that Dr. Lee felt she had no administrative alternatives and that in the absence of someone capable of affecting scheduling changes, she would be placing patients at potential harm if she did not proceed to complete her scheduled shifts, regardless of the status of her licensure. This was deemed the 'lesser of two evils.'

[15] Council for Dr. Lee identified that she was not paid for the work done while unlicensed. Further comments were made with respect to the forthright manner in which she admitted her wrongdoing and that her discipline is warranted. The relative youth of Dr. Lee was offered as a mitigating factor in the determination of penalty.

[16] Relevant case law presented included:

e. Dr. Smith, CPSS 2007
f. Dr. Nagai, CPSS 2011
g. Dr. Ernst, CPSS 2017
h. Dr. Richardson, CPSBC 2015
i. Dr. Figurski, CPSS 2010

[17] Case law presented focused on ensuring that a determined penalty is not disparate from similar circumstances. All cases were presented as examples of similar severity of indiscretion.

Reasons for the Penalty Decision

[18] The Council agreed with the penalty suggestions of the Registrar's Office.

[19] Council deliberated in-camera and considered arguments submitted by Counsel for Dr. Lee regarding her conduct. Deliberation included discussions regarding the potential mitigating factors of youth, external pressures, a suggested misunderstanding of the application process and the perceived absence of administrative support. There was considerable argument put forward by both counsels regarding the factors involved in determining appropriate penalty given the circumstances. Case law presented by both counsel was not found to be particularly helpful in determining penalty.

[20] Council recognized that Dr. Lee appears to be a competent and well trained intensivist. Council concedes that Dr. Lee demonstrated a true concern for the wellbeing of the patients whom she was scheduled to care for. However, Council was unable to accept that this concern for patient wellbeing justified her willingness to practice medicine without licensure to do so. Similarly, Council was unable to accept that there was no member of SHR administration who could not have served to modify the ICU physician rosters in the event of a physician being unlicensed to practice. It is established fact that every health region in Saskatchewan has an administrator and senior physician on call at all times to deal with such logistically urgent scenarios.

[21] Council also considered the presentation made by Dr. Lee herself. Dr. Lee was found to be contrite and remorseful. It is accepted that given her expertise, there was no specific risk of harm to patients.

[22] Legal counsel for the Registrar's Office argued several aggravating factors in this penalty presentation. The actions were not accidental. The Registrar's Office disputes the contention that Dr. Lee did not understand the situation. Dr. Lee had been informed by the registration services staff that her license to practice medicine in Saskatchewan was not yet in place, but despite that she proceeded to practice medicine in Saskatchewan. Her action was therefore deliberate, considering all factors present in the sequence of the events of her conduct. The issue of CMPA coverage, although she was a full member of the CMPA in Ontario, was discretional, and not a given fact. This provided uncertainty as to whether the public would have been protected, should something have gone wrong which thankfully it did not.

[23] Council also discussed the need to maintain the public's confidence in the integrity of the College to properly supervise the professional conduct of its members.

Accepted by the Council of the College of Physicians and Surgeons of Saskatchewan: Saturday 1 December, 2018