Indexed as: Austin, R. C. (Re)

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. RICHARD CONOLLY AUSTIN

PANEL MEMBERS:

DR. E. STANTON (CHAIR)
D. GIAMPIETRI
DR. S. KAPOOR
S. BERI
DR. A. FALCONER

Hearing Date:	March 18, 2014
Decision Date:	March 18, 2014
Release of Written Reasons:	July 4, 2014

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 March 18, 2014. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Austin 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 he has failed to maintain the standard of practice of the profession;

2. under paragraph 1(1)3 of O. Reg. 856/93, in that he abused patients verbally or physically;

3. under paragraph 1(1)4.1 of O. Reg. 856/93 in that he practised the profession while he knew that he had deficient clinical ability; and

4. under paragraph 1(1)33 of O. Reg. 856/93 in that he 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. Austin is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. Austin was not present at the hearing. Through his legal counsel, who was in attendance, he admitted the first allegation in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession. Counsel for the College withdrew the remainder of the professional misconduct allegations and the allegation of incompetence.

FACTS AND EVIDENCE

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

PART I – THE FACTS

1. Dr. Richard Conolly Austin ("Dr. Austin") was first granted a post-graduate education certificate by the College of Physicians and Surgeons of Ontario (the "College") on July 1, 1967. On June 26, 1968, Dr. Austin was granted a certification of authorization authorizing independent practice. In 1973, Dr. Austin was certified by the Royal College of Physicians and Surgeons of Canada in obstetrics and gynaecology.

2. In April 2007, Dr. Austin agreed to terms, conditions and limitations on his certificate of registration that restricted his obstetrical practice to office pre-natal care only, and required that his major gynaecological surgery and elective caesarean sections only be performed in the presence of another obstetrician/gynaecologist. These terms were to remain in effect until May 26, 2007, after which he would cease such surgery completely and would independently perform only minor gynaecological surgery. In 2008, Dr. Austin resigned his membership with the College.

Patient A

3. In early 2005, Patient A was referred by her family physician to Dr. Austin for an assessment and treatment of suprapubic pain. Dr. Austin recommended a

laparoscopy and possibly lysis of adhesions from previous surgery.

4. Patient A had undergone numerous prior abdominal surgeries, which included two previous sub-umbilical vertical incisions, and had suffered from peritonitis.

5. Patient A met with Dr. Austin three times prior to undergoing a laparoscopy performed by him at Hospital 1 in June 2005. During the surgical procedure, Dr. Austin encountered significant adhesions that he concluded could not be managed laparoscopically and he therefore terminated the procedure. Patient A was discharged home the same day. Patient A's bowel had been perforated during the procedure performed by Dr. Austin, but it was undiagnosed at the time.

6. Patient A did not see Dr. Austin after her surgery in June 2005 prior to her discharge.

7. The next day, Patient A was taken by ambulance to the Emergency Department at Hospital 1 with vomiting and severe pain. A perforated bowel was diagnosed and repaired later that same day by a general surgeon. Patient A was discharged from hospital mid-June 2005.

8. The College retained Dr. X, obstetrician and gynaecologist, to provide an independent opinion. Dr. X concluded in part, as follows:

> I believe Dr. Austin did *not* meet the standard of practice in performing a laparoscopic procedure due to inappropriate patient selection. I do not believe he had full disclosure of the risks that could occur if the patient chose to proceed with a laparoscopic procedure. I am also very unclear as to the full disclosure to his patient following the complication. According to the SOGC [Society of Obstetrics and Gynaecologists of Canada] Committee Opinion, No. 98, November 2000 (2) "it is important for the laparoscopist to understand possible complications and to have a fully informed discussion with the patient prior to surgery and after an adverse outcome, should one occur." Risk factors such as "obesity, previous bowel surgery, inflammatory bowel disease, *peritonitis following previous surgery, and two prior midline incisions* may contribute to failure to achieve pneumoperitoneum and thus may contribute to bowel injury". Recommendations to minimize operative laparoscopy risks in the SOGC committee opinion result from literature review and examination of the CMPA experience. Number one is selection of appropriate patients for laparoscopy. [Patient A] had two risk factors, the first being previous bowel obstruction or peritonitis, in that she had an exploratory laparotomy for an appendicitis and a

> prolonged ileus following her vault suspension. As well she had at least two previous sub-umbilical vertical incisions for her appendectomy and vault suspension. Dr. Austin as well knew that she had "extensive adhesions" from his own notes. She may have had up to three or four previous midline incisions if in addition she had a caesarean section and lysis of adhesions.
>
> …
>
> In choosing to perform a laparoscopy for lysis of adhesions in a patient with numerous laparotomies and known adhesions he displays a lack of judgment.

Patient B

9. In October 2005, Patient B was referred by her family physician to Dr. Austin for a right ovarian cyst along with suprapubic and left lower quadrant pain with bowel movements.

10. In November 2005, Dr. Austin assessed Patient B and advised her to return after a previously scheduled colposcopy.

11. In January 2006, Patient B returned to see Dr. Austin. The ultrasound report confirmed the presence of a right ovarian cyst. Dr. Austin recommended that Patient B undergo a laparoscopic right oophorectomy (removal of the right ovary).

12. During the surgery in February 2006 at Hospital 1, Dr. Austin identified and cauterized a long adhesion. Patient B was discharged home the same day.

13. A few days later, Patient B returned to the Emergency Department of the hospital with complaints of progressive abdominal distention, abdominal pain, shortness of breath and nausea. She was admitted with an obstruction of the intestines and received a nasogastric tube. Her conditioned worsened and a general surgeon had to perform a Hartmann resection and drainage of multiple abdominal abscesses for a perforated sigmoid colon, which had occurred during the surgery performed by Dr. Austin.

14. The College retained Dr. X to provide an independent opinion. Dr. X concluded, in part, as follows:

    I believe Dr. Austin fell below the standard of practice expected of a gynecologist

> by not fully assessing the risk of malignancy of a simple ovarian cyst in a postmenopausal woman. Dr. Austin did not clearly document the risk of operative intervention versus conservative management in [Patient B's] case.
>
> Having an intra-operative complication from a possible thermal injury is a recognized complication of any operative laparoscopic procedure and the patient may present a number of days following the initial procedure. However, I do believe Dr. Austin fell below the standard expected by not reviewing and documenting the discussion that should have taken place with [Patient B] once the complication was identified.

Patient C

15. In September 2006, Dr. Austin performed a laparoscopy on Patient C in response to adhesions that had developed after an appendectomy performed in 2001.
16. Patient C was a very complex patient. Dr. Austin's medical records should have contained a detailed description of his pre-operative discussions with Patient C regarding her condition, her various management options, and the risks and benefits of proceeding with surgery. They did not include this information. The operative report itself also lacked sufficient description of the surgery.

17. Dr. Austin failed to maintain the standard of practice of the profession with respect to Patient C in that he failed to adequately document his assessment of Patient C and failed to adequately document a description of the surgery he performed.

Patient D

18. In September 2005 Dr. Austin performed a bladder lift and an episiotomy revision on Patient D.

19. Patient D did not see Dr. Austin again until early October 2005, several days after her surgery, at which time he informed Patient D for the first time that he had cut, or perforated her bowel during the surgery.

20. Patient D was discharged home with a foley catheter in situ and was re-admitted to the hospital with a urinary tract infection (e-coli).

21. Since the surgery in September 2005, Patient D has experienced ongoing issues with bladder/bowel control, and sexual functioning.

22. Dr. Austin should have advised Patient D about the bowel perforation promptly after the surgery (as soon as the patient was stable and able to comprehend the information). He also should have told her how the complication was managed and advised her of any possible future consequences that might arise as a result of the complication. In failing to do so, he did not comply with the College's Policy on Disclosure of Harm, a copy of which is attached as Appendix A.

PART II – ADMISSION

23. Dr. Austin admits to engaging in professional misconduct in that he failed to maintain the standard of practice of the profession in respect of his care and treatment of the four patients as follows:

    (a) with respect to Patient A:
        (i) selected an inappropriate procedure for this patient (a laparoscopic procedure); and
        (ii) failed to take into account, discuss and/or document the specific risk factors for complications that this patient had, including a failure to make full disclosure and/or document full disclosure following the patient's complication from surgery.

    (b) with respect to Patient B:
        (i) did not fully assess the risk of malignancy of a simple ovarian cyst in a post-menopausal woman; and

        (ii) did not clearly consider and/or document the risk of operative intervention as compared with conservative management.

    (c) with respect to Patient C:

(i) failed to adequately document his assessment of Patient C and failed to adequately document a description of the surgery he performed.

(d) with respect to Patient D:

(i) failed to comply with the College's Policy, Disclosure of Harm, when a complication arose during Patient D's surgery.

FINDINGS

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Austin's admission and found that he committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The Committee was mindful of the law that a joint submission should be accepted by the Panel unless to do so would be contrary to the public interest and bring the administration of justice into disrepute.

The relevant penalty principles in this case are general deterrence, maintaining the integrity of the profession and providing public confidence that the profession is being regulated in the public interest. Considering that Dr. Austin had resigned from the College, public protection, specific deterrence and rehabilitation would not apply in this case.

The Committee considered aggravating and mitigating factors. The principal aggravating factor accepted by the Committee was that Dr. Austin's errors covered not just one area of care, but the spectrum of care of the four individual patients. Specifically, he fell below the standard of care in appropriate patient selection, in appropriate procedure selection, in lack of timely disclosure of harm, and in lack of appropriate documentation. The lack of appropriate patient selection and procedure selection led to patient harm.

A mitigating factor was the Agreed Statement of Facts and the Joint Submission on Penalty, which avoided the costs and time of a contested hearing.

Although Dr. Austin resigned from the College, disciplinary action serves as a general deterrent, maintains integrity of the profession, and maintains public confidence in self-regulation in the public interest. A professional misconduct hearing must consider not only the individual, but also the effect of the misconduct on patients, and on the reputation and integrity of the profession as a whole. Public confidence and trust in the medical profession can be eroded by the misconduct of an individual physician.

The Committee accepted the joint submission on penalty and costs as appropriate in the circumstances.

The Committee took into account that Dr. Austin failed to maintain the standard of practice of the profession in the four cases placed before it. By not completely assessing or considering the risks or the operative interventions, he put his patients in harm's way. Patients expect that their physicians will not only perform an appropriate assessment, but also explain the risks and complications and the alternatives to the operating procedure being contemplated.

In addition, it is expected that the physician fully document the assessment and the possible risks and complications. Dr. Austin failed to do this. As well, it is the duty of the physician to make a full disclosure of any complications following the operation procedure and document that disclosure.

Dr. Austin's actions have disgraced the profession and put his patients at risk of harm. This behaviour will not be condoned by the profession or the public at large who put their trust in the medical profession.

ORDER

Therefore, having stated its findings of professional misconduct in paragraph 1 of its written order of March 18, 2014, the Committee ordered and directed, on the matter of penalty and costs, that:

2. the Registrar revoke Dr. Austin's certificate of registration, effective immediately.

3. Dr. Austin appear before the panel to be reprimanded.

4. Dr. Austin pay to the College costs in the amount of $4,460.00, within 30 days of the date of this Order.

At the conclusion of the hearing, the Committee delivered in writing a public reprimand, on the consent of counsel for the parties.