SUMMARY

DR. ANDREW WINSTON TAYLOR (CPSO# 64009)

1. Disposition

On July 20, 2018, the Inquiries, Complaints and Reports Committee (the Committee) ordered Opthalmologist Dr. Taylor to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Taylor to:

- Practice for three months under the guidance of a Clinical Supervisor acceptable to the College; and
- Undergo a reassessment of his practice by an assessor selected by the College approximately six months after the completion of his remediation.

The Inquiries, Complaints and Reports Committee (the Committee) also required Dr. Taylor to appear before a panel of the Committee to be cautioned with respect to ensuring that all procedures undertaken are clinically indicated, particularly since unindicated procedures expose patients to inappropriate therapy that carries a risk of harm because of their associated risks, and that all clinically indicated procedures must be accompanied by appropriate documentation regarding the diagnosis and assessment that led to the procedure.

2. Introduction

The patient complained to the College that Dr. Taylor performed a laser eye procedure which did not have any effect on her vision, provided an unnecessary treatment that affected her spinal cord, curved her body posture, and increased her pain (intravitreal AntiVEGF injections), and that he performed both procedures without informed consent.

Dr. Taylor responded that the patient fully consented to the laser procedure to clear a posterior capsular opacity in each eye. He stated that this treatment was appropriate for her condition.

Dr. Taylor added that he suggested antiVEGF injections because of the patient's increased central retinal thickening, and that he obtained her consent for this procedure. He stated that this particular patient did not have classical signs of wet age-related macular degeneration (AMD), but did have persistent retinal thickening, loss of visual acuity, and worsening central metamorphopsia. He did not perform an Intravenous Fluorescein Angiograhpy because the patient declined and it was not readily available locally. He sought an opinion from another physician, who was supportive of his care in using antiVEGF treatments.

Dr. Taylor stated that the patient never indicated she felt she was suffering from spinal cord degeneration after her antiVEGF therapy, and was not aware of any association between these treatments and neurological impairment, including spinal cord degeneration.

3. Committee Process

As part of this investigation, the Committee obtained an opinion from an independent opinion (IO) provider to comment on Dr. Taylor's care in this case.

A Surgical Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee was satisfied that Dr. Taylor did obtain signed consent forms for all procedures, but was unsure whether he transmitted the appropriate information during verbal discussions. The Committee stated its expectation that physicians have a full discussion of the risks and benefits of procedures with patients.

The Committee determined that the laser procedure was appropriate, and that a physician cannot guarantee a patient's satisfaction with the outcome of such a procedure.

In regards to the antiVEGF therapy, the Committee determined that there is no information which suggests the patient's neurological symptoms resulted from the treatment. However, the Committee agreed with the IO provider that Dr. Taylor did not meet the standard of care by performing this procedure.

Specifically, the IO provider noted that there was inadequate documentation of the presence of wet AMD prior to initiating therapy, and that Dr. Taylor recommended the patient continue the therapy despite the absence of clinical or optical coherence tomography (OCT) indications to do so. The IO provider indicated that Dr. Taylor's practice in the management of wet AMD has the potential to expose patients to risk of harm, as they may be subjected to unnecessary treatments and the risks of complications associated with those treatments.

Despite Dr. Taylor's supportive second opinion, the IO provider's opinion, the second opinion sought by the patient, and Dr. Taylor's documented history of providing unnecessary procedures for financial gain concerned the Committee. As a result, the Committee decided that supervision was necessary to ensure that patients are not placed at a risk of harm and to ensure that Dr. Taylor has the necessary knowledge to treat wet AMD.