SUMMARY

DR. THOMAS ALBERT BOTLY BELL (CPSO# 50134)

1. Disposition

On April 20, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required plastic surgeon Dr. Bell to appear before a panel of the Committee to be cautioned with respect to his legal obligation to comply with requests for records and his duty to cooperate with the College.

2. Introduction

The College received a complaint from a patient of Dr. Bell's who underwent a surgical procedure in 2014. The patient was dissatisfied that one of the procedures Dr. Bell performed (excision of a sebaceous cyst) caused a big indentation/scar on the patient's nose. The patient also expressed concern that Dr. Bell refused to release the patient's pre and post-operative photographs.

The College requested Dr. Bell's records and response to the patient's complaint in November 2015. The College received Dr. Bell's response in March 2016. Dr. Bell described his care of that patient and noted that the procedure to remove the cyst was uneventful. According to Dr. Bell, initially, the patient appeared satisfied but as time went on the patient became "obsessed" with the appearance of the very slight, hypo-pigmented depression on the nasal tip. He continued to provide care to the patient until November 2015 when the patient's inappropriate behaviour and remarks to office staff caused him to ask the patient to leave the office. Dr. Bell stated that his office did provide the requested photographs to the patient.

3. Committee Process

A 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

On review of the investigative record, the Committee was satisfied that the available documentation supported Dr. Bell's response, and that his clinical and surgical care of the patient, including his excision and treatment of the patient's sebaceous cyst, was acceptable and in keeping with the standard of practice. The Committee took no further action on this aspect of the complaint. It also appears, based on e-mail correspondence from Dr. Bell's office to the patient that the office provided the patient with both pre- and post-operative photographs.

The Committee was extremely concerned, however, that College staff had to make repeated requests over several months before Dr. Bell responded to the complaint. The Committee felt this was unacceptable. Dr. Bell's delayed response occurred despite College staff's pointing out to him section 30 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, which indicates that "failing to respond appropriately or within a reasonable time to a written inquiry form the College" may constitute an act of professional misconduct.

The Committee further noted that, in addition to his delayed response, Dr. Bell did not submit the patient's post-operative photographs to the College until April 2016, and, despite repeated requests by College staff, he did not produce the patient's pre-operative photographs.

The Committee's concern was amplified by Dr. Bell's history of a prior complaint in which the Committee issued advice regarding his "duty to comply with policy on medical records and specifically to maintain control and integrity of patient records and to provide a copy of the patient chart upon request."

The Committee felt that, based on the totality of the information before it, Dr. Bell would benefit from attending at the College before a panel of the Committee to be cautioned regarding his obligations to the College.