NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Ciro Anthony Adamo, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of patients or any information that could disclose the identity of the patients pursuant to subsection 45(3) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

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

93(1) Every person who contravenes an order made under section 45 or 47 is guilty of an offence and on conviction is liable to a fine of not more than $10,000 for a first offence and not more than $20,000 for a subsequent offence.

On March 30, 2007, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Adamo [2007] O.J. No. 1168.

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

IN THE MATTER OF a Hearing directed by the Executive Committee and the Complaints Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 36(1) and 26(2) of the ***Health Professional 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. CIRO ANTHONY ADAMO

PANEL MEMBERS:	DR. J. DOHERTY (CHAIR) DR. I. BAXTER P. BEECHAM DR. O. KOFMAN J. DHAWAN
Hearing Dates:	April 4-7, 2005
Decision/ Release Date:	September 2, 2005

Publication Ban

On March 30, 2007, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Adamo [2007] O.J. No. 1168.

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on April 4, 5, 6 and 7, 2005. At the conclusion of the hearing, the Committee reserved its decision.

PUBLICATION BAN

On April 4, 2005, the Discipline Committee made an order pursuant to subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, prohibiting the publication or broadcast of the names of patients in this proceeding, or any information that could disclose the name or identities of patients.

ALLEGATIONS

The Notice of Hearing alleged that Dr. Ciro Anthony Adamo committed an act of professional misconduct:

1. Under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

2. Under paragraph 1(1) 1 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 ("O. Reg. 856/93") in that he has contravened a term, condition or limitation on his certificate of registration.

3. Under paragraph 1 (1) 16 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 ("O. Reg. 856/93") in that he has falsified a record relating to his practice.

The Notice of Hearing also alleged that Dr. Adamo is incompetent as defined by subsection 52(1) of the Code, in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

RESPONSE TO ALLEGATIONS

Dr. Adamo denied the allegations as set out in the Notice of Hearing.

EVIDENCE

a) Overview of the Issues

The issues in this case are as follows:

(1) Did Dr. Adamo's failure to identify the technologist amount to professional misconduct, and did it warrant such a finding?

(2) Did Dr. Adamo contravene a term, condition or limitation on his certificate of registration?

(3) Did Dr. Adamo falsify a record relating to his practice?

(4) Did Dr. Adamo engage in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional? (by virtue of the acts alleged above) and

(5) Finally, is Dr. Adamo incompetent? Specifically, the Panel has to decide,

(i) if there was excessive use of x-rays in disregard of their clinical necessity without any justifiable reason;

(ii) whether Dr. Adamo's reporting of x-rays was done without appropriate clinical acumen;

such that it demonstrates that he is unfit to continue to practise or that his practice should be restricted.

(b) Summary of the Evidence

The Panel heard the evidence on behalf of the College of Dr. A, an expert witness, and of Dr. B. Various exhibits were filed including an Agreed Statement of Fact, (Exhibit 2), a book of Clinical

Practice Parameters for Independent Health Facilities, (Exhibit 5), as developed by the Canadian Association of Radiologists (CAR) and adopted by the College of Physicians and Surgeons to fulfill their responsibilities under the *Independent Health Facilities Act* (IHFA), various letters of complaint from patient C and related replies and responses, and assessment reports done for the College of Physicians and Surgeons under the IHFA, which are part of the Joint Book of Documents (filed as Exhibits 3A, 3B and 3C).

On behalf of Dr. Adamo, the Panel heard the evidence of Dr. Adamo, and received various exhibits, in particular, the report of Dr. D regarding Dr. Adamo's practice, prepared at the request of the defence, and submitted to the College, and which is also part of the Joint Book of Documents, (Exhibit 3A).

The Panel carefully considered all of the evidence including all those exhibits referred to above as well as all the other exhibits before it.

(c) The Evidence

The following Agreed Statement of Fact was filed as Exhibit 2 and presented to the Committee:

Agreed Statement of Fact

Part I - Background

1. Dr. Ciro Anthony Adamo (Dr. Adamo) is a member of the College of Physicians and Surgeons of Ontario (the College) and was first registered at the College in June 1986.

2. Dr. Adamo is a Diagnostic Radiologist and practised at a number of independent health facilities, owned by corporations owned by Dr. Adamo and his wife, and operating as Metro Radiology, including the Metro Radiology location at 100-2010 Eglinton Avenue West in Toronto, Ontario. All of the licenses for these clinics were held, directly or indirectly, by Dr. Adamo or his wife.

3. As of September 22, 2003, there were twelve independent health facilities operated by Metro Radiology and currently billing services to OHIP. These facilities were:

AP12	Metro Radiology (L'Amoreaux)	3850 Finch Ave. East (Scarborough)
AP53	Metro Radiology	3850 Finch Ave. East (Scarborough)
AQ24	Metro Radiology (Glencairn)	2797 Bathurst Street (Toronto)
AP18	Metro Radiology (Eglinton)	2010 Eglinton Ave. West (Toronto)

AQ68	New Dufferin Diagnostic Imaging	2010 Eglinton Ave. West (Toronto)
AR69	Metro Radiology Ltd.	2010 Eglinton Ave. West (Toronto)
AP20	Metro Radiology (Finch)	1280 Finch Ave. West (Downsview)
AP21	Metro Radiology (Woodbridge)	4600 Highway 7 West (Woodbridge)
AU81	Metro Radiology (Lakeshore)	3170 Lakeshore Blvd. W.(Etobicoke)
AR44	Bluewater Radiology	704 Mara Street (Sarnia)
AR40	Metro Radiology (Yonge & Eglinton)	150 Eglinton Ave. East (Toronto)
AR41	Cliffside X-Ray & Ultrasound Services	2494 Danforth Ave. (Toronto)

4. As of October 21, 2004, the following fifteen independent health facilities operated by Metro Radiology were listed as operational by the Ministry of Health and Long Term Care:

AP12	Metro Radiology (L'Amoreaux)	3850 Finch Ave. E. (Scarborough)
AP53	Metro Radiology	3850 Finch Ave. E. (Scarborough)
AP18	Metro Radiology (Eglinton)	2238 Dundas Street W. (Toronto)
AP19	Metro Radiology (Wilson)	1280 Finch Ave. W. (Toronto)
AP20	Metro Radiology (Finch)	3901 Highway 7 (Vaughan)
AP21	Metro Radiology (Woodbridge)	4600 Highway 7 W. (Woodbridge)
AQ24	Metro Radiology (Glencairn)	2797 Bathurst Street (Toronto)
AR37	Birchmount X-ray	7155 Woodbine Ave. (Markham)
AR40	Danforth Diagnostic Services	150 Eglinton Ave. East (Toronto)
AR41	Cliffside X-Ray & Ultrasound Services	2494 Danforth Ave. (Toronto)
AR44	Bluewater Radiology	704 Mara Street (Point Edward)
AR69	Metro Radiology Ltd.	2010 Eglinton Ave. East (Toronto)
AQ68	New Dufferin Diagnostic Imaging	2010 Eglinton Ave. W. (Toronto)
AU81	Metro Radiology (Lakeshore)	3170 Lakeshore Blvd. W.(Etobicoke)
AR39	Oldmill Radiology & US Service	3170 Lakeshore Blvd. W.(Etobicoke)

5. Dr. Adamo was Quality Advisor for all clinics up to September 1, 2004.

6. Effective August 12, 2004, the Executive Committee suspended Dr. Adamo's certificate. On September 1, 2004, the Executive Committee rescinded the suspension and imposed a number of terms, conditions and limitations on Dr. Adamo's certificate.

7. Effective November 11, 2004, the Executive Committee suspended Dr. Adamo's certificate.

Part II - Facts Relating to Patient C

8. On or about October, 2002, the complainant, Mr. C, attended at the Metro Radiology Clinic located at 100-2010 Eglinton Avenue West in Toronto, Ontario for a barium enema procedure.

9. Mr. C was taken to the examination room. The radiologist, Dr. Adamo, explained the procedure to Mr. C and took his pertinent history. Dr. Adamo then initiated the procedure by inserting the barium enema tube into Mr. C's rectum and introduced the liquid barium.

10. Dr. Adamo also introduced air insufflations to distend the bowel, manoeuvred the patient to coat his bowel with the barium and took x-ray images of the flexures.

11. In addition to the radiologist, an x-ray technologist was also present and participated in the completion of the procedure.

12. On or about October, 2002, Mr. C was taken by ambulance to ahospital. X-rays performed at that time revealed that Mr. C had experienced barium impaction following the procedure at Metro Radiology (Eglinton). The impaction was removed at the Hospital and Mr. C was discharged from the facility later that day. There is no evidence that the impaction was due to any want of care on the part of Dr. Adamo.

13. Mr. C contacted the Clinic following this incident. In a letter dated December 12, 2002, Mr. E, Manager, Metro Radiology, apologized to Mr. C for his inconvenience and told him that the technologist that performed the examination had only worked for the Clinic for two weeks and had since been released from his employment.

14. On or about January 10, 2003, Mr. C. notified the College of his intention to register a complaint against Dr. Adamo as a result of the barium enema procedure.

15. In the course of its investigation, Dr. Adamo was contacted by an Investigator at the College on or about May 27, 2003. The Investigator requested that Dr. Adamo provide her with the names of the other staff involved in the barium enema procedure performed on Mr. C.

16. By letter to the College dated June 2, 2003, Dr. Adamo stated that "the technologists involved with the barium enema examinations are" Mr. F and Mr. G. Dr. Adamo also provided the registration numbers of both individuals and stated that each had been employed at Metro Radiology for approximately 11 years.

17. By letter to the College dated June 16, 2003, Dr. Adamo stated that the technologist on the date of Mr. C's barium enema was a Mr. F, who was covering the shift of the regular technician, Mr. G.

18. The College Investigator contacted the Director of Professional Regulations at the College of Medical Radiation Technologists of Ontario to obtain information available to the public regarding Mr. F and Mr. G. The Investigator was informed that the registration numbers provided by Dr. Adamo belonged to Mr. F and Mr. H.

19. Mr. H was known to Dr. Adamo and Metro Radiology staff as "[H]" and was billed under the name "[I] Enterprises".

20. On or about June 18, 2003, the Investigator contacted Mr. H. Mr. H informed the Investigator that although he did work at three Metro Radiology clinics, including the one located at 2010 Eglinton, he was not working at the Clinic on the date in question, and did not participate in the barium enema procedure performed on Mr. C.

21. On or about June 18, 2003, the Investigator spoke to Mr. F. Mr. F informed her that he had never worked at Metro Radiology (Eglinton) and had never been involved in any patient

procedures at Metro Radiology (Eglinton) clinic. Mr. F did work at Cliffside X-Ray and U/S Services, another facility owned and operated by Metro Radiology.

22. On or about June 24, 2003, the Investigator spoke to Dr. Adamo, who informed her that he was not 100% sure that Mr. F was the technologist during Mr. C's barium enema procedure. Dr. Adamo further stated that he was 95% sure that Mr. F was the technologist present and that he did not have any documentation to support or confirm that Mr. F was the technologist present during the procedure.

23. On October 20, 2003, in response to the College Investigator's letter of October 17, 2003 to Dr. Adamo, the Investigator was contacted by telephone by Mr. J, an employee at Metro Radiology, and was provided with a response to Item 5 of her letter.

24. Between late October 2003 and December 2003, Dr. Adamo contacted the College Investigator or her assistant by telephone on approximately three occasions to advise her that he was delayed in responding to her request for information and the reasons for delay, including his efforts to retain counsel.

25. On June 7, 2004, Dr. Adamo, through his counsel, advised the College Investigator:

> "As indicated, Dr. Adamo cannot identify the technologist who assisted with Mr. C's procedure."

26. On June 8, 2004, Dr. Adamo, through his counsel, advised the College Investigator:

> "Dr. Adamo advises that he cannot recall the identity of the particular technologist who assisted with that procedure on that particular day and his records do not allow him to identify that individual."

27. Dr. Adamo is unable to provide the name of any technician, technologist or other employee who was present and/or assisted in performing the barium enema procedure on Mr. C at Metro Radiology (Eglinton) on or about October 9, 2002.

Part III - Facts Relating to the s. 37 Order

28. On September 1, 2004, the Executive Committee terminated the suspension of Dr. Adamo's certificate of registration and directed the Registrar to impose certain terms, conditions and limitations on Dr. Adamo's certificate of registration. In addition, Dr. Adamo was not permitted to practise until he had satisfied the following conditions as set out in the notice from the Executive Committee:

***

5. He shall appoint a quality advisor for his clinics who is acceptable to the College and shall provide the College with a copy of the agreement between him or the clinic and the quality advisor, such agreement to be reviewed by and acceptable to the College.

6. He shall advise the quality advisor of the policies and procedures in the clinic and of the quality advisor's obligation to ensure that the policies are being followed.

***

29. Dr. Adamo provided to the College a copy of an agreement, dated as of September 1, 2004, between Metro Radiology (the Owner) and Dr. K (the Quality Advisor) which provided that Dr. K would act as a quality advisor for seven Metro Radiology clinics.

30. In a letter dated September 3, 2004, the College notified Dr. Adamo's legal counsel that Dr. K was not "a quality advisor acceptable to the College" as required before Dr. Adamo returns to any form of practice.

31. On October 14, 2004, College staff from Investigations and Resolutions, attended the Metro Radiology clinic at 100-2010 Eglinton Avenue West. On attending Dr. Adamo acknowledged that he was engaged in the practice of medicine, in violation of the Order dated September 1, 2004.

32. At that time, Dr. Adamo provided the Investigator with a copy of an agreement between Metro Radiology and a Dr. B, Quality Advisor, dated as of September 1, 2004. The agreement listed four clinics that would be involved. Although this document bears a signature that purports to be that of Dr. B, this agreement was not personally signed by Dr. B. Dr. B had not been accepted by the College.

33. Although Dr. Adamo informed the Investigator that a copy of the agreement had been sent via facsimile to the College on October 14, 2004, the College has no record of receiving a copy of the agreement and Dr. Adamo could not provide evidence to confirm its receipt by the College.

34. A second agreement between Metro Radiology and Dr. B, also dated as of September 1, 2004, was received by the College on October 25, 2004. This agreement covers three clinics and was signed by Dr. B in October 2004. Neither Dr. B nor any other proposed Quality Advisor was accepted by the College. On November 11, 2004 Dr. Adamo's certificate of registration was suspended.

35. Upon review of records available from OHIP regarding Dr. Adamo's claims payment history covering the period August 1, 2004 through January 10, 2005:

    (a) There were no billings for procedures with a service date falling between August 12 and August 31, 2004, the period that Dr. Adamo was initially suspended by the Executive Committee;

    (b) There were billings for procedures with a service date between September 1, 2004, the date the Executive Committee imposed the terms, conditions and limitations on Dr. Adamo's certificate and October 14, 2004, the date that College staff attended Metro Radiology.

(1) failure to identify the technologist

The Panel considered the matter of the failure of Dr. Adamo to identify the technologist involved with the examination of patient C, or to admit that he could not do so.

The evidence of Dr. Adamo was that, in communications with the College investigator, Dr. Adamo identified staff members whom he believed had been, or might have been involved in the procedure, based on his understanding of who was employed at the Eglinton Clinic at the time, and on patient C's description of the technicians involved. He was not able to locate records, or to discuss the enquiry with his office manager, since the office manager had left employment by May 2003.

Dr. Adamo's evidence was that the technologists who performed each procedure were supposed to initial the film bag holding the films. He admitted that this was not being done and he gave testimony that changes have been made as a result of this problem. Dr. Adamo has instituted a new protocol, namely: an electronic punch clock for employees for each day; all requisitions must be signed by technicians before they can be scanned into the system; cameras have been installed into the reception areas of the clinics; Dr. Adamo regularly reviews requisitions to ensure that they have been initialed by the technician, and he sends reminders by e-mail to staff of the importance of doing so; and, finally, Dr. Adamo has personally taken over the maintenance of employee records.

Dr. Adamo admitted in his testimony that, though he delegated responsibility for employee record keeping to his office manager, he is, himself, ultimately responsible. He also admitted that he had not been forthright enough in the initial stages in admitting to the College that he could not identify the technician. He claimed that the changes made were indication that he had acted responsibly to prevent a recurrence. The College did not introduce any evidence that there were any other instances of failure or inability by Dr. Adamo to identify a technician.

The College alleges that the inability to identify the technician or his failure to admit the inability was an incident amounting "disgraceful, dishonourable or unprofessional conduct".

The Panel notes that an inability to identify a technician is not an enumerated ground of professional misconduct as set out in Regulation 856/93 to the *Medicine Act*, S.O. 1991, c. 30 nor is there any requirement to record the technician's name in the Clinical Practice Parameters and Facility

Standards developed by the Canadian Association of Radiologists (Ex. 5). Of course, it is not necessary that there be any such specific requirement expressly enumerated in order to make a finding of professional misconduct. Standards of the profession, if established as standards by the evidence, are not required to be in writing. In the circumstances of this case, the Panel does not consider that the inability to identify the technician was intentional, blatant or callous. The Panel does find proven to its satisfaction that Dr. Adamo failed to admit his inability to identify the technician.

The Panel however concludes that, in the particular circumstances of this case, Dr. Adamo's failure to identify the technician and his failure to admit this inability did not amount to professional misconduct. Dr. Adamo did make efforts to identify the technician and has taken steps to prevent a recurrence of any such inability.

(2) contravening a term, condition or limitation on his certificate of registration, and

(3) falsifying a record relating to his practice

(4) disgraceful, dishonourable or unprofessional conduct

The Panel considered these three issues together, since they are, to some degree, inter-related.

The Executive Committee directed the Registrar to suspend Dr. Adamo's certificate of registration as of August 12, 2004, pursuant to section 37 of the Code, (Exhibit 3A, Joint Book of Documents, Vol. I, Tab 26). This suspension was then terminated and certain terms, conditions and limitations were imposed on Dr. Adamo's certificate of registration, and he was not permitted to practise until he had satisfied these conditions (Exhibit 2, Agreed Statement of Facts, Paragraph 28). The conditions included that Dr. Adamo was to appoint a Quality Advisor who was acceptable to the College for his clinics, and to provide the College with a copy of the agreement between him or the Clinic and the Quality Advisor, such agreement to be reviewed by and acceptable to the College; and that he shall advise the Quality Advisor of the policies and procedures in the clinic and of the Quality Advisor's obligation to ensure that these are being followed.

Dr. Adamo admitted in his testimony, and it is also set out in the Agreed Statement of Facts, that he was aware of the restrictions on his certificate of registration.

In regard to appointing a Quality Advisor for his clinics, it is accepted that Dr. Adamo provided the College with a copy of an agreement dated September 1, 2004, between Metro Radiology and Dr. K, as Quality Advisor, which was rejected by the College because Dr. K was not a Quality Advisor acceptable to the College (Exhibit 2, Agreed Statement of Fact, paragraphs 29 and 30). The Panel heard evidence from Dr. Adamo that Dr. K's signature on the abgreement, which the College rejected, was electronic having been affixed by Dr. Adamo after speaking with Dr. K.

Dr. Adamo had a rapid response from the College in rejection of his initial choice of Dr. K as the Quality Advisor. The evidence from Dr. Adamo was that he then faxed an agreement with Dr. B to the College on September 7th, which was not received by the College, for unknown reasons. Dr. Adamo produced a facsimile transmittal sheet, dated September 7, 2004, to the College (Exhibit 16), which purports to be the accompanying sheet for this agreement between the Metro Radiology Clinic and the Quality Advisor. Dr. Adamo could not provide a fax confirmation sheet or any other evidence that the agreement had actually been sent.

Dr. Adamo's testimony was that he refrained from practicing during this period to allow time for the College to reply. He stated that the College had replied promptly in rejecting Dr. K, and he felt that, after seven days without a response, it was reasonable for him to assume that Dr. B had been accepted.

In paragraph 31 of the Agreed Statement of Facts, Dr. Adamo admits that on October 14, 2004 when College staff attended the Metro Radiology Clinic at 100 - 2010 Eglinton Avenue West, he acknowledged that he was engaged in the practice of medicine. On October 14, 2004, Dr. Adamo provided the investigator with a copy of an agreement between Metro Radiology and Dr. B as Quality Advisor for four (4) clinics. Although the agreement bore Dr. B's electronic signature, she had not personally signed it. Dr. B had not been accepted by the College. Dr. Adamo told the investigator that a copy of the agreement had been sent by fax to the College. The College has no record of receiving a copy and Dr. Adamo could not provide evidence to confirm receipt by the College (Paragraphs 32 to 34 of the Agreed Statement of Facts, Exhibit 2).

It is also in the Agreed Statement of Facts, Exhibit 2 (paragraph 34) that, following the visit of the College investigator on October 14th, a second agreement was received by the College on October 25th, dated September 1, 2004, covering three clinics, and signed by Dr. B in October 2004. Neither Dr. B nor any other Quality Advisor was accepted by the College.

In her testimony, Dr. B was unequivocal that the signature on the first agreement of September 1st, for four clinics, was not hers, and she denied that it was a true electronic signature of hers. She was also adamant that her electronic signature should be used only for signing reports and that she did not give her permission for it to be used for signing a contract.

Dr. B did acknowledge that she had signed the second agreement.

The evidence from OHIP billing records also shows that Dr. Adamo was practicing during the period in question when his certificate of registration was under restrictions and he had not complied with the requirements.

There was evidence from Dr. Adamo that he had affixed Dr. K's signature electronically to Dr. K's Quality Advisor agreement, and that proceeding in this fashion was Dr. Adamo's usual practice. Dr. Adamo also testified that he believed that he had Dr. B's agreement to act as Quality Advisor , on September 7, 2004, and there was e-mail correspondence between them concerning the requirements.

In her testimony, Dr. B said she had reservations, but expressed her willingness to perform the duties, and stated that she did not say that she was not going to do it. She said that she told the College investigator, Ms. M that she had agreed to act as Quality Advisor for only three (3) clinics.

Dr. B also stated that it was entirely possible that she had left Dr. Adamo with the impression that she had agreed to fulfill the role of Quality Advisor, and she told the Panel that she thought that Dr. Adamo himself believed that she would fulfill the role.

Dr. Adamo's testimony was that billings, from OHIP records, during the period from September 1st, when his licence was placed under restriction, were actually the dates of the procedures, and the

radiologist's services were performed on September 13th and 14th and that he was refraining from practicing until he felt that Dr. B had been accepted as Quality Advisor.

Dr. B gave evidence that in the period from September 1st, to October 14th, 2004, she read films from the clinics listed in the agreement, and exercised some quality assurance functions. Dr. Adamo's evidence was that during this same period, he had ongoing discussions with Dr. B about issues, including the Quality Advisor role.

Dr. Adamo's testimony was that on October 14th, one month after resuming practising, when an investigator from the College called at the Clinic, he readily acknowledged that he was practicing, and immediately produced at that time, the Agreement appointing Dr. B as Quality Advisor, and which he believed was in effect, but which the College said they had not received.

On Monday, October 17th, he was advised by his legal advisor that there was a problem with the Quality Advisor issue, and he did not practice after this point.

Dr. B executed a further Quality Advisor agreement on October 24th, dated from September 1st, as at Tab 32 in the Joint Book of Documents. This indicates that she was willing to assume the duties of Quality Advisor from September 1st, and she agreed in cross-examination that she was in fact performing some Quality Advisor duties during that period.

Dr. Adamo states that he did not perform or bill for, any procedures after October 15th, 2004. Some procedures were billed in his name during this period, but both he and Dr. B gave testimony that these were mostly bone density studies, which were erroneously billed in his name, but which were in fact done by Dr. B, or Dr. N.

While Dr. Adamo testified that he faxed the agreement to the College, there is no other evidence supporting his assertion and the Panel does not accept Dr. Adamo's testimony on this point. Even if Dr. Adamo did fax the agreement to the College, he knew that Dr. B had not been accepted by the College and, therefore, he should not have practised. The College was very prompt in its response with respect to Dr. K and it was not reasonable in the circumstances of this case for Dr. Adamo simply to assume that he had the agreement with Dr. B to act as Quality Advisor, or that he had Dr.

B's authority to execute an agreement on her behalf. It was also not reasonable for Dr. Adamo to assume he had the acceptance by the College of her fulfilling that role. In addition, the Panel accepts Dr. B's evidence that she never gave her approval to affix her electronic signature to any agreement. Even if Dr. Adamo mistakenly believed he had Dr. B's agreement to act as Quality Advisor, he certainly did not have any authority from her to sign an agreement on her behalf and, in so doing, he has falsified a record relating to his practice.

Therefore, the Panel finds that Dr. Adamo did contravene the terms, conditions and limitations on his certificate of registration, and did falsify a record relating to his practice and, therefore, committed those acts of professional misconduct as alleged. The Panel also finds that the contravention and the falsification would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Therefore, the Panel finds the fourth issue above proven to the requisite standard.

(5) incompetence

The Panel considered the allegation of incompetence. The relevant evidence includes the testimony of Dr. A, the report of Dr. D, (Joint Book of Documents, Exhibit 3A, Tab 34), and OHIP Billing Records (regarding alleged excessive use of x-rays and views).

Testimony of Dr. A

Dr. A testimony was that, if and when he was acting as an Independent Health Facility ("IHF") Assessor for the College, he must attend the IHF physically, look at equipment, take an inventory list, observe practitioners, and prepare a joint report with the technologist. An Assessor will look at prior tests and observe live ultrasounds/mammograms (usually with the technician for the latter). Dr. A stated that he tended to pull random views of prior films within a six-month period, using viewing equipment at the IHF.

Dr. A's testimony was that he reviewed Dr. Adamo's practice in 2004. He did not visit any Metro Radiology Clinic and has never done so, nor has he viewed equipment or observed barium enemas, upper GI or other exams there. The films, which he reviewed, were on disc including the barium enema and GI series, and some were copied radiographs. For his review of Dr. Adamo's practice, he relied on IHF Program Assessment Reports of April 22, 2003 and May 12, 2003 by Dr. O (Joint

Book of Documents, Exhibit 3A, Tab 18), the report of October 14, 2003 by Dr. P (Exhibit 3A, Tab 19), personnel information, six CD ROM's, paper copies of ultrasound examinations and nine bags of radiographs. He also received radiographs which were original records of upper GI series on twenty different patients and CD's of images on twenty different patients having double contrast barium enemas.

Regarding record keeping, it was Dr. A's opinion that there was a failure to record the technologist's initials for identification on one occasion only, that of patient C. This recording of initials could be on the x-ray bag with the older system and, now, done electronically. He stated that this management of systems, technologist identification, and making sure that technologists are appropriately registered with their respective Colleges, would be the responsibility of the Quality Advisor. He was of the opinion that record keeping and correspondence regarding patient C was a "shambles", and that Dr. Adamo didn't know who was working, and was lacking in standard "regarding the business part of his practice". He stated that it was important to know which technologist was present, in case there had to be a review of complications, adverse outcomes, etc., of the procedure being undertaken which the Panel found to be a compelling argument. The Panel was not shown where the identification of the technician was a requirement or a standard of the Clinical Practice Parameters of the Canadian Association of Radiologists (Exhibit 5) although the Panel again notes that practice standards do not have to be codified or reduced to writing in order to be the standard of practice.

Regarding the examination of patient C, Dr. A gave testimony that the barium enema report signed by Dr. Adamo does note "sub-optimal coating", and that repeat examination in three to six months was recommended (Joint Book of Documents, Exhibit 3A, Tab 2), but Dr. Adamo did not agree with Dr. A's report. Dr. A felt that the studies did not meet the standards of the profession as a matter of professional opinion but we were not sure whether he meant technically due to substandard equipment, or professionally due to poor ability.

In an addendum to the report of IHF Assessor Dr. O, dated June 6, 2003, (Tab 17), Dr. O records that he reviewed patient C's barium enema. His letter includes:

> "The overhead images were incomplete and no spot films were in the film file. I'm not certain whether the films were lost or not performed, although I am familiar with Dr. Adamo's routine and suspect that the films were misplaced. The overhead films that were present were of poor diagnostic quality, and could not be used to give an accurate diagnosis in this case. As the technologists do not initial their examinations, it was not possible to talk to the technologist in question. My understanding from the manager is that the technologist who performed the exam no longer works at the clinic."

The Panel finds this as evidence of failure to meet the Standards of the Canadian Association of Radiologists (CAR), set out in the Clinical Practice Parameters. (Exhibit 5).

On the matter of upper GI series and barium enemas in general, Dr. A opined that they did not meet the standards in any patient. Not demonstrating anatomy in each patient may miss pathology. As part of his review, Dr. A also reviewed two sets of barium enemas and upper GI series only, from early 2004. Dr. A also testified that Dr. Adamo's report to referring physicians did not always include qualifiers to reflect deficiencies.

Dr. Adamo's evidence was that, at the time of the assessments of the 2010 Eglinton Clinic in April and May 2003, until mid-2004, fluoroscopy equipment was in the process of upgrade and adaptation to make it compatible with a digital imaging system (Picture Archiving Computer System [PACS]). He testified that a problem with cassettes affected his ability to do spot films and he was attempting to compensate for this in how he performed fluoroscopy. In the report of Dr. O (Joint Book of Documents, Exhibit 3A, Tab. 17) under fluoroscopy, there is criticism that, at initial assessment, there was poor coating and poor distension in many cases, and that half the studies were not diagnostic. These limitations were not documented in the report. Examples were not given or listed only a general overview of "many cases" without specification. The flexure shots were incomplete and did not adequately image the anatomy of those regions.

At the time of the second visit by Dr. O, two upper GI examinations were observed, and these were competently and expertly handled, and the image quality represented a significant improvement. Dr. O also reviewed six upper GI studies, four of which were diagnostic and two were not optimal: this was documented so that the referring physician was aware. By the time of this second visit, there

was evidence of much better clinical competence and much improved image quality. We note that, by this date, new fluoroscopy equipment had been installed.

Five barium enemas were reviewed by Dr. O. Four were diagnostic, one was not, due to poor distension, and this was not indicated to the referring physician. The four diagnostic studies that were not perfect clearly had their limitations documented.

In his testimony, Dr. Adamo did not dispute Dr. A's conclusion that he failed to meet CAR standards in still images in that the still images did not sufficiently demonstrate the anatomy in each patient separately. In cross-examination, Dr. A agreed that being the performing radiologist gives the radiologist limited extra information from the fluoroscopy, apart from the spot films, and also that he never asked to observe Dr. Adamo performing examinations or using his equipment so that the Panel felt that, since Dr. A had not been present at any examinations, he could not make observations on Dr. Adamo's competence in this respect. Dr. A could not say whether or not pathology was missed, or that any patient received inappropriate treatment, or was deprived of appropriate medical treatment.

Number of x-ray views and of ultrasound examinations

There was criticism of the number of views being taken by Dr. Adamo at his facility. The statistics for this came from evidence of the Monthly Services Reports of the IHF Department of the College as set out in the Joint Book of Documents (Exhibit 3A, at Tab 19) for four clinics over brief periods of time prior to May 2003. The evidence suggested that numbers of both ultrasounds and of mammograms could be for purely financial reasons, rather than clinically based.

The Panel does not find that there were excessive ultrasounds and mammograms for the following reasons. In his testimony, Dr. A stated that breast ultrasounds are not the primary method of determining breast pathology, but rather an adjunct to mammograms. If a patient were to be referred for ultrasound of the breast, it would most likely be for one breast in a specific sector where pathology was suspected, usually following mammogram. It is noted from the assessment reports in the Joint Book of Documents, Exhibit 3A, Tabs 17 and 18 and Tabs 38-41, that no concerns were expressed about ultrasounds being performed unnecessarily or inappropriately at Metro Radiology Clinics. Dr. A testified that doing breast ultrasounds is innocuous, and that this is really only a

billing/compensation issue. The Panel therefore finds there was not persuasive evidence of excessive ultrasound examinations.

Regarding mammograms, Dr. A gave testimony that a large number of patients were referred for bilateral mammograms, and also a large number received additional views. His evidence was that the standard is that each patient receives two views of each breast, and that in the Ontario Breast Screening Program (OBSP), ten percent (10%) would receive extra views. In Dr. Adamo's practice, the figure for extra views was sixty to seventy percent (60-70%). The risks to the patient of the extra view is of excessive exposure of sensitive organs to radiation, and induction of tumours, in eyes, breasts, gonads, and bone marrow.

Dr. A testified that he did not know if Dr. Adamo's clinic participated in the OBSP. Dr. Adamo testified that he does not participate in the OBSP, which is a screening program, and is self-referred by the patient. If any suspicious lesion is detected, the patient would be asked to return, through their doctor, for more views. Dr. Adamo also testified that his patients are referred by their doctors because suspicious lesions have already been detected clinically by their doctor, and this may necessitate extra views of that breast and also of the other breast. This would also apply to ultrasounds as an adjunct. Dr. Adamo also testified that another reason for additional views of the breasts was that his cassettes were too small for the examination of large breasts. His practices have changed since November 2003 and, now, if a patient is found to have pathology, they are first referred back to their own physician for further instructions on further views. Dr. Adamo also testified that he now has more up to date equipment with cassettes that will cover the entire examination field. Dr. A testified that Dr. Adamo's clinic was a primary clinic and that, at such a clinic, the radiologist may determine the number of views to be taken.

The Panel was not persuaded that the number of views taken for mammography constituted incompetence or professional misconduct.

Regarding lumbo-sacral spine x-rays

Dr. A testified that an excessive number of views were being taken of the lumbo-sacral spine, with consequent concern about excessive radiation of sensitive organs. At Tab 17 of the Joint Book of Documents (Exhibit 3A), the recommendations were that, if additional views were to be taken, the

request should be documented, because of the very high radiation dose. Dr. Adamo's evidence was that, in 1998, an IHF Assessor of his Woodbridge Clinic advised him that it was proper to do five views of the L/S spine "as a routine". He relied on this with some comfort and Dr. A agreed in evidence that the Assessor's observations that what was being done at another clinic would be re-assuring that what he was doing at his clinic was quite appropriate.

Dr. Adamo also testified that he surveyed several Toronto hospitals in 1998, and found that most considered that it was appropriate to do four views of the lumbar spine, four plus two views of the lumbo-sacral spine and two views of the sacrum, and that that is his clinic's current practice. Dr. B confirmed Dr. Adamo's testimony in her evidence, and that the radiologists working there are all comfortable with it.

In cross-examination, Dr. Adamo testified that he is not aware that the risks of radiation to which his patients are exposed outweigh the benefits of the procedures, and that the radiation risk is difficult to quantify.

It is recorded in Dr. O's Assessment Report (Exhibit 3A, Tab 17) that "at the time of the exit interview, Dr. Adamo indicated that physicians who dealt with motor vehicle accidents or other trauma requested the cases in question. The additional views were standard procedure for those select physicians."

Dr. A agreed that, regarding lumbo-sacral spine x-rays, there are no Canadian Association of Radiologists standards, only guidelines. This is in agreement with Exhibit 5, IHF Clinical Practice Parameters, page 61, and at page 62, where the number of views to be taken is not specific, but based on the radiologist's clinical decision. Dr. A had concerns that too many views were being taken, and that one could render an opinion with fewer views and less radiation risk to the patient.

As regards Dr. Adamo's skills as a diagnostic radiologist and his overall competence, Dr. A testified that he had concerns about Dr. Adamo's handling of barium enemas and of upper GI series. His opinion was that Dr. Adamo did not meet the standards and was concerned that a sub-standard test may miss pathology. In cross-examination, however, Dr. A agreed that none of the assessment reports for Metro Radiology Clinics dated February 2004 report any deficiencies in the quality of

images or any diagnosis relating to radiography, barium enemas, upper GIs or ultrasound examinations (Tabs 38, 39, 40, and 41 of Joint Book of Documents, Exhibit 3B).

Dr. A testified that Dr. Adamo lacked in judgment, and did not believe that Dr. Adamo is competent as a Quality Advisor. Dr. A does not believe that an individual radiologist ought to be a Quality Advisor, feeling that he ought to be external to the facility. The Committee was not presented with evidence that there was any prohibition with respect to a radiologist from the facilities being a Quality Advisor for that same facility. However, apart from the criticisms listed, Dr. A testified that he had no concerns about Dr. Adamo's skills in any other areas of diagnostic radiology, and recognized that he was well trained at a centre with the highest of reputations. Dr. A agreed in cross-examination that:

(i) he had no difficulty with the ultrasound films he reviewed;

(ii) he had no basis for criticizing Dr. Adamo's images of spine, or ability to diagnose musculo-skeletal pathology;

(iii) he had no basis for criticizing his images of breast, or ability to diagnose pathology of the breast;

(iv) he had no basis for criticizing his images of bone mineral density or ability to diagnose osteoporosis.

The Health Professions Procedural Code reads:

52.(1) Incompetence - A panel shall find a member incompetent if the member's professional care of a patient displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted.

It is important to distinguish between professional misconduct for failure to maintain standards, which is not alleged in this aspect of the case, and incompetence, which is alleged and which speaks to present status. A physician may be found to have committed acts of professional misconduct for failure to maintain standards but, if he has demonstrated insight into his failure, and has shown that

he has acquired knowledge, skill and judgment since the time of that failure, and has changed his practice to meet present standards, he would not be found to be incompetent.

The Panel agrees with the defence submission that "a mere failure to maintain the standards of the profession does not necessarily constitute incompetence". Also, the defence submits that, for incompetence to be found, there must be a failure in conduct at the time of the events which led to the hearing, and that there must be evidence of continuing or current failure in conduct. In several cases, including Morgan (Re) [1993] O.C.P.S.D. No. 12 (CPSO) (QL) and Dobrowolski (Re) [1995] O.C.P.S.D. No. 12 (CPSO) (QL), the Discipline Committee has considered whether there must be evidence of continuing or current failure in order to find incompetence. Justice Greer, dissenting in part in the case College of Physicians and Surgeons of Ontario v. P.M.P., [2003] O.J. No. 2865 (Div. Ct.), discusses this aspect of continuing or current failure.

The Panel finds that, on the evidence heard, Dr. Adamo's record keeping was not up to what is reasonably considered to be an appropriate standard. However, the Panel also finds that extensive and appropriate changes have been made by Dr. Adamo, and are now in effect, such that this is no longer a problem. Therefore, the Panel finds that, on this matter of record keeping, there is no current failure to maintain appropriate standards and, therefore, no incompetence.

The Panel finds that, regarding the performance of barium enemas and upper gastro-intestinal examinations, there was a problem with equipment affecting Dr. Adamo's ability to take spot films. Dr. Adamo's evidence was that he attempted to overcome this by the way he performed the fluoroscopy. Dr. A gave testimony of these still images falling below standard. Dr. Adamo agreed that they did fall below standard at that time. Dr. A never observed the performance of fluoroscopy by Dr. Adamo. The fluoroscopy equipment has now been extensively upgraded, such that the standards are met. In Dr. D's report of July 2004, the standards were met, and Dr. A testimony was that he had no dispute with this fact. Therefore, the Panel finds that, although there was failure to maintain standards at the time of the alleged incidents, there was no evidence that Dr. Adamo is not now practicing appropriately and in accordance with standards. In fact, the evidence is that his current practice meets appropriate standards.

Regarding the examination of patient C, the Panel finds that there was no lack of care or incompetence in the matter, and that the barium impaction is a complication, which occurs infrequently, and was appropriately handled. The inability to identify the technician, while regrettable, had no bearing on the end result. In addition as discussed above, Dr. Adamo has made significant changes in record keeping and equipment such that deficiencies with respect to patient C have now been rectified.

The Panel considered the allegation of excessive views being taken for certain examinations. These were breast ultrasounds, mammography, and views of the lumbo-sacral spine. The inference was that this might be inappropriately for financial gain, and might be exposing the patient to harm by excess radiation.

Breast Ultrasounds. Dr. A gave testimony that these should be used as an adjunct to mammography. The Panel notes that the assessment reports from 2003 made no suggestion that breast ultrasounds were being performed in inappropriate circumstances or excessively. Ultrasound examinations are a matter of clinical debate as to their usefulness, and Dr. Adamo gave testimony that he considers them useful as an adjunct to mammography, but also useful even without mammography. He stated that, if a doctor orders one, then he would do it. The Panel does not have any compelling evidence before it that this is below the standard of care.

Mammography. Dr. A suggested in his testimony that an excessive number of views of breasts were being taken in one period in 2003. The Panel heard evidence that Dr. Adamo's clinics did not perform mammograms for the Ontario Breast Screening Program (OBSP), which Dr. A did not know. Patients examined under this program are self-referred. If there is found to be a problem, their family doctor is contacted, and they are called back for further examination. Dr. Adamo's clientele are referred to him by their doctor because of a perceived problem; and, in the light of the findings on that mammogram, further views are taken at the radiologist's discretion. Additionally, before the equipment was upgraded and because of the cassette size not being adequate for large breasts, extra views had to be taken to ensure full coverage. The Panel agrees that the extra views involve additional exposure of the patient to radiation, but the evidence before the Panel was that this could not be quantified, nor the risk of radiation estimated. In the circumstances, the Panel considers the extra views justified, and the situation has now rectified itself with the installation of

new equipment. The Panel does not find, in this case, that extra mammography views constitute incompetence, nor does it constitute unprofessional conduct.

Lumbo-sacral Spine X-rays. The Panel considered the evidence of Dr. A that he had examined the OHIP billing numbers for certain of the Metro Radiology Clinics for a six month period in 2003, in regard to numbers of lumbo-sacral spine x-rays. Dr. A agreed in cross-examination that, for some clinics, the numbers did not suggest too many extra views were being taken. He also agreed that one should also take into consideration what was written on the requisition, which he did not have the benefit of doing. He further agreed that he did not have any figures for other Toronto IHF's to establish a norm. Dr. Adamo testified that, in 1998, he had checked with an IHF assessor as to how many x-rays of lumbar spine should be taken and, finding out those numbers, he had instituted that, and all the radiologists were comfortable with it. Dr. B confirmed this practice in her testimony. Accordingly, the Panel finds that this is not below the standard of practice, and that the benefits outweigh the risks of radiology exposure.

The Panel finds that Dr. Adamo is a well-trained radiologist, as attested to by Dr. A on his evidence. Dr. Adamo has responded to criticism where needed and made changes. We found no evidence that any harm was being done to patients by his care although the Panel recognizes that harm need not be caused in order to make a finding of incompetence. Dr. A agreed that he had no basis for criticizing any ultrasound or x-ray images, or of Dr. Adamo's ability to diagnose competently, other than in the occasional case where it could be a genuine case of difference in clinical opinion. None of the assessment reports for Metro Radiology Clinics for February 2004 indicate any deficiencies in quality of images or diagnosis. The Panel finds that there is no current lack of skill in Dr. Adamo's work and, therefore, makes no finding of current incompetence.

In conclusion, after weighing all of the evidence presented, the Panel finds that Dr. Adamo committed acts of professional misconduct in that he has contravened a term, condition or limitation on his certificate of registration and falsified a record relating to his practice. In so doing, Dr. Adamo has engaged in conduct and acts relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Panel does not find that Dr. Adamo's inability to identify the technician, or his failure to admit his inability to identify the technician, amounts to professional misconduct. Last, the

Panel finds that the allegations of incompetence pursued in the hearing were not proven and it appears, in the areas discussed above, that Dr. Adamo is currently meeting appropriate standards of practice.

On March 30, 2007, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Adamo [2007] O.J. No. 1168.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Ciro Anthony Adamo, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of patients or any information that could disclose the identity of the patients pursuant to subsection 45(3) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

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

93(1) Every person who contravenes an order made under section 45 or 47 is guilty of an offence and on conviction is liable to a fine of not more than $10,000 for a first offence and not more than $20,000 for a subsequent offence.

On March 30, 2007, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Adamo [2007] O.J. No. 1168.

Indexed as: **Adamo (Re)**

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

IN THE MATTER OF a Hearing directed by the Executive Committee and the Complaints Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 36(1) and 26(2) of the ***Health Professional 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. CIRO ANTHONY ADAMO

Hearing Date: November 15, 2005
Decision/ Release Date: November 15, 2005

Publication Ban

On March 30, 2007, the Divisional Court altered the Discipline Committee's decision on penalty. See College of Physicians & Surgeons (Ontario) v. Adamo [2007] O.J. No. 1168.

REASONS FOR DECISION ON PENALTY AND COSTS

The Discipline Committee of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on April 4, 5, 6 and 7, 2005.

On September 2, 2005, the Committee delivered in writing its decision and reasons for decision, stating its finding that Dr. Adamo committed acts of professional misconduct in that he contravened a term, condition or limitation on his certificate of registration, falsified a record relating to his practice, and engaged in conduct and acts relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee heard evidence and submissions on penalty on November 15, 2005, and released its order orally and in writing at the conclusion of the hearing, with reasons to follow.

PUBLICATION BAN

On April 4, 2005, the Discipline Committee made an order pursuant to subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, prohibiting the publication or broadcast of the names of patients in this proceeding, or any information that could disclose the name or identities of patients.

EVIDENCE AND SUBMISSIONS ON PENALTY AND COSTS

Counsel for Dr. Adamo filed a brief of Reference Letters from professional colleagues and friends, and other evidence including community involvement and sponsorships, recent CME courses and supportive psychiatric evidence.

Counsel for the College submitted that the appropriate penalty would be the imposition of certain specified terms, conditions and limitations on Dr. Adamo's certificate of

registration and a recorded reprimand. College counsel also requested costs in the amount of $10,000.

Counsel for Dr. Adamo submitted that a reprimand was appropriate but that this was not a case for terms, conditions and limitations on Dr. Adamo's certificate, except perhaps for a course on medical ethics. She also submitted that costs should only be in the amount of $4,000.

DECISION AND REASONS FOR DECISION ON PENALTY AND COSTS

The Committee considered its findings, the evidence, and the submissions made by counsel in determining what the appropriate order should be.

The Committee took into account the factors of specific and general deterrence as well as the rehabilitation of the member. The Committee accepted that a recorded reprimand and a course on medical ethics were appropriate. However, the Committee concluded that, in the interest of public protection, additional terms, conditions and limitations on Dr. Adamo's practice were necessary because of the findings relating to honesty, integrity, and governability.

The Committee considered that certain of the terms, conditions and limitations proposed by counsel for the College were not appropriate, as they were directed primarily to the issue of incompetence, which was found by the Committee not to be proved, or to the issue of failure to maintain clinical standards of practice, which had not been alleged. The penalty order that a panel makes must relate to and bear upon the findings made. In another context this is expressed as "the punishment must fit the crime".

The Committee noted that the Regulations under the *Independent Health Facilities Act* require that the operator of facilities such as those operated by Dr. Adamo must have a quality advisor. The role of the quality advisor is to advise the operator with respect to the quality and standards of service provided in the independent health facility. A duty of the quality advisor is to ensure that policies and procedures designed for public safety at

the facility are being followed. This provides checks and balances and protects the integrity of the facility and the wellbeing of patients.

Although the Regulations call for an independent quality advisor, the Regulations permit, in exceptional circumstances, for an operator to be his own quality advisor. In the interest of public safety, having regard to the Committee's findings relating to a lack of honesty, integrity and governability, it is the view of the Committee that it should be a term, condition and limitation on Dr. Adamo's certificate of registration that he not be his own quality advisor in the diagnostic facilities that he and his family own or operate. Dr. Adamo's facilities are all in a large urban area where a suitable independent quality advisor should be readily available.

The Committee put its mind to the concern expressed by Dr. Adamo's counsel about the indefinite nature of such a restriction. It is our view that the public safety must be the key factor in our decision. Given the fundamental importance of trust, ethics and honesty in professional practice the Committee concluded that no time limit should be imposed on the duration of this restriction. If Dr. Adamo wishes to apply in the future for a removal of or amendment to such a restriction, where, for example, he is unable to find a qualified person to be a quality advisor for any specific facility, it would be open to him to do so and for another panel to consider any proposal in that regard. At this time it is our view that the duration of the term, condition and restriction should be indefinite. We would hope that Dr. Adamo would see it to be in his own best interest to have an independent quality advisor to advise him in respect to the facilities he operates.

In a case such as this the Committee would normally impose a period of suspension. However, since Dr. Adamo has already been prevented from practicing for thirteen and a half months, which is an even longer period than is likely to have been imposed, no further suspension is necessary or appropriate.

Finally the Committee decided that costs in the amount of $5000 were appropriate, rather than the $10,000 requested by the College, in view of the fact that some of the allegations were not proved.

ORDER

The Discipline Committee therefore ordered and directed that:

1. Dr. Adamo appear before the panel to be reprimanded;

2. The Registrar impose the following terms and conditions on Dr. Adamo's certificate of registration:

    i) Dr. Adamo shall complete a course in medical ethics approved by the College, at his own expense, and shall provide proof of having done so to the Registrar of the College or his designate on or before December 31, 2006;

    ii) Dr. Adamo shall appoint a quality advisor for his and his families' clinics who is acceptable to the College, and shall provide the College with a copy of the agreement between him or the clinic and the quality advisor, such agreement to be reviewed by and acceptable to the College.

    iii) Dr. Adamo shall inform the quality advisor of the policies and procedures in the clinic and of the quality advisor's obligation to ensure that the policies are being followed.

3. The results of this proceeding to be included on the register.

4. Dr. Adamo to pay the College costs in the amount of $5,000.00 within twelve (12) months of the date of this order