Indexed as: Handscomb (Re)

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

IN THE MATTER OF a Hearing directed by the Executive Committee of the College of Physicians and Surgeons of Ontario, pursuant to Section 36(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:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ARTHUR ROBERT GEORGE HANDSCOMB

PANEL MEMBERS:

DR. W. KING (CHAIR)
S. BERI
D. EATON-KENT
DR. F. SLIWIN
DR. J. WATTS

Hearing Date: September 8, 2008
Decision/Release Date: September 8, 2008
Release of Written Reasons Date: November 7, 2008

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") heard this matter at Toronto on September 8, 2008. At the conclusion of the hearing, the Committee stated its finding that Dr. Handscomb had committed an act of professional misconduct, and delivered its penalty order in writing, with written reasons to follow.

THE ALLEGATIONS

The Committee granted a motion brought by the College with the consent of counsel for Dr. Handscomb to amend a minor clerical error to the Notice of Hearing pursuant to Section 40 of the Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act* 1991, S.O. 1991, c.18 as amended (the "Code").

The amended Notice of Hearing dated September 5, 2008 alleged that Dr. Arthur Robert George Handscomb, a member of the College, had committed an act of professional misconduct:

i) Under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, in that he failed to maintain the standard of practise of the profession, and

ii) that Dr. Handscomb 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*, 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 practise, or that his practise should be restricted.

RESPONSE TO THE ALLEGATIONS

Dr. Handscomb admitted to the first allegation in the Notice of Hearing, that he failed to maintain the standard of practise of his profession with respect to his gynaecological

practice. Counsel for the College withdrew the second allegation in the Notice of Hearing - that of incompetence.

FACTS AND EVIDENCE

The following Agreed Statement of Facts was filed as an exhibit and presented to the Committee:

Facts

Background

1. Dr. Handscomb is a 73-year-old gynaecologist practising in Windsor, Ontario.

2. Dr. Handscomb obtained his medical degree at the University of Glasgow in 1960. He then completed a rotating internship in general medicine, surgery, gynecology, and obstetrics. In 1964, Dr. Handscomb became a member of the Royal College of Obstetricians and Gynecologists in England. In 1968, Dr. Handscomb moved to Canada and commenced practicing in Windsor, Ontario, where he has practiced since that time.

3. Dr. Handscomb obtained his specialist certification in obstetrics and gynecology from the Royal College of Physicians and Surgeons of Canada on December 3, 1969 and became a Fellow on September 23, 1972. Dr. Handscomb became a Fellow of the Royal College of Obstetricians and Gynecologists in London, England on June 1, 1978.

4. Dr. Handscomb held full privileges at all of the hospitals in Windsor until he relinquished some of those privileges when he voluntarily ceased obstetrics approximately eight years ago. When Dr. Handscomb turned 70 years of age, he was required by hospital rules to relinquish his surgical privileges.

Investigation by the College of Physicians and Surgeons of Ontario ("College")

5. In 2006, the Executive Committee of the College approved an appointment of investigators under section 75(a) of the *Health Professions Procedural Code* after a complaint was filed by patient A in October 2005, regarding the treatment and care provided to her by Dr. Handscomb.

6. The College retained the services of Dr. Z to review twenty-five patient charts from a walk-in clinic where Dr. Handscomb provided consultation services and fifteen patient charts from Dr. Handscomb's office practice.

7. Dr. Z opined that Dr. Handscomb met the standard of practice of the profession in his treatment and care of some of the patients, but failed to meet the standard of practice in the treatment and care provided to other patients. Specifically, Dr. Z opined that Dr. Handscomb failed to meet the standards of practice with respect to ruling out precancerous and cancerous lesions of the genital tract and in the management of abnormal laboratory test results. Attached at Tab 1 [to the Agreed Statement of Facts] are copies of Dr. Z's reports, dated August 31, 2007 and September 27, 2007 and December 4, 2007.

8. On September 2, 2008, Dr. Handscomb entered into an undertaking with the College to restrict his practice. Attached at Tab 2 [to the Agreed Statement of Facts] is a copy of the Undertaking signed by Dr. Handscomb.

9. Dr. Handscomb has registered and paid for the College's Record-Keeping for Physicians course scheduled for October 17, 2008.

Admission

10. Dr. Handscomb admits that he failed to maintain the standard of practice of the profession with respect to ruling out precancerous and cancerous lesions of the genital tract and in the management of abnormal laboratory test results in the treatment and care provided to some of the patients whose charts were reviewed by Dr. Z.

Dr. Z's reports dated August 31, 2007, September 27, 2007 and December 4, 2007 were attached to the Agreed Statement of Facts. Dr. Z opined that Dr. Handscomb met the standard of practise of the profession in the treatment and care of most of his patients but failed to do so with respect to the following specific issues which are summarised by the Committee as follows:

1. Failure to provide appropriate treatment or advice in the prevention of osteoporosis to a menopausal patient.
2. Failure to inform a patient of an abnormal test for diabetes mellitus.
3. Failure to initiate or perform an endometrial biopsy in five patients with abnormal uterine bleeding over the age of 40 years.
4. Inappropriate use of Provera in three of the above patients.
5. Failure to initiate further investigation of a possible pre-cancerous or cancerous lesion of the vulva in a timely fashion.
6. Failure to initiate or perform colposcopy in two patients where this was indicated

On September 2, 2008, Dr. Handscomb entered into an undertaking with the College to restrict his practise as follows:

1. To surgical assists only when a certified surgeon or other qualified physician is performing the surgery and in attendance.

2. To consulting at the Pregnancy Option Clinic operated out of the Windsor Regional Hospital at which he may counsel patients, give orders for ultrasounds and routine blood work and prescribe medications as required, only under the supervision of the clinic supervisor until January 31, 2009.

Dr. Handscomb has registered and paid for the College's Record-Keeping for Physicians course scheduled for October 17, 2008.

FINDING

The Discipline 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. Handscomb's admission and found that Dr. Handscomb had committed an act of professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he failed to maintain the standard of practise of the profession.

PENALTY

The Committee received a joint submission on penalty to include a reprimand and costs with the penalty to appear on the Register.

In its decision to accept the joint penalty submission, the Committee took the following facts and factors into consideration. The Committee heard from College counsel that the conduct should be regarded as serious, in that it consisted of a repetitive failure to follow-up potentially life-threatening illness, particularly in those instances of a failure to further investigate the signs of cancerous or pre-cancerous lesions. Failure to follow-up potentially abnormal laboratory results and failure to inform patients of those results, also represented significant failures to maintain the standard of care. In mitigation, counsel emphasized that Dr. Handscomb had given an undertaking to cease his office gynaecological practice and to restrict his activities to two areas in which continuing supervision could be maintained. In the case of surgical assistance, this supervision would be necessarily continuing; in the case of practise in the Pregnancy Options Clinic, it would be subject to supervision and monthly reports from the supervisor to the College,

at least until January 31, 2009. To date, all such reports have been satisfactory. Counsel also submitted that Dr. Handscomb had no previous disciplinary findings by the College in all his 40 years of practice in Ontario. Furthermore, Dr. Handscomb had been completely compliant with the College's requirements to date and his cooperation had saved the costs of a much longer hearing.

The Committee accepted the rule of law that a joint submission on penalty should only be rejected if it is felt to be contrary to the public interest and likely to bring the administration of justice into disrepute. The Committee was satisfied that the proposed penalty was appropriate with respect to the protection of the public (which the Committee regarded as being of prime importance) as well as individual and general deterrence, and the rehabilitation of Dr. Handscomb. The Committee also accepted the similarity between this penalty and two similar cases that were quoted by counsel – *viz.*, *CPSO v. Dr. Xuereb*, November 23, 1995 and *CPSO v. Dr. Vaidyanathan,* September 20, 2006.

The Committee therefore accepted the joint submission as to penalty made by counsel for the College and counsel for Dr. Handscomb.

ORDER

Therefore, the Committee ordered and directed that:

1. Dr. Handscomb appear before the Discipline Committee to be reprimanded, with the fact of the reprimand recorded on the Register.

2. Dr. Handscomb pay costs to the College in the amount of $3,650.00 by October 8, 2008.

3. The results of this proceeding to be included in the Register.

At the conclusion of the hearing, Dr. Handscomb waived his right to appeal to the Divisional Court with respect to both finding and penalty and the Committee administered the reprimand.