ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Duic,* 2025 ONPSDT 11
Date: March 18, 2025
Tribunal File No.: 24-011

BETWEEN:

College of Physicians and Surgeons of Ontario

College

- and -

Marko Duic

Registrant

FINDING AND PENALTY REASONS

Heard: February 6, 2025, by videoconference

Panel:
Jay Sengupta (panel chair)
Madhu Azad (physician)
Jose Cordeiro (public)
Joanne Nicholson (physician)
Linda Robbins (public)

Appearances:
Sayran Sulevani, for the College
Keary Grace and Azin Samani, for the registrant

RESTRICTION ON PUBLICATION

Pursuant to Rule 2.2.2 of the OPSDT Rules of Procedure and ss. 45-47 of the Health Professions Procedural Code, no one shall publish or broadcast the names of patients or any information that could identify patients or disclose patients' personal health information or health records referred to at a hearing or in any documents filed with the Tribunal. There may be significant fines for breaching this restriction.

Introduction

[1] On February 21, 2022, 19-year-old Patient A arrived at the emergency department of a hospital by ambulance. Patient A was assessed, treated and discharged by the registrant, Dr. Marco Duic, later that same day. She returned by ambulance on February 22, 2022. She required resuscitation, developed episodes of cardiac arrest and was admitted to the intensive care unit with septic shock post medical abortion. Following emergency surgery and another cardiac arrest from which she could not be resuscitated, Patient A died on February 24, 2022.

[2] The registrant did not contest the College's allegation that he committed professional misconduct by failing to maintain the standard of practice of the profession, and we made that finding at the hearing.

[3] We accepted the jointly proposed penalty of a reprimand, an immediate three-month suspension of the registrant's certificate of registration, a six-month period of clinical supervision by a College-approved supervisor upon his return to practice, followed by a reassessment of his practice by a College approved assessor and monitoring for compliance with these conditions. We also ordered payment of the College's costs in the amount of $6,000 in accordance with the tariff.

[4] The reasons for our decision are set out below.

Uncontested Evidence of Professional Misconduct

[5] Upon Patient A's return by ambulance to the emergency department on February 21, 2022, 23 days after a medical termination of pregnancy, she was seen by the registrant. He assessed her, noting diffuse abdominal tenderness with a peritonitic abdomen and diffuse guarding. The registrant ordered intravenous morphine, point of care urinalysis, laboratory studies, a pelvic ultrasound, and chest and abdominal x-rays. The registrant did not document a reassessment or a differential diagnosis of Patient A. He noted a provisional diagnosis of "abdominal pain not yet diagnosed ? cyclic vomiting" and discharged her with a prescription of 16 pills of oxycodone (Percocet).

[6] Two experts retained by the College, who are themselves experienced emergency medicine physicians, opined that the registrant had failed to maintain the standard of practice, demonstrated a lack of knowledge, skill and judgment in his care and treatment of Patient A and exposed Patient A to risk of harm and injury. They pointed to his failure

to perform additional tests, such as a CT scan to determine the cause of the patient's peritonitis, and to document and establish a reassessment, adequate differential diagnosis or discharge instructions prior to discharge.

[7] One of the experts also stated that the care provided in this case, with deficits in history taking, differential diagnosis and clinical reasoning, if provided to populations of patients, would likely cause harm to a substantial proportion of such patients.

[8] In light of the plea of no contest, and relying on the expert evidence, we found that the College had established the registrant failed to maintain the standard of practice of the profession under s. 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, SO 1991 c. 30, and had therefore committed professional misconduct.

Penalty

[9] The parties made a joint submission regarding penalty and costs. While the Tribunal has the discretion to accept or reject a joint submission made by the parties, we must exercise restraint and should not reject a joint submission unless it meets the "undeniably high threshold" that the proposed penalty "would be viewed by reasonable and informed persons as a breakdown in the proper functioning of the justice system" (see *R. v. Anthony-Cook*, 2016 SCC 43 at para 34; *Ontario College of Teachers v. Merolle*, 2023 ONSC 3453 (Div. Ct.) at paras. 27 and 28).

[10] The parties argued and we agreed that the proposed penalty is appropriate and reasonable in the circumstances.

[11] In *College of Physicians and Surgeons of Ontario v. Fagbemigun,* 2022 ONPSDT 22 at paras. 7 and 8, the purposes and goal of penalty orders are outlined as follows:

> Several purposes or values should be considered throughout the analysis and underlie the analysis of individual factors. The most important goal of a penalty order is the protection of the public. The public must have confidence in the member, the profession and in the College's ability to govern the profession in the public interest. Patients place their physical and mental health, their bodies and lives in the hands of physicians. The public expects that every member of the medical profession will protect that trust by acting in the interests of their patients and the public, upholding the high standards of the profession.
>
> Other penalty purposes support the goal of protecting the public. These include discouraging the member and other physicians from

> committing misconduct (specific and general deterrence), rehabilitating the physician, ensuring a safe return to practice where appropriate and expressing the Tribunal and the profession's disapproval of the misconduct.

[12] The misconduct in question is undoubtedly serious. The registrant's actions, specifically his failure to take certain steps (including ordering additional testing and making a referral) and the manner in which he took others (discharge with opioid pain killers), exposed the patient to a risk of harm and injury.

[13] While the registrant has a history of concerns brought before the ICRC when he was counselled and cautioned on four occasions regarding similar issues, he does not have a discipline history with the College. We agreed with the College that the absence of a discipline history is not a mitigating factor, but represents the absence of an aggravating one, and is more properly viewed as a neutral factor.

[14] There have been no substantiated complaints since the incidents at the heart of this matter. We accepted that this fact, along with his cooperation in this matter, the plea of no contest and proceeding by way of a joint position, obviating the necessity of a full hearing, are mitigating factors.

[15] While no two cases are completely alike, we were satisfied that the proposed penalty is in line with others put before us by the parties, in light of the goals of penalty orders as outlined in *Fagbemigun* (see *College of Physicians and Surgeons of Ontario v. Ghumman*, 2023 ONPSDT 9; *College of Physicians and Surgeons of Ontario v. Ateya*, 2019 ONCPSD 56, *College of Physicians and Surgeons of Ontario v. Yau*, 2017 ONCPSD 20; *College of Physicians and Surgeons of Ontario v. Sumner, M.G.*, 2013 ONCPSD 17). Having reviewed the specifics of those cases, we found that a three-month suspension is within a reasonable range of outcomes in similar circumstances.

[16] The reprimand, delivered at the hearing, along with the three-month suspension conveys the disapproval of the profession and the Tribunal of the misconduct. This serves the goals of both specific and general deterrence, while the supervision, reassessment and monitoring of the conditions are aligned with the goals of rehabilitation of the registrant and protection of the public.

[17] Accordingly, we granted the order sought jointly by the parties.

Order

[18] We therefore ordered:

Penalty

1. The Tribunal requires the registrant to appear before the panel to be reprimanded.

2. The Tribunal directs the Registrar to:

(i) suspend the registrant's certificate of registration for three (3) months commencing February 7, 2025, at 12:01 a.m.; and

(ii) place the following terms, conditions and limitations on the registrant's certificate of registration effective February 7, 2025, at 12:01 a.m

Clinical Supervision

(a) Prior to resuming practice after the suspension of his certificate of registration, Dr. Duic shall retain, at his own expense, a College-approved clinical supervisor, who has executed an undertaking in the form attached to this Order at Schedule "A" (the "**Clinical Supervisor**").

(b) For a period of six (6) months commencing on the date Dr. Duic resumes practice after the suspension of his certificate of registration, Dr. Duic may practice only in accordance with the terms of the Clinical Supervision set out herein and in Schedule "A".

(c) Dr. Duic shall cooperate fully with the Clinical Supervision of his practice, which shall include the following elements:

1. Dr. Duic and the Clinical Supervisor shall have an initial meeting to discuss the objectives for the Clinical Supervision and practice improvement recommendations;

2. Dr. Duic shall meet with the Clinical Supervisor at his Practice Location once every month after the initial meeting;

3. The Clinical Supervisor shall review at least fifteen (15) of Dr. Duic's patient charts at every meeting, selected at the sole discretion of the Clinical Supervisor;

4. The Clinical Supervisor shall keep a log of all patient charts reviewed along with patient identifiers;

5. The Clinical Supervisor shall discuss with Dr. Duic any concerns arising from the chart reviews;

6. The Clinical Supervisor will observe at minimum three (3) patient encounters at every meeting, to be selected at the sole discretion of the Clinical Supervisor;

7. The Clinical Supervisor will make recommendations to Dr. Duic for practice improvements and ongoing professional development and inquire into Dr. Duic's compliance with the recommendations;

8. The Clinical Supervisor will perform any other duties, such as reviewing other documents or conducting interviews with staff or colleagues, that the Clinical Supervisor deems necessary to Dr. Duic's Clinical Supervision; and

9. The Clinical Supervisor will provide a report to the College, at a minimum of once per month, or more frequently if the Clinical Supervisor has concerns about Dr. Duic's standard of practice. Such reports shall be in reasonable detail and shall contain all information the Clinical Supervisor believes might assist the College in evaluating Dr. Duic's standard of practice, as well as Dr. Duic's participation in and compliance with the requirements set out in this Order.

(d) Dr. Duic shall abide by the recommendations of the Clinical Supervisor.

(e) If a Clinical Supervisor who has given an undertaking as set out in Schedule "A" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Duic shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a person who is acceptable to the College and ensure that it is delivered to the College within that time.

(f) If Dr. Duic is unable to obtain a Clinical Supervisor in accordance with this Order, he shall cease to practice until such time as he has done so.

<u>Assessment of Practice</u>

(g) Approximately six (6) months after the completion of the period of Clinical Supervision, Dr. Duic shall, at his own expense, undergo a reassessment of his practice (the "**Reassessment**") by a College-appointed assessor (the "**Assessor(s)**"). The Reassessment may include chart reviews and direct observation, an interview with Dr.

Duic, his colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. The Assessor(s) shall submit a written report on the results of the Reassessment to the College.

(h) Dr. Duic shall cooperate fully with the Reassessment and with the Assessor(s).

(i) The results of the Reassessment will be provided to Dr. Duic and reported to the College and the Reassessment may form the basis of further action by the College.

Monitoring

(j) Dr. Duic must inform the College of each and every location at which he practices, delegates, or has privileges, including, but not limited to, any hospitals, clinics, offices, and any Out-of-Hospital Premises or Independent Health Facilities with which he is affiliated, in any jurisdiction (collectively the "Practice Location" or "Practice Locations"), within five (5) days of this Order. Going forward, Dr. Duic will inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.

(k) Dr. Duic will submit to, and not interfere with, unannounced inspections of his Practice Locations and patient records by a College representative for the purposes of monitoring his compliance with the provisions of this Order.

(l) Dr. Duic shall give his irrevocable consent to the College to make appropriate enquiries of OHIP, NMS and/or any person who or institution that may have relevant information, in order for the College to monitor his compliance with the provisions of this Order, and shall promptly sign such consents as may be necessary for the College to obtain information from these persons or institutions.

(m) Dr. Duic shall consent to the sharing of information between the Clinical Supervisor(s), Assessor(s) and the College as any of them deem necessary or desirable in order to fulfil their respective obligations.

(n) Dr. Duic shall be responsible for any and all costs associated with implementing the terms of this Order.

Costs

3. The Tribunal requires the registrant to pay the College costs in the amount of $6,000.00 by March 7, 2025.

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Marko Duic

Registrant

The Tribunal delivered the following Reprimand by videoconference on Thursday, February 6, 2025.

*****NOT AN OFFICIAL TRANSCRIPT*****

Dr Duic,

You have committed professional misconduct by failing to meet the standard of practice of the profession in your care of Patient A.

In the emergency room, patients – often acutely ill, distressed and highly vulnerable – rely on their physician for life-saving care. In this high-pressure setting, you are expected to take time-sensitive actions and use your critical reasoning skills to assess and determine an appropriate course of treatment. Failing to do so can lead to an increased risk of morbidity and mortality. Patients place their trust in you, expecting that you will prioritize their care.

Your management of Patient A—a 19-year-old who presented with a constellation of symptoms that you should have identified and promptly acted upon—showed a lack of knowledge, skill and judgment. This was evidenced by deficiencies in history-taking, the failure to formulate an appropriate differential diagnosis, and an absence of discharge instructions.

You did not take or document reasonable steps to mitigate the risk of serious harm in the event that Patient A had a life-threatening condition. Rather, you discharged Patient A with an opioid prescription for pain, with no plan for ongoing monitoring and reassessment.

Patient A later died.

These were not simply minor oversights; your care fell short of the standard of care expected of a reasonable, competent and responsible emergency room physician. One of the College's experts concluded that, if this pattern of care were applied broadly, it would likely cause harm to a substantial number of patients.

Your history before the College's Inquiries, Complaints and Reports Committee (ICRC) reflects previous concerns in your emergency room care, including deficiencies in assessments, incomplete examinations, inappropriate prescribing of opioids and inadequate documentation. This history has provided ample opportunity for you to address these areas of concern and improve. We are deeply concerned that despite these opportunities you are before this Tribunal today.

First and foremost, it is our duty to ensure that the penalty that this Tribunal orders is in the public interest. As such, your certificate of registration will be suspended for 3 months followed by significant terms, conditions and limitations upon your return to practice. These include a 6-month period of clinical supervision, followed by a practice assessment and then ongoing monitoring of your practice at all locations.

We strongly urge that you utilize this penalty as an opportunity for serious reflection and improvement. An unwavering commitment to delivering quality patient care is essential as a member of the medical profession. We hope this is the last time you appear before this Tribunal.