NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Bernard Norman Barwin, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the names and any information that could disclose the identity of patients and their families referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Patient A and Patient A's family are not subject to the publication ban, therefore, the terms set out above are not applicable to them.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 … is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Barwin, 2019 ONCPSD 39

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

IN THE MATTER OF a Hearing directed by
the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario
pursuant to Section 26(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:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. BERNARD NORMAN BARWIN

PANEL MEMBERS: **DR. S. BODLEY**
MR. P. PIELSTICKER
DR. M. DAVIE
MR. P. GIROUX
DR. R. SMITH

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. CAROLYN SILVER
MR. KIRK MAIJALA

COUNSEL FOR DR. BARWIN:

MS. MEGHAN O'BRIEN

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. GIDEON FORREST

Hearing Date: **June 25, 2019**
Decision Date: **June 25, 2019**
Written Decision Date: **August 19, 2019**

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on June 25, 2019**.** At the conclusion of the hearing, the Committee released a written order stating its finding that Dr. Bernard Norman Barwin committed an act of professional misconduct. In its Order, the Committee also set out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Barwin committed an act of professional misconduct:

a) 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 in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and

b) under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93), in that he has failed to maintain the standard of practice of the profession.

The Notice of Hearing also alleged that Dr. Barwin was incompetent as defined in subsection 52(1) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, as amended (the "Code").

RESPONSE TO THE ALLEGATIONS

Dr. Barwin did not attend the hearing. Counsel for Dr. Barwin attended on his behalf and entered a plea of no contest to the allegations in the Notice of Hearing.

PART I: THE FACTS

The following facts were set out in a Statement of Uncontested Facts and Plea of No Contest, which was filed as an exhibit and presented to the Committee:

1. Bernard Norman Barwin ("Dr. Barwin") is an 80-year-old former physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College") on August 17, 1976. Dr. Barwin resigned his certificate of registration with the College on August 30, 2014.

2. At the relevant times, Dr. Barwin practised at the Ottawa General Hospital and later at a clinic in Ottawa, Ontario. Dr. Barwin's practice involved infertility, hormone therapy, weight loss and transgender care.

Patient A and Ms AA

3. In around 1989, Patient A went to Dr. Barwin with her husband for infertility treatment in order to conceive a child. Patient A's husband stored sperm with Dr. Barwin, which Dr. Barwin was to use to artificially inseminate Patient A.

4. Patient A and her husband attended at Dr. Barwin's clinic on a number of occasions in 1989 for insemination attempts. Dr. Barwin represented to Patient A that he was inseminating her with her husband's sperm. At each insemination attempt, Dr. Barwin showed Patient A and her husband the straw containing the sperm that he was using to inseminate Patient A. Dr. Barwin asked Patient A and her husband to verify that her husband's initials or name were on it, in order to verify that Dr. Barwin was using Patient A's husband's sperm for the inseminations.

5. Patient A conceived through the infertility treatment provided by Dr. Barwin, and had a daughter, Ms AA, in 1990.

6. From the time of her birth until her young adult years, Patient A, her husband and Ms. AA believed that Ms. AA was the biological daughter of Patient A's husband.

7. In 2016, Ms. AA was diagnosed with celiac disease, which is genetic. Patient A and her husband do not have celiac disease. Ms AA and Patient A's husband underwent blood testing. Ms. AA's blood type is O+, but Patient A's husband's blood type is AB. Patient A's family learned that it is impossible for a person with type AB blood to conceive a child with type O blood. Patient A's family underwent DNA testing, which revealed that Patient A's husband was not Ms. AA's biological father. Patient A, her husband, and Ms. AA were shocked.

Patient B and Ms BB

8. In around 1990, Patient B and her husband went to Dr. Barwin for infertility treatment. Patient B and her husband decided to try to conceive a child through artificial insemination using sperm from an anonymous donor. Patient B and her husband were shown a donor card with biographical information about the donor, including that he was a medical student. They selected this donor because of certain traits and characteristics the donor had that were important to them.

9. Patient B and her husband attended at Dr. Barwin's clinic on a number of occasions for insemination attempts. Dr. Barwin represented to Patient B and her husband that all of the insemination attempts were performed using the anonymous donor sperm they had selected.

10. Through the infertility treatment provided by Dr. Barwin, Patient B became pregnant, and had a daughter, Ms. BB, in 1991.

11. Until late 2015, Patient B and her family believed that Ms. BB was conceived with anonymous donor sperm.

12. In the summer of 2015, Ms. BB became curious about her genetic background and decided to look for half-siblings. She contacted an online DNA registry, which matched her with a second cousin of hers who lived in New York City. Through contact with her second cousin and family tree research, Ms. BB determined that her second cousin was a relative of Dr. Barwin. Ms. BB began to suspect that Dr. Barwin was her biological father.

13. Ms. BB contacted Dr. Barwin to inquire whether he was her biological father. Dr. Barwin arranged for a DNA test and in an email dated October 2015, a copy of which is attached as Tab

1 to the Statement of Uncontested Facts and Plea of No Contest, confirmed to Ms. BB that he was her biological father. Dr. Barwin also sent an email in April 2016 to Patient B's husband, a copy of which is attached as Tab 2 to the Statement of Uncontested Facts and Plea of No Contest, and met with him to discuss the matter. In these emails and when he met with them, Dr. Barwin told Ms. BB and Patient B's husband that he did not know how this had happened and that the only occasion he had used his own semen was when he was calibrating an automatic sperm counter. This was false. Patient B and her husband felt betrayed and violated by Dr. Barwin.

14. In September 2016, Ms. BB and Ms. AA compared their DNA test results, which strongly suggested that they were half-siblings. Further DNA testing confirmed that they were half-sisters by way of the same biological father. Dr. Barwin is that biological father.

Civil Proceeding

15. Dr. Barwin is now the defendant in a class action lawsuit from his former patients and their children. It is alleged that:

(a) 50-100 children were conceived after their mothers received the wrong semen from Dr. Barwin;

(b) Of these, 11 children are genetically matched to Dr. Barwin through DNA testing with Ms. AA and/or Ms. BB;

16. The class action was commenced in 2016 and attracted media coverage. The College initiated an investigation on the basis of the media coverage.

Patient C

17. Patient C and her husband were referred to Dr. Barwin for infertility treatment around 1975-1976. They decided to try to conceive a child through artificial insemination performed by Dr. Barwin. Patient C's husband provided sperm samples to Dr. Barwin, which were to be used to inseminate Patient C.

18. Patient C and her husband attended at the hospital for a number of insemination attempts performed by Dr. Barwin. Dr. Barwin represented to Patient C that all of the inseminations were performed using her husband's sperm.

19. After a number of attempts, Patient C conceived through the treatment provided by Dr. Barwin, and had twins, a boy and a girl. Dr. Barwin also provided pre-natal care to Patient C.

20. Until 2016, Patient C had complete trust in Dr. Barwin and believed that her children were the biological children of her husband. Patient C continued to see Dr. Barwin for routine gynaecological care for ten to fifteen years after her children were born.

21. Patient C and her husband raised their two children. They always believed them to be the biological children of Patient C's husband.

22. In 2016, Patient C and her husband saw media coverage about Ms. AA and Ms. BB. They subsequently obtained DNA testing for their children, which confirmed that their twin children are not the biological children of her husband, and that they are the half-siblings of Ms. AA and Ms. BB by way of the same biological father. Dr. Barwin is that biological father.

Patient D

23. Patient D and her husband went to see Dr. Barwin for infertility treatment in around 1975-1977 in order to conceive a child through artificial insemination performed by Dr. Barwin using Patient D's husband's sperm.

24. Patient D conceived through the artificial insemination treatment performed by Dr. Barwin. Her son was born in 1978.

25. Patient D raised her son believing him to be the biological son of her husband.

26. In 2016, Patient D's son saw media coverage about Ms. AA and Ms. BB, and noted similarities in appearance between Ms. AA and Ms. BB and himself. When he was in school, people had often joked that they thought he was adopted. Patient D's son subsequently

underwent DNA testing, which confirmed that he is the half-sibling of Ms. AA by way of the same biological father. Dr. Barwin is that biological father.

Patient E

27. Patient E and her husband went to Dr. Barwin for infertility treatment in around 1982. They were unable to conceive children and decided to try to conceive a child through artificial insemination provided by Dr. Barwin. The insemination was to be performed by Dr. Barwin using donor sperm chosen by Patient E, which Dr. Barwin represented was provided by an anonymous local medical student. Patient E specifically requested that Dr. Barwin use a donor who resembled her husband.

28. Patient E and her husband attended at the hospital to see Dr. Barwin for a number of insemination attempts. Dr. Barwin represented to Patient E that all of the inseminations were performed using the donor sperm chosen by Patient E.

29. Patient E conceived through the treatment provided by Dr. Barwin, and had a daughter in 1983.

30. Patient E and her husband returned to Dr. Barwin again for infertility treatment in 1986. Patient E again underwent artificial insemination provided by Dr. Barwin. The insemination was to be performed by Dr. Barwin using the same donor sperm as was used for her daughter, so that her daughter would have a full biological sibling. Patient E told Dr. Barwin that this was very important to her, and Dr. Barwin told her that it was the same donor.

31. Patient E conceived again, and gave birth to another daughter in 1987.

32. Patient E often felt that her first daughter resembled Dr. Barwin, but she would push those thoughts aside because she could not believe that Dr. Barwin would have used his sperm to father her child. Patient E and her husband saw media coverage about Ms. AA in 2016, and noticed that Ms. AA resembled their first daughter. Patient E's daughters subsequently underwent DNA testing, which confirmed that her first daughter is the half-sibling of Ms. AA by way of the same biological father. Dr. Barwin is that biological father. DNA testing revealed that

Patient E's other daughter is not the biological child of Dr. Barwin. This means that Patient E's children are biological maternal half-siblings, rather than biological full siblings. Patient E's family found this traumatic.

Patient F

33. Patient F and her husband went to see Dr. Barwin for infertility treatment in around 1989. Patient F decided to undergo artificial insemination provided by Dr. Barwin. The artificial insemination was to be performed by Dr. Barwin using donor sperm chosen by Patient F from an anonymous local medical student. Dr. Barwin told Patient F and her husband some information about the donor's background, appearance and interests. Patient F requested that Dr. Barwin use this donor for her alone. It was important to her to have children who were full biological siblings.

34. Patient F and her husband attended at Dr. Barwin's clinic for a number of insemination attempts. Dr. Barwin represented to Patient F and her husband that all of the inseminations were performed using sperm from her chosen donor.

35. Patient F became pregnant through treatment provided by Dr. Barwin, and had a daughter in 1990.

36. Patient F and her husband returned to Dr. Barwin for infertility treatment in around 1992. Patient F again underwent artificial insemination provided by Dr. Barwin. The artificial insemination was to be performed by Dr. Barwin using the same donor as for her first daughter, so that her daughter would have a full biological sibling. Dr. Barwin knew that Patient F wanted to have children who were biological siblings, and assured her that the sperm from her previous donor had been saved and would be used for her alone.

37. Patient F became pregnant through Dr. Barwin's treatment a second time, and her son was born in 1993.

38. In 2017, Patient F saw media coverage about Ms. AA, who she saw resembled her daughter. Patient F's daughter subsequently underwent DNA testing, which confirmed that she is

the half-sibling of Ms. AA by way of the same biological father. Dr. Barwin is that biological father. The DNA testing also confirmed that Patient F's son is not the biological child of Dr. Barwin. This means that Patient F's children are biological maternal half-siblings, rather than biological full siblings.

Mr. G

39. Mr. G was born in 1989. When he was in his twenties, Mr. G's parents told him that they had received fertility treatments to conceive him through *in vitro* fertilization (IVF) in Ottawa.

40. In around 2016 or 2017, Mr. G registered his DNA on a DNA registry website, which put him in contact with Dr. Barwin's family member in New York. Dr. Barwin's family member told Mr. G about Ms. AA and Dr. Barwin.

41. Mr. G subsequently underwent DNA testing, which confirmed that he is the half-sibling of Ms. AA by way of the same biological father. Dr. Barwin is that biological father.

Patient H

42. Patient H and her husband went to see Dr. Barwin for infertility treatment in around 2002 in order to conceive a child. Patient H and her husband decided to try to conceive a child through artificial insemination provided by Dr. Barwin. Initially, the inseminations were to be performed by Dr. Barwin using her husband's sperm, but after a number of attempts Patient H and her husband decided to try using donor sperm that she and her husband selected from a sperm bank, based on characteristics that were important to them.

43. Patient H and her husband attended at Dr. Barwin's clinic for a number of insemination attempts. At each appointment, Dr. Barwin showed Patient H the vial to verify that the donor number was printed on the label and that he was using the donor sperm she and her husband had chosen.

44. Patient H became pregnant through the treatment provided by Dr. Barwin, and her son was born in 2003.

45. Patient H later tried to have a second child through artificial insemination provided by Dr. Barwin. This child was supposed to be a full biological sibling of her son. Patient H purchased all the remaining samples from her donor and underwent several more treatments with Dr. Barwin. Dr. Barwin told Patient H that he would split the remaining samples and only use half of a vial at each attempt, in order to make them last longer. Patient H did not conceive another child.

46. After seeing media coverage about Ms. AA and Ms. BB in November 2016, Patient H looked for the donor on a donor sibling registry website. The donor that she had selected had voluntarily put his contact information on the site. Patient H contacted the donor and obtained DNA testing for her son and her chosen donor, which confirmed that her son is not the biological child of the donor she had chosen. The testing also confirmed that her son is not a half-sibling of Ms. AA or Ms. BB.

47. Patient H's son has learning disabilities. She is unable to locate any information about the medical history of her son's biological father. This has been very difficult for Patient H.

Patient I

48. Patient I and her husband were not able to have children, so they attended Dr. Barwin for infertility treatments in around 1987-1988. Patient I decided to try to have children through artificial insemination provided by Dr. Barwin. Patient I was to receive artificial insemination for two children, both from the same anonymous donor. Dr. Barwin told Patient I that the donor was a local medical student and gave Patient I some information about the donor, including that he had a similar background and the same blood type as Patient I's husband. Dr. Barwin only ever provided Patient I with a single donor profile.

49. Patient I and her husband attended at Dr. Barwin's clinic for a number of insemination attempts. Dr. Barwin represented to Patient I that he performed all of her inseminations with sperm from the same donor.

50. Patient I conceived twice through treatment provided by Dr. Barwin, and had two children: a daughter born in 1988, and a son born in 1989.

51. Patient I always trusted Dr. Barwin to use the same donor sperm for all inseminations. As such, she believed that her children were full biological siblings.

52. After Patient I heard about the lawsuit involving Dr. Barwin, she obtained DNA testing for her children, which confirmed that they are biological maternal half-siblings rather than biological full siblings.

Patient J

53. Patient J and her husband attended Dr. Barwin for infertility treatment in around 2003 and 2005. Patient J's husband provided samples of his semen that were frozen in 2002, which Dr. Barwin was to use to artificially inseminate her.

54. Patient J and her husband attended at Dr. Barwin's clinic for a number of insemination attempts. At each appointment, Dr. Barwin showed Patient J and her husband the vial, with her husband's name and date of birth printed on the sticker, in order to verify that he was using her husband's sperm. During the inseminations, Dr. Barwin had Patient J's husband push the plunger on the syringe, which was supposed to contain his sperm.

55. Patient J conceived through treatment provided by Dr. Barwin twice and had two children: a daughter, born in 2003; and a son, born in 2005.

56. In 2016, Patient J saw media coverage about Ms. AA and Ms. BB. Patient J subsequently obtained DNA testing for her children that confirmed that her husband was not their biological father.

57. Patient J's children are full biological siblings. Through DNA registry websites, Patient J was able to track down the donor that was used to conceive her children. The news that Patient J's children are not the biological children of her husband was very difficult for their family.

Patient K

58. Patient K attended Dr. Barwin for fertility treatment in around 1991-1993. Patient K underwent 11 artificial insemination procedures provided by Dr. Barwin. The artificial

insemination was supposed to be performed using sperm from a donor selected by Patient K from donor profiles provided by Dr. Barwin. Patient K reviewed the donor profiles Dr. Barwin provided and selected a donor based on the donor's medical history. The donor number selected by Patient K was stored in her patient chart, and Dr. Barwin represented to Patient K that all of her inseminations were performed using the donor sperm she had selected.

59. Patient K conceived through the treatment provided by Dr. Barwin, and her son was born in 1993.

60. Patient K decided to have a second child, and returned to Dr. Barwin for further artificial inseminations after her son was born. The insemination was supposed to be performed by Dr. Barwin using the same donor she had chosen for her son. Dr. Barwin knew that Patient K wanted her son to have a full biological sibling.

61. Patient K became pregnant again through the treatment provided by Dr. Barwin, and had a daughter, born in 1994.

62. After her daughter was born, Patient K requested a copy of the donor profile she selected from Dr. Barwin. Dr. Barwin provided Patient K with a donor profile that was not the one she had selected for her children. When Patient K pointed out to Dr. Barwin that the profile she had been given was not the donor she had selected, Dr. Barwin told Patient K that she should just be happy that she had two children. Patient K was upset, because it was important to her for Dr. Barwin to have used the donor selected and to have the information about that donor.

63. After seeing media coverage about the lawsuit against Dr. Barwin, Patient K obtained DNA testing for her children, which confirmed that they are biological maternal half-siblings, rather than biological full siblings. This confirmed that, contrary to what she had been told at Dr. Barwin's clinic, Dr. Barwin did not use the same donor for both of her children.

Patient L

64. Patient L went to see Dr. Barwin for fertility treatment in around 1994-1996. She underwent artificial insemination provided by Dr. Barwin. The artificial insemination was

supposed to be performed by Dr. Barwin using donor sperm. Dr. Barwin provided Patient L with background information on the donor, including ancestry, height, and eye colour.

65. Patient L conceived through the treatment provided by Dr. Barwin, and her son was born in 1994.

66. Patient L returned to Dr. Barwin for further artificial insemination after her son was born. Dr. Barwin was supposed to perform the insemination with the same sperm donor as was used for her son.

67. Patient L conceived again, and her daughter was born in 1996.

68. Patient L's two children have undergone DNA testing, which confirmed that they are not biological full siblings, and that Dr. Barwin did not use the same donor sperm for both of Patient L's children.

Patient M

69. Patient M and her husband went to see Dr. Barwin for infertility treatment in 2002. Patient M's husband had previously frozen his semen prior to receiving treatment for a medical condition. Patient M underwent a number of artificial inseminations provided by Dr. Barwin. Dr. Barwin was to use the sperm Patient M's husband had previously frozen and provided to Dr. Barwin. At the appointments, Dr. Barwin showed Patient M the straw with her husband's name and birth date on it in order to verify that he was using her husband's sperm.

70. Patient M conceived through the treatment provided by Dr. Barwin, and her daughter was born in 2003.

71. After Patient M saw media coverage about Dr. Barwin, she obtained DNA testing for her daughter. The DNA test confirmed that her daughter is not the biological daughter of Patient M's husband.

72. Patient M's daughter grew up believing Patient M's husband to be her father. Patient M and her husband have not told their daughter that Patient M's husband is not her biological

father. Patient M and her husband have had a difficult time as a result of the news that Patient M's husband is not her child's father.

Dr. Ed Hughes

73. The College retained Dr. Edward G. Hughes, an experienced obstetrician/gynecologist who practises fertility medicine and works as a faculty member at McMaster University, to review this matter and opine on Dr. Barwin's care. In his reports, Dr. Hughes opined as follows:

> ***Was Dr. Barwin's care below the standard for the relevant time period?***
>
> My response to this question is based on the practice of other REI [Reproductive Endocrinology and Infertility] clinics and physicians at that time and what was taught to Residents and Fellows in training. It was always made clear to these clinicians that preparing and administering gametes to patients is a very serious process with a debt of care to both the potential parent(s) and unborn children. As such, profound care and diligence were expected and required in this process, similar in many ways to the administration of a blood transfusion or the transplantation of an organ. Failure to get this right could result in serious harm to recipients and their children. And yet the actual process of handling and administering gametes was and is, straightforward. It requires great care and attention to detail, but the steps required are simple: careful cleaning, preparation, identification and labeling, careful handling of gametes, then multiple cross-checking with staff and the recipient-patient(s). Careful, accurate and secure record keeping is also mandatory. This degree of care and attention ensures that patients receive the correct sample: the one with which they expected to be inseminated.
>
> Dr. Barwin's handling and administration of gametes to his patients fell well below the expected standard of care. […] That standard was to provide safe, effective and secure management of patients' gametes, to communicate with them clearly and honestly about the nature of the

> husband- or donor- sample being used for insemination and to keep accurate and complete records of what has transpired. Repeatedly, over several decades, his care fell below this standard. However, it is the scale of this deficiency that's startling, with up to 51 cases so far identified with the wrong paternal DNA and 11 so far identified with Dr. Barwin's as the biological father.
>
> ***Lack of knowledge, skill or judgment?***
>
> …
>
> Though it's hard to be certain, Dr. Barwin was likely well informed and up to date with developments at the time. However, the extraordinary number of cases involving the administration of incorrect samples to patients, suggest that he lacked the basic skills required and expected, in the management of samples and records relating to them.
>
> Regarding the insemination of patients with his own sperm, could lack of knowledge or skill have been to blame? Dr. Barwin suggested to two patients that his paternity must have occurred as a result of accidental contamination, resulting form *[sic]* his failure to clean an automated counting chamber that he tested using his own sperm (explanation given to Patient B's husband, Ms. BB's father…). He told Ms. BB and her father that "at the time I was testing a new automated sperm counter and used my own sample as a control" (email to Ms. BB's father).

74. Dr. Hughes considered Dr. Barwin's explanation involving Dr. Barwin's use of an automated sperm counter, which Dr. Barwin provided to Ms. BB and Patient B's husband as the reason for him being the biological father of Ms. BB. Dr. Hughes outlined several reasons why Dr. Barwin's explanation is implausible, and concluded that it could not have been the cause of all of the errors:

> "Counting" sperm is a process that uses only a tiny aliquot of the whole semen sample and that aliquot is always subsequently discarded. It usually measures between 50 to 70 microliters or approximately 3% of a 2.5ml ejaculate. The aliquot is taken from the whole sample with a clean, sterile, disposable plastic micropipette tip and placed on a microscope slide or into an automated counting chamber for evaluation. The micro-pipette tip used to draw up the aliquot is immediately discarded, once the 75 microliter droplet has been placed into the counting chamber. Once that evaluation is done, whether manually or automatically, that slide is also discarded. The micro-drop of semen assessed is never, ever, reintroduced into the sample being processed for insemination. Failure to clean the counting chamber might thus interfere with and confound the counting of the next sample to be evaluated, but would not introduce any of Dr. Barwin's sperm into the patient's insemination sample.
>
> …
>
> For a single pregnancy to have occurred in these ways would have been remarkable. For eleven pregnancies to have been sired in this way, over two or more decades is neither statistically plausible nor believable.
>
> …
>
> … Even if Dr. Barwin had continued to make the same error over and over again, because he was testing yet another 'new automated sperm counter,' the 11 pregnancies so far identified from his sperm would simply not have been conceived, based on the above explanations and probabilities. The use of his own sperm thus appears to be unrelated to poor skill, knowledge or judgment.

75. Dr. Hughes opined on whether Dr. Barwin's actions caused harm to patients:

… Dr. Barwin's actions have resulted in significant pain and suffering that will extend forward through future generations, as offspring have their own children and grandchildren.

Whether Dr. Barwin's actions were accidental or willful, the suffering he has caused remains deep and wide. Husbands and partners have been denied a genetic link to their offspring. Siblings now find that not only do they have an unknown man as their biological parent, they are not paternally related to each other. Mothers expecting their husbands' sperm or those of a particular donor's to be used, instead have conceived and birthed biologically unrelated children.

Offspring are living an avoidable genetic disconnection from their fathers and have no access to their genetic heritage. This clearly has and will continue to create stress, angst and pain among families. The children whom Dr. Barwin fathered himself are burdened in these and other even more profound ways. They know that their own DNA and that of their children and beyond, will always be linked to him and his actions.

…

It is thus clear that Dr. Barwin's insemination practice leaves in its wake, deep, wide and extraordinary harm to the parents who in good faith and trust, sought his care and to their affected offspring. His patients trusted him.

….

The children whom Dr. Barwin's patients bore, also attest to the pain he caused. The sample of interviews conducted by Ms. Jenereaux sheds some light on the scope of this harm, but many other voices have not informed this report. Some of those are seeking redress through a class action suit, but still other patients may be suffering in silence because fear or shame prevents them from coming forward. It is impossible to know how many of

> those cases exist, but it seems likely to me that patients who know about, but have been unable to face up to their circumstances, may actually be suffering more acutely and deeply than those who have come forward, because they have no options for support or redress.
>
> Remember too, that many patients in a fertility practice fail to conceive. As many as half of the couples presenting for care may remain childless, because of advanced maternal age and other negative prognostic factors. Thus, for 51 children to have been born with incorrect sperm heritage, as many as 100 may have received the wrong sperm during their treatment. And for 11 babies to have been born as a result of Dr. Barwin inseminating women with his own sperm, others were very likely subjected to it, but failed to conceive. The point here is that we are seeing some of the scope of harm, but not all of it.

76. Dr. Hughes concluded:

> Clearly, when delivering care to patients, accidental harm occasionally occurs, despite due diligence and adherence to the standard of care. The appropriate response to such accidental harm is to understand and learn from what has happened, take responsibility for any avoidable elements and make redress for those. Did Dr. Barwin adhere to these standards? With regard to the 51 babies conceived with the 'wrong sperm,' clearly not. Regarding the use of his own sperm, could Dr. Barwin have done this accidentally? With eleven offspring so far identified and an implausible explanation given to two of them, again I believe not.
>
> Did Dr. Barwin's practice fall below the standards of care for that time? Absolutely.
>
> Was his knowledge below standard? Uncertain.
>
> Were his skills below standard? Yes.

Was his judgment below standard? Yes.

Was harm done to patients? Yes. This is a tragic situation, in which a sea of avoidable harm was done.

PART II – PLEA OF NO CONTEST

77. Dr. Barwin pleads no contest to the facts as set out above and does not contest that, based on these facts, he failed to maintain the standard of practice of the profession, contrary to paragraph 1(1)2 of O. Reg. 856/93, engaged in acts or omissions relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonorable or unprofessional contrary to paragraph 1(1)33 of O. Reg. 856/93, and is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code.

RULE 3.02 - PLEA OF NO CONTEST

Rule 3.02 of the Discipline Committee's Rules of Procedure regarding a plea of no contest states as follows:

> 3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:
>
> (a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
> (b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
> (c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

FINDINGS

The Committee accepted as correct all of the facts set out in the Statement of Uncontested Facts and Plea of No Contest. Having regard to these facts, the Committee found that Dr. Barwin committed an act of professional misconduct in that, he has engaged in an act or omission relevant

to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and he has failed to maintain the standard of practice of the profession. The Committee also found that Dr. Barwin is incompetent.

STATEMENT OF FACTS RELEVANT TO PENALTY

Dr. Barwin's History with the College

1. On February 15, 2012, Dr. Barwin entered into an undertaking with the College to voluntarily cease the practice of artificial insemination and intrauterine insemination (IUI).

2. Dr. Barwin was the subject of a Discipline Committee hearing on January 31, 2013 regarding errors in his IUI practice. A copy of the reasons of the Discipline Committee, dated March 27, 2013, is attached at Tab 1 to the Agreed Statement of Facts on Penalty.

3. The hearing proceeded by way of an agreed statement of facts and admission. Dr. Barwin admitted that in two cases, he failed to use the donor sperm selected by the patients, and that in two other cases, unbeknownst to the patients, he failed to use the patients' husbands' sperm. The Committee ordered a two month suspension of his certificate of registration, a reprimand, and costs.

4. Following another complaint involving a child conceived with sperm that did not match the intended father, Dr. Barwin entered into an undertaking effective August 30, 2014, resigning his certificate of registration with the College. Dr. Barwin's undertaking to the College agreeing to resign and never re-apply is attached at Tab 2 to the Agreed Statement of Facts on Penalty.

PENALTY AND REASONS FOR PENALTY

Counsel for the College presented a draft order for the Committee to consider as to an appropriate penalty and costs order. The proposed penalty and costs order included: revocation of Dr. Barwin's certificate of registration; a public reprimand; and costs to the College in the

amount of $10,370 for the one day hearing. Counsel on behalf of Dr. Barwin did not contest the proposed penalty.

Counsel for Dr. Barwin indicated that Dr. Barwin has not practised for five years, and that if the Committee determined that it would impose a reprimand, Dr. Barwin would waive his right to appeal so that the reprimand could be administered today. Counsel for Dr. Barwin indicated that Dr. Barwin would not be attending for a reprimand even if the Committee ordered him to attend in person at a later date.

In considering a proposed penalty, the Committee must take into account the principles underlying penalty orders. A penalty must, first and foremost, protect the public. It must express the denunciation of the profession of the misconduct. A penalty must maintain public confidence in the integrity of the profession and in the College's ability to regulate the profession in the public interest. It must provide specific deterrence to the member and general deterrence to the membership, and where applicable, serve to rehabilitate the member.

The Nature of the Misconduct

Dr. Barwin's misconduct is of the most egregious kind. His actions were unimaginable, with a complete and utter disregard for his patients, their partners, their offspring and indeed future generations in perpetuity. He completely violated his patient's trust, as well as their bodies, by using his own sperm in place of the sperm of the patient's husband or their chosen anonymous donors. In other instances, Dr. Barwin used the sperm of either a different donor than the one chosen by the patient, or used the sperm of a donor in place of the sperm of the donor's husband. Each of these acts similarly violated his patients' trust and their bodies.

The Committee notes that Dr. Barwin provided no explanation to the fact that many of his patients were inseminated with his own sperm. The explanation Dr. Barwin provided to his patients (that he was testing a "new automated sperm counter") is completely unbelievable, in light of the opinion of Dr. Hughes. Dr. Hughes's opinion was that the use of Dr. Barwin's own sperm appears to be unrelated to poor knowledge, skill or judgment. In the absence of any credible explanation, the Committee does not know why Dr. Barwin deliberately used his own

sperm in place of the sperm of the patient's husband or selected donor. Whatever his motives for doing so, such deliberate actions, which are so contrary to a physician's duties, are reprehensible and abhorrent.

Further, the charade of permitting patients to specifically request insemination with the same donor sperm for subsequent pregnancies so their children could be full biological siblings, but using different sperm (either different donor sperm or his own sperm), was despicable. As Dr. Hughes comments in his expert report, "It was always made clear to these clinicians that preparing and administering gametes to patients is a very serious process with a debt of care to both the potential parent(s) and unborn children. As such, profound care and diligence were expected and required in this process." Dr. Barwin's actions clearly indicate he did not abide by this basic tenant of infertility care.

Dr. Barwin's patients trusted him. He violated that trust. His unsuspecting, extremely vulnerable infertility patients turned to him fully expecting and deserving to be treated ethically and professionally. Dr. Barwin abused his position of power as a physician in an incredibly cavalier and cruel manner.

The Statement of Uncontested Facts and Plea of No Contest, expert report excerpts of Dr. Hughes, and the heart wrenching victim impact statements, reveal the immense trauma and long-term consequences caused by Dr. Barwin's actions. Families have been disrupted, children's worlds shaken, some now with unknown paternal medical histories, all potentially with understandably significant pain and suffering caused by Dr. Barwin's substandard infertility care.

As Patient M stated in her victim impact statement:

> "How do you tell a child she is actually not related to her father?? I have tremendous anxiety about telling her as I'm not sure how she will take this news. That her father is not her biological father. That she is not exactly who she thinks she is."

Impact statements were also received from Mr. B, the husband of Patient B, and Mr. J., the husband of Patient J., directly speaking to the impact of Dr. Barwin's actions on them and how they felt violated by Dr. Barwin. As Mr. J. stated:

> "The final punch came as my wife and I settled into the reality of our situation and realized that there would be no living genetic legacy of the great love we've had for each other for the last twenty years…I see their mother's reflection when I look into their eyes but when I'm gone, my wife will not see me reflected back in her children. Instead she will see the eyes of a stranger whose genetic material was wrongly and perhaps maliciously put into my hands so that I could create someone else's babies."

The Committee finds Dr. Barwin's actions to be mindboggling. In addition, his actions cast a terrible shadow, not only on him, but on the profession as a whole.

Aggravating Factors

The Committee was aware that Dr. Barwin was disciplined previously for failure to maintain the standard of practice of the profession for insemination sample errors. It is of note that at that time, in 2013, there was no evidence that Dr. Barwin had used his own semen to inseminate a patient. Advances in technology with readily available DNA testing have revealed the astoundingly repetitive nature of the misconduct in this 2019 hearing. While a previous finding of professional misconduct is normally an aggravating factor, in this case, all of the patients in question were treated prior to his 2013 hearing. A finding of professional misconduct made after the conduct at issue cannot be used as an aggravating factor in determining the appropriate penalty.

However, staggering aggravating factors are that Dr. Barwin's unspeakable violations spanned decades of practice and involved many patients. To quote Ms. AA in her poignant victim impact statement, "…the scale of the impacts of Dr. Barwin's action is clear to everyone: it affects all sixteen of us who have found out that we were conceived with his sperm, it affects our parents, our partners and our children."

Dr. Barwin's initial attempt to explain away his paternity with Patient B, as an equipment error, is wholly unbelievable and particularly aggravating as he knew full well what he had done to betray the trust of Patient B, Ms. BB and indeed many, many others.

Further, when Patient K discovered that Dr. Barwin had not used the donor she selected and not used the same donor for both of Patient K's children (contrary to Patient K's instruction), Dr. Barwin's flippant and insensitive reaction was to tell her she should just be happy she has two children. This is shocking to the Committee and well outside the realm of any standard of practice of the profession. The deception, callousness, and failure to grasp the infinite repercussions of his actions are truly astonishing.

Mitigating Factors

Dr. Barwin's plea of no contest saved hearing time and the need for the College to call the patients to testify. However, unlike an admission of professional misconduct, a plea of no contest does not demonstrate that the member has admitted responsibility for the misconduct.

In light of the seriousness of the misconduct and the number of patients affected, the Committee gives little weight to Dr. Barwin's plea of no contest as a mitigating factor.

Prior Cases

Fortunately, there are no precedent cases of such appalling misconduct in Ontario. Dr. Barwin stands alone. The College did put a case from the Indiana Professional Licensing Agency before the Committee for consideration - *In the Matter of the License of Donald L. Cline, M.D.*

Like cases can be helpful to the Committee for guidance on disposition but of course are not binding on the Committee. Dr. Donald L. Cline surrendered his licence to practise medicine in the State of Indiana after it was revealed that he used his own sperm for insemination while telling his patients that he used their husbands' sperm.

It is of significance that Dr. Barwin entered into an undertaking in February 2012 to cease the practice of artificial insemination and intrauterine insemination before his first discipline hearing

in January 2013. In July 2014, Dr. Barwin signed a further undertaking to resign from the College. He also undertook to never re-apply in Ontario or any other jurisdiction. These previous undertakings ensured protection of the public from the date Dr. Barwin ceased the practice of insemination.

Conclusion

The Committee concluded that Dr. Barwin's atrocious misconduct must be sanctioned in the most strenuous way possible - by revocation of his certificate of registration. The Committee does not consider that any penalty short of revocation would be appropriate in the circumstances of this case. There is no place for the likes of Dr. Barwin in our medical profession.

A public reprimand serves to denounce a physician's misconduct, express the Committee's disapproval of the conduct, and send a strong message to the public and the profession that such misconduct will not be tolerated. It is regrettable that Dr. Barwin would not attend his public reprimand. The Committee was very disappointed by the profound disrespect for the College and indeed Dr. Barwin's patients and their families shown by his refusal to attend for the reprimand.

The Committee has the jurisdiction to order costs in appropriate cases where a finding is made. This is such a case. The amount of $10,370.00 is the tariff rate for one day of hearing and the Committee considered it appropriate to make such an award.

ORDER

The Committee stated its findings in paragraphs 1 and 2 of its written order of June 25th, 2019. In its Order, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Barwin attend before the panel to be reprimanded.

4. The Registrar revoke Dr. Barwin's certificate of registration effective immediately

5. Dr. Barwin pay costs to the College in the amount of $10,370 within 30 days of the date of this Order.

At the conclusion of the hearing, Dr. Barwin waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND
Delivered June 25th, 2019
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. Bernard Norman Barwin

The Panel would first like to express its frustration at your decision not to appear before it to receive what is clearly a well-deserved reprimand. It seems immensely unfair that you're not here to face the victims of your disgraceful conduct.

Your behaviour has been beyond reprehensible. Your patients represent a group who were vulnerable and you placed themselves and their families completely in your trust. You betrayed that trust, and by your actions deeply affected individuals and their families and caused irreparable damage that will span generations.

We have heard heart-wrenching Impact Statements that attest to the deep-seated harm that you have inflicted. Panel reprimands are generally used to communicate censure of our colleagues who have in some way failed the profession or our patients. That clearly seems inadequate in this case, as your appalling behaviour spanning decades and affecting multiple families and individuals, leads to a sense of disgust on the part of this Panel. I'm certain that sense is shared across the entire spectrum of our society.

It's unfortunate that at this time, all we can do is revoke your licence to practice medicine and to deliver this reprimand. We do, however, take some solace in the fact that you are no longer in a position to cause further harm.

Thank you. That concludes this hearing.