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 no person shall publish or broadcast the names and any information that could disclose the identity of patients 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.

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 or 47… 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: Barwin, N. B. (Re)

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. W. KING
S. DAVIS
DR. J. KIRSH
M. FORGET
DR. S. KAPOOR

Hearing Date: January 31, 2013
Decision Date: January 31, 2013
Release of Written Reasons: March 27, 2013

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 January 31, 2013. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered 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:

1. 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; and

2. under paragraph 1(1)33 of O. Reg. 856/93, 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.

The Notice of Hearing also alleged that Dr. Barwin is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the "Code"), which is schedule 2 to the *Regulated Health Professions Act*, 1991.

RESPONSE TO THE ALLEGATIONS

Dr. Barwin admitted the first allegation of professional misconduct in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession. Counsel for the College withdrew the second allegation of professional misconduct and the allegation of incompetence.

FACTS AND EVIDENCE

The following Agreed Statement of Facts was filed as an exhibit:

1. Dr. Barwin is a general practitioner with additional training in obstetrics and gynaecology. He has practised in Ontario in artificial insemination, among other areas of medicine since 1973.

Patient A

2. In 2003 and 2004, Patient A went to Dr. Barwin for the purpose of being artificially inseminated.

3. Patient A became pregnant in or about June 2004 as a result of the artificial insemination conducted by Dr. Barwin. Approximately three years later, Patient A found out, through DNA testing, that her child was not the product of the donor sperm she had instructed Dr. Barwin to use to inseminate her.

Patient B

4. In or about late 2006/ early 2007, Patient B went to Dr. Barwin with her sister, Patient C, who had agreed to act as Patient B's surrogate. Dr. Barwin was to artificially inseminate Patient C with the sperm of Patient B's husband.

5. Patient C became pregnant as a result of Dr. Barwin's artificial insemination of her, but discovered, through DNA testing in 2008, that her child was not the biological child of Patient B's husband.

Patient D

6. In or about 1985 and 1986, Patient D went to Dr. Barwin for the purpose of being artificially inseminated with her husband's sperm that he had frozen prior to receiving treatment for cancer in 1984.

7. Patient D became pregnant as a result of Dr. Barwin's artificial insemination of her. In approximately 2011, Patient D discovered, through DNA testing, that her son was not her husband's biological child.

Prior Error

8. The errors in the inseminations of Patients A and C occurred after Dr. Barwin had been notified by the College of an error he made in his insemination of another patient, Patient E, in 1994. Patient E discovered, following the birth of her child in June, 1995, that the child was not the product of the donor sperm she had instructed Dr. Barwin to use to inseminate her. Dr. Barwin was notified of this error by the College of Physicians and Surgeons of Ontario and states that he took some steps to endeavour to ensure that no such errors would occur in his practice in the future.

Expert Review

9. Although Dr. Barwin and an expert review were unable to identify any evident errors in the conduct of the artificial inseminations or in Dr. Barwin's office policies and procedures regarding his artificial insemination practice, in view of the outcomes in these cases, Dr. Barwin accepts that errors in his practice, which would fall below the standard of care, resulted in his failure to provide his patients with offspring from their intended biological fathers.

10. These concerns do not involve any other areas of Dr. Barwin's medical practice.

FINDING

The 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. Barwin's admission and found that he committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Barwin made a joint submission as to an appropriate penalty and costs order, which included a suspension of Dr. Barwin's certificate of registration, a public reprimand, and an order that Dr. Barwin pay costs to the College. In addition to the joint submission, counsel for Dr. Barwin entered into

evidence a brief of documents comprising Dr. Barwin's curriculum vitae, letters of support from his professional colleagues and past patients, and examples of Dr. Barwin's past awards and honours, following which counsel for the College read into the record patient impact statements from Patients B and D.

The Committee considered the proposed penalty with the knowledge that a joint submission should be modified and/or rejected only if to accept it would be contrary to the public interest and bring the administration of justice into disrepute. The proposed penalty was considered by the Committee to adequately satisfy the general principles of penalty, including upholding the integrity of the profession. Specifically, the suspension and reprimand are serious expressions of the profession's abhorrence of Dr. Barwin's misconduct, and will provide both a specific deterrent to Dr. Barwin as well as a general deterrent to the profession against similar acts. Dr. Barwin advised that he has ceased the practice of artificial insemination. Consequently, the public will be protected from any further misconduct of this nature.

Dr. Barwin's misconduct is somewhat mitigated by his cooperation with the College and admission of the allegations, thus sparing his patients from the stress and discomfort of testifying, and all parties from the time and expense of a lengthy contested hearing. However, Dr. Barwin's misconduct is aggravated by the fact that these errors occurred after he had been notified by the College of a prior error, of a similar nature.

Therefore, the Committee accepted the order as jointly proposed.

ORDER

Having stated the finding in paragraph 1 of its written order of January 31, 2013, on the matter of penalty and costs, the Committee ordered and directed that:

1. the Registrar suspend Dr. Barwin's certificate of registration for a period of two (2) months commencing immediately.

2. Dr. Barwin attend before this panel to be reprimanded.

3. Dr. Barwin pay costs to the College in the amount of $3,650.00 within thirty (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.